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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Richard Kennedy,
Petitioner,

vs.

Touchette Regional Hospital,
Respondent.

19IWCC0702

NO: 17 WC 26798

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 20, 2019, is hereby affirmed and adopted.

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

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

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

DATED: DEC 24 2019
O
DLS/rm
046

Deborah L. Simpson

Barbara N. Flores

DISSENT

I respectfully dissent from the decision of the majority. I would have increased the permanent partial disability awards for Petitioner's nasal fracture and multi-level cervical disc herniations to 15 percent and 25 percent of the person as a whole, respectively.

19IWCC0702

Petitioner, a 37-year-old psychiatric nurse, was attacked by an acutely ill and concomitantly aggressive patient on June 11, 2017. Petitioner sustained a nasal fracture with a deviated septum as a result of being punched in the face by the patient, with such force that the impact also resulted in cervical spine disc herniations at two levels between C3 and C5. While the arbitrator considered and gave appropriate weight to the Section 8.1b factors in the Act, I do not believe the overall permanent partial disability awards of 10 percent of the person as a whole for Petitioner's nasal injuries and 22 of the person as a whole for Petitioner's disc herniations fairly compensate Petitioner for the extent of the injuries sustained taking into consideration the particular facts of this case.

Petitioner underwent a nasal septal closed fracture repair and bilateral inferior turbinate submucous resection following the violent incident at work. He suffered from sleep apnea and nasal congestion that prevented uninterrupted sleep requiring additional treatment to ameliorate the ongoing symptoms after his accident.

Petitioner then underwent treatment for his neck pain, headaches, and right ear tinnitus. A cervical CT showed mild cervical spondylosis greatest at C5-C6 along with an associated disc bulge/protrusion and bilateral uncovertebral joint hypertrophy resulting in spinal canal or neural foraminal narrowing. Ultimately, Petitioner's condition was such that he was recommended for, and underwent, a two-level cervical disc replacement surgery not yet at age 40. When Petitioner submitted to a Section 12 examination by Dr. Hurford at Respondent's request she diagnosed a work-related injury, status-post nasal fracture and surgery with cervicogenic headaches, cervical disc herniation, and left upper extremity radiculitis. She opined that Petitioner's cervical disc problems required ongoing attention and gave work restrictions of limited patient contact, no lifting greater than 15 to 20 pounds, and no over-the-shoulder activities. Dr. Hurford further opined that Petitioner's pre-accident headaches reported on May 22, 2017 were consistent with atypical migraine and were different in quality than the traumatic headaches Petitioner now experienced. Petitioner continued to undergo medical treatment for his varied conditions after invasive surgeries and without complete relief requiring ongoing conservative care or at-home treatment to maintain some modicum of daily living given the outcome of his injuries.

Petitioner testified that he continues to suffer from bilateral hearing loss and tinnitus in his ears. He also continues to have daily neck pain and occasional radiating pain into his arm. While Petitioner returned to full duty work and has obtained employment that did not impact his earnings ability, his injuries have limited his quality of life and required him to modify the type of work that he performs within his industry given his ongoing symptoms. Therefore, I believe Petitioner's nasal fracture and multi-level disc herniations warranted awards of 15 and 25 percent permanent partial disability of the person as a whole, respectively.

Therefore, I respectfully dissent from the decision of the majority.

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

19IWCC0702

KENNEDY, RICHARD Case# **17WC026798**
Employee/Petitioner

TOUCHETTE REGIONAL HOSPITAL
Employer/Respondent

On 6/20/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.13% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0969 RICH RICH & COOKSEY PC
THOMAS C RICH
6 EXECUTIVE DR SUITE 3
FAIRVIEW HTS, IL 62208

5196 CLAYBORNE SABO & WAGNER
JENNIFER L BARBIERI
525 W MAIN ST SUITE 105
CHICAGO, IL 60602

19IWCC0702

19IWCC0702

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
CORRECTED ARBITRATION DECISION
NATURE AND EXTENT ONLY

RICHARD KENNEDY
Employee/Petitioner

v.

TOUCHETTE REGIONAL HOSPITAL
Employer/Respondent

Case # 17 WC 26798

Consolidated cases:

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Collinsville**, on **March 25, 2019**. By stipulation, the parties agree:

On the date of accident, June 11, 2017, 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 the accident was given to Respondent.

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

In the year preceding the injuries, Petitioner earned $59,999.68, and the average weekly wage was **$1,153.84**.

At the time of injuries, Petitioner was **37** years of age, ***married*** with **2** dependent children.

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

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

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 $692.30/week for a further period of **162.5** weeks, as provided in Section **8(d)2** of the Act, because the injuries sustained caused **the 32.5% loss of the body as a whole,** representing 10% loss of the body as a whole with respect to Petitioner's nose, and 22.5% loss of the body as a whole with respect to Petitioner's cervical spine.

Respondent shall pay Petitioner compensation that has accrued from **December 13 2018,** through **March 25, 2019**, 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.

Edna Lee
Signature of Arbitrator

6/20/19
Date

JUN 20 2019

19IWCC0702

FINDINGS OF FACT

On June 11, 2017, Petitioner was employed as a psychiatric registered nurse for Respondent, Touchette Regional Hospital. (T.8). On that day, Petitioner was working on the acute psychiatric unit with an aggressive patient. *Id.* Due to threats the patient was making against staff and other patients, it was determined that the patient should be medicated. *Id.* Petitioner called security to escort the patient to his room, where he gave the patient an intermuscular injection into his right deltoid. *Id.* After receiving the injection, however, the patient again became combative and aggressive, and Petitioner made the determination that the patient should be moved to a seclusion room until the medication took effect. *Id.* Petitioner exited the room to unlock the seclusion room when he was approached from behind by the combative patient, who had evaded the security guards in his path. (T.9-10). The patient spit on the right side of Petitioner's face, and threw a "big hook" at Petitioner's face, punching him on the left side of his nose. (T.10-11). Petitioner testified that he suffered a broken nose, a deviated septum, and two ruptured discs in his neck as a result of this incident. (T.10). Petitioner confirmed that he never had any treatment for issues with his nose or neck before this incident. (T.11).

After the assault occurred, Petitioner presented to the emergency department at Touchette Regional Hospital. (PX3). The triage department in the emergency room noted that Petitioner was an employee in the hospital's behavioral health department who had been "sucker punched" in the face by a patient, and noticed a deformity to his nose with a 1-2 centimeter laceration to the bridge of his nose. *Id.* A CT scan of Petitioner's maxillofacial bones was performed, which revealed a displaced nasal bone fracture and a deviated nasal septum on the right. *Id.* Petitioner was given prescription medication for pain, and advised to follow up with a specialist. *Id.*

Several days later, Petitioner followed up with Dr. Richard Maack, an ear nose and throat specialist. (PX4). Dr. Maack noted that Petitioner had sustained a nasal fracture after being punched in the face by a patient at work. (PX4, 6/13/17). The injury affected Petitioner's left eye, left cheek and nose, and he was having difficulty breathing through both nostrils. *Id.* Additional symptoms of nasal tenderness, nasal swelling, nasal obstruction nasal congestion, ear pressure, fatigue, throbbing pain in the forehead, left eye and posterior scalp were also documented. *Id.* Petitioner also had trouble concentrating, reading and writing. *Id.* It was noted that Petitioner had no prior problems with his nose. *Id.* On physical exam, Dr. Maack documented swelling in Petitioner's medial cheeks, lower eyelids, that his nose was shifted to the right, as well as deviated septums in the right nasal cavity anteriorly, and in the left nasal cavity posteriorly. *Id.* A nasal endoscopy was performed that day to confirm Dr. Maack's diagnoses of nasal fracture, septal deviation, nasal congestion and turbinate hypertrophy. *Id.* After the diagnoses were confirmed, Dr. Maack recommended surgery in the form of a closed nasal reduction. *Id.*

Surgery was performed on June 16, 2017 in the form of a nasal septal fracture repair, closed reduction of nasal fracture, and bilateral inferior turbinate submucous resection. *Id.* Intraoperatively, Dr. Maack identified a deviated portion of the bony maxillart crest, a bony spur, as well as septal fractures. *Id.*

Following surgery, Petitioner unfortunately developed thrush, for which he was prescribed Clotrimazole. (PX4, 6/19/17). Petitioner also experienced post-operative apneic spells during which he would wake up gasping for air. (PX4, 6/29/17). Suction of his nose was performed which revealed a large amount of debris, which was removed. *Id.* Petitioner was taken off work for another week due his inability to sleep. *Id.* At his final follow up appointment, it was noted that Petitioner still had congestion, and had been restless, with continued trouble sleeping without the use of sleep aids like hydrocodone, Nyquil or melatonin. (PX4, 7/11/17). Pain in Petitioner's occipital scalp was also documented, as well as posterior neck pain. *Id.* Petitioner was advised to follow up as needed. *Id.*

Petitioner ultimately sought consultation with an orthopedic spine specialist, Dr. Matthew Gornet, to address the symptoms of pain in his neck he experienced following the assault. (T.13). Specifically, Petitioner testified that he initially believed his symptoms were related to whiplash, but once he returned to work, he began experiencing shooting pain into his arms, particularly on the left side. (T.13-14).

Dr. Gornet evaluated Petitioner on September 1, 2017. (PX7, 9/1/17). He took the history of Petitioner's injury, and specifically that he had been punched in the face by a combative patient who he was attempting to sedate. *Id.* He noted Petitioner's ongoing complaints of neck pain and frequent headaches to both sides, left trapezius and left shoulder, as well as tinnitus in his right ear. *Id.* Petitioner did not recall any previous problems of significance with respect to his neck or shoulder. *Id.* On physical exam, Dr. Gornet noted a mild decrease in range of motion on flexion and extension. *Id.* Dr. Gornet recommended a cervical spine MRI, which was performed that day, and revealed a large disc herniation/annular tear at C5-6 as well as a bilobular herniation at C3-4 and particularly a large fragment in the foramen. *Id.* Dr. Gornet believed that Petitioner sustained a disc injury at C3-4 and C5-6, and recommended that Petitioner undergo injections centrally at C3-4 and C5-6. *Id.* If he was not improved, consideration could be given to disc replacement surgery at C3-4 and C5-6. *Id.* Dr. Gornet also prescribed Meloxicam and Cyclobenzaprine. *Id.* He also gave Petitioner light duty restrictions. *Id.*

Petitioner underwent the injections as recommended by Dr. Gornet, which were performed on October 10, 2017 and October 26, 2017. (PX9). Petitioner returned to Dr. Gornet following the injections with persistent symptoms in his neck, as well as headaches, and pain into the left trapezius and left shoulder. (PX7, 11/9/17). At that point, Dr. Gornet recommended disc replacement surgery at C4-5 and C5-6. *Id.* A CT myelogram was also recommended pre-operatively. (PX11; PX7, 11/9/17, 11/20/17).

Surgery was performed on December 8, 2017 in the form of cervical disc replacements at C3-4 and C5-6 with Prestige LP. (PX7, 12/8/17; PX12, 12/8/17). Intraoperatively, Dr. Gornet identified a large central annular tear at C5-6 as well as a central herniation with a component to the right as well as a foraminal component to the left. *Id.* He also identified a left foraminal herniation at C3-4, which he described as a much harder dissection. *Id.* At his initial post-operative appointment, Dr. Gornet also showed him an operative video documenting the large tear in his disc. (PX7, 12/21/17).

Petitioner was released to return to full duty work on January 22, 2018. (PX76, 1/18/18). Dr. Gornet noted that Petitioner continued to have symptoms of tinnitus in his right ear, for which he referred him back to an ENT specialist. *Id.* Petitioner continued to progress following surgery, and was ultimately released from care on December 13, 2018 at maximum medical improvement. (PX7, 12/13/18). It was noted that Petitioner had returned to work in psychiatric nursing. *Id.*

Respondent had Petitioner examined pursuant to Section 12 of the Act by Dr. Patricia Hurford on September 20, 2017. (PX14). Dr. Hurford took the history of Petitioner's injury on June 11, 2017, and noted that Petitioner had been punched in the front of his face from the right side, which resulted in a nasal fracture and noticeable neck and bilateral shoulder pain. *Id.* Dr. Hurford likewise noted that Petitioner had a marked increase in neck pain when he attempted to return to work, and that he ultimately came under the care of Dr. Gornet. *Id.* Dr. Hurford also noted that prior to Petitioner's work injury, he suffered three headaches in one week, which lasted approximately one (1) hour each, for which he was treated in the emergency room with a CT scan. *Id.* He was advised that the CT scan was normal, and Petitioner was diagnosed with an atypical migraine. *Id.* Dr. Hurford noted no ongoing headache symptoms as a result of those instances. *Id.*

On physical exam, Dr. Hurford documented significant tightness in the left posterior scalene versus the right, as well as tightness in the upper trapezius muscles with palpation, and trigger point in the cervical splenius capitas on the left-hand side. *Id.* Dr. Hurford's impression was status post work-related injury, post nasal fracture, cervicogenic headaches, cervical disc herniation and left upper extremity radiculitis. *Id.* She believed that Petitioner required additional medical treatment to address his cervical disc problems, and specifically, if the injections did not relieve Petitioner's symptoms, surgical consideration would be an acceptable approach. *Id.* Dr. Hurford believed that the headaches reported by Petitioner in May of 2017 were consistent with atypical migraines, and, by Petitioner's history, the quality and quantity of these headaches were different than the traumatic headaches he was currently experiencing. *Id.* She recommended light duty work restrictions for Petitioner. *Id.*

Petitioner submitted several photographs into evidence documenting his visible injuries in the days and weeks following the assault. (PX13). The Arbitrator notes that Petitioner's nose is noticeably broken in several of the photographs, and both of Petitioner's eyes are blackened and bruised. *Id.*

Respondent submitted several medical records into evidence confirming that Petitioner underwent testing for headaches on May 22, 2017 and May 24, 2017. (RX3)

Petitioner testified that despite the improvement following surgery with Dr. Maack, he still suffers from an ongoing problems in his right eardrum, as well as tinnitus, or a continuous ringing in both ears. (T.17). He also testified that he notices a static-like sound in his right ear with loud noises. (T.17). He testified that he returned to Dr. Maack, who advised him there was no further treatment he could offer him for the tinnitus. (T.19).

With respect to his neck, despite the improvement following surgery by Dr. Gornet,Petitioner testified he still has pain in his neck on a daily basis, for which he takes over-the-counter ibuprofen and Tylenol. (T.19). He testified he continues to notice pain and soreness in his scalp, and tightness in his shoulders. (T.19). Petitioner indicated he will still occasionally experience some pain radiating down his arm. (T.19). He testified that he still suffers from some reduced range of motion in his neck, and is cautious about looking too quickly over his shoulder. (T.20).

Petitioner testified that he is currently employed as a psychiatric nurse at St. Alexius Hospital in St. Louis performing essentially the same type of work he previously did for Respondent. (T.16). At work, he indicated that he is now unable to sit and chart for the same duration as he could prior to his injury, and notices a significant amount of tightness in his neck when he attempts to do so. (T.20). He testified that he will take intermittent breaks from the computer due to his lack of stamina. (T.20). Petitioner also testified that he will often experience a headache or an ache in his shoulder or neck after performing a physical hold on a patient. (T.20-21). Petitioner confirmed that while he did have a series of headaches prior to his injury, the headaches he has experienced following the work-related assault are different and come more regularly. (T.22).

Lastly, Petitioner testified that since the attack, he notices symptoms of PTSD, and specifically, that he is always conscious of his surroundings and looks over his shoulder or in mirrors to make sure no patients approach him from behind. (T.23). He testified that he feels very anxious when patients approach him from the rear. (T.23).

On cross-examination, Petitioner testified that he was involved in a motor vehicle collision approximately one year ago and confirmed that he was not injured. (T.26).

CONCLUSIONS OF LAW

Pursuant to §8.1b of the Act, permanent partial disability from injuries that occur after September 1, 2011 are to be established using the following criteria: (i) the reported level of impairment pursuant to subsection (a) of the Act; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. 820 ILCS 305/8.1b. The Act provides that, "No single enumerated factor shall be the sole determinant of disability." 820 ILCS 305/8.1b(b)(v).

(i) **Level of Impairment**: Neither Party submitted an AMA rating. Therefore, the Arbitrator gives no weight to this factor.

(ii) **Occupation**: Petitioner continues to work as a psychiatric nurse performing essentially same type of job duties he performed while employed with Respondent. (T.16). He testified that he must perform physical holds on patients, and will often notice pain or weakness in his neck or shoulder area after performing this type of maneuver. (T.20-22). He also testified that his ability to sit and chart for long periods of time has been adversely affected. *Id.* Therefore, the Arbitrator places greater weight on this factor.

(iii) **Age**: Petitioner was 37 years old at the time of his injury. He is extremely young and must live and work with his disability for the majority of his work-life expectancy. Pursuant to *Jones v. Southwest Airlines*, 16 I.W.C.C. 0137 (2016) (wherein the Commission concluded that greater weight should have been given to the fact that Petitioner was younger [46 years of age] and would have to work with his disability for an extended period of time), the Arbitrator places moderate weight on this factor.

(iv) **Earning Capacity**: There is no direct evidence of reduced earning capacity contained in the record. Based on the severity of Petitioner's injuries, however, the requisite treatment, and the strenuous nature of Petitioner's employment, it is reasonable to conclude that such repercussions will manifest in the near future. Therefore, the Arbitrator places no weight on this factor.

(v) **Disability**: As a result of his injury, Petitioner sustained serious injuries in the forms of a nasal facture with a deviated septum, and multi-level cervical disc herniations, both of which required surgical intervention. Specifically, Petitioner underwent a nasal septal fracture repair, closed reduction of nasal fracture, and bilateral inferior turbinate submucous resection, which revealed significant intraoperative findings. (PX4). Despite improvement following surgery, Petitioner testified that he has tinnitus in his ears, and hears a static-type of noise. (T.17) Petitioner's level of disability was corroborated by the medical records. Specifically, Dr. Gornet's records confirm that after both surgeries, Petitioner continued to have tinnitus in his right ear, for which Dr. Gornet referred him back to an ENT specialist. (PX7, 1/18/18).

Petitioner also underwent a two level cervical disc replacement surgery at C3-4 and C5-6 with significant intraoperative findings confirming disc herniations at multiple levels (PX7; PX12). Despite his improvement following surgery, Petitioner testified that he still experiences soreness in his neck on a daily basis, and takes over-the-counter ibuprofen and Tylenol to manage his symptoms. (T.19). He testified he continues to notice pain and soreness in his scalp, and tightness in his shoulders. (T.19). Petitioner indicated he will still occasionally experience some pain radiating down his arm. (T.19). He testified that he still suffers from some reduced range of motion in his neck, and is cautious about looking too quickly over his shoulder. (T.20).

Based upon the foregoing factors, the Arbitrator finds that Petitioner sustained serious and permanent injuries that resulted in the 32.5% loss of his body as a whole, representing 10% loss of his body as a whole for the injuries sustained to his nose, and 22.5% loss of his body as a whole with respect to his cervical spine pursuant to 8(d)(2) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Richard Sockol,
Petitioner,

vs.

City of Chicago,
Respondent.

19IWCC0703

NO: 12 WC 16021

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 17, 2019, 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.

There is no bond for the removal of this cause to the Circuit Court by Respondent pursuant to §19(f)(2) of the 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: DEC 24 2019
o12/5/19
DLS/rm
046

Deborah L. Simpson
Deborah L. Simpson

Barbara N. Flores

Marc Parker
Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

19IWCC0703

SOCKOL, RICHARD
Employee/Petitioner

Case# **12WC016021**

CITY OF CHICAGO
Employer/Respondent

On 6/17/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.14% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0391 HEALY SCANLON
DAVID P HUBER
111 W WASHINGTON ST SUITE 1425
CHICAGO, IL 60602

0113 CITY OF CHICAGO LAW DEPT
STEPHANIE LIPMAN
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

19IWCC0703

Richard Sockol
Employee/Petitioner

v. Case # **12** WC **16021**

City of Chicago
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Brian T. Cronin,** Arbitrator of the Commission, in the city of **Chicago,** on **March 22, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ 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 2, 2011***, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

Petitioner ***did*** sustain an accident December 2, 2011.

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

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

In the year preceding the injury, Petitioner earned ***$73,216.00***; the average weekly wage was ***$1,408.00.***

On the date of the accident, Petitioner was ***46*** 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 ***has*** paid Petitioner TTD and Maintenance benefits from ***December 29, 2011*** through ***February 12, 2017***, which represents ***267-4/7*** weeks, at a rate of ***$938.67***/week. AX1, RX1.

Respondent shall receive a credit for TTD and Maintenance benefits paid in the amount of ***$251,171.97***. AX1, RX1.

Neither Penalties or nor attorney's fees shall be imposed upon Respondent.

ORDER

Respondent shall pay the following unpaid medical bills as reflected in Petitioner's Exhibits 8, 9 and 10: from Midwest Orthopaedics at Rush in the amount of ***$310.80***, from Athletico in the amount of ***$573.00*** and from ATI Physical Therapy in the amount of ***$8,720.28***, respectively, pursuant to Section 8(a) and subject to Section 8.2 of the Act.

Respondent shall pay Petitioner ***$695.78***/week for ***262.50*** weeks since the December 2, 2011 accident has resulted in a ***52.5%*** loss of use of his person as a whole, pursuant to Section 8(d)2 of the Act.

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

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

Signature of Arbitrator

June 15, 2019
Date

JUN 17 2019

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Richard Sockol,	)	
	)	
Petitioner,	)	**12 WC 16021**
v.	)	
	)	
City of Chicago,	)	**Arbitrator Brian Cronin**
	)	
Respondent.	)	

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT:

This matter was previously heard by Arbitrator Peter O'Malley on Petitioner's Motion pursuant to §19(b) of the Act. Findings regarding accident, injury causation and necessity of medical treatment were made on March 27, 2013.

Petitioner's Testimony

On December 2, 2011, Petitioner was a 5'11", 215 lb., right-handed cement laborer foreman for Respondent, City of Chicago. Petitioner was a member of Local 76 Laborers Union. Petitioner testified that he was employed by the City of Chicago, Respondent, as a cement laborer since 1990. At the time of hearing, March 22, 2019, Petitioner was a member of Local 1001 Laborers, working for Respondent. Petitioner's work activities in 2011 included using tools to dig holes, using a jackhammer, shoveling stone, sand and debris, and pouring concrete. Petitioner testified that a jackhammer weighed approximately 95 pounds. He also used gas-powered saws and moved various construction materials including dirt, stone and concrete. Petitioner moved in and out of excavations frequently. Petitioner's employment in 2011

afforded him the opportunity to work overtime hours. On December 2, 2011, Petitioner arrived at work and was able to perform all of his duties without difficulty.

On December 2, 2011, Petitioner was working for Respondent in the capacity of laborer foreman with a Gradall earthmoving machine crew. On that date, the Gradall earthmoving machine on which Petitioner worked was inoperative. Therefore, Petitioner operated a Bobcat and to break up sidewalk concrete. He inserted the forks of the Bobcat under the concrete to lift it up. The forks flipped a piece of concrete into the air that proceeded to strike struck him on his left leg. His left knee was painful. He reported the incident to his superintendent, who witnessed the incident.

On cross-examination, Petitioner testified that he is not able to ski now. Pre-accident, he and his family skied every couple of years. He has three children. The oldest is 29 and the youngest is 18. Petitioner testified that he coached hockey this year and last year. Now he is on the ice with Dr. Amin's blessing. Before that, he had to coach from the bench. Petitioner testified that he attempted to kneel a couple of days ago but that his left leg sticks way out. Notwithstanding, he was able to change a tire. Petitioner testified that he is currently being accommodated by the City and that he is happy to be back at work. Petitioner testified that he never injured his left leg before the accident, and that since the accident, he injured his left leg when he slipped on ice.

Petitioner's Medical Treatment

On the date of accident, Petitioner reported to MercyWorks Medical Center. The staff examined him and released him to return to work. He worked with difficulty and experienced pain and swelling in his left knee. On December 28, 2011, his left knee was so inflamed that he was unable to bend it; he could not get out of his car. On December 29, 2011, he underwent an

MRI of his left knee. The radiologist concluded that he sustained an intrasubstance tear of the posterior horn of the medial meniscus. The radiologist also concluded that he had knee joint effusion and a contusion of the medial femoral condyle. PX 2, pg. 117. Petitioner continued to treat.

Petitioner saw orthopedic surgeon Brian J. Cole, M.D., on March 22, 2012. PX 2. Dr. Cole recommended a repeat MRI of the left knee to evaluate the contusion and meniscal tear and to assess whether Petitioner was suffering from Complex Regional Pain Syndrome ("CRPS"). Respondent denied authorization for the recommended MRI.

On May 5, 2012, Petitioner was taken by ambulance to Resurrection Medical Center with complaints of ongoing left knee pain that became worse after falling on his knee that day. PX 5 At that time, Petitioner was unable to straighten his left leg and was experiencing shooting pains in the leg. PX 5, pg. 84. On July 9, 2012, Petitioner returned to Dr. Cole at Midwest Orthopaedics at Rush who reiterated his recommendation that Petitioner undergo a repeat MRI of the knee to properly assess its condition. PX 2, pg. 91. On July 30, 2012, Dr. Cole noted that Petitioner was experiencing left knee osteonecrosis and avascular necrosis. He recommended Petitioner undergo pain management for CRPS and referred Petitioner to Sandeep D. Amin, M.D., at Rush Pain Center. PX 2, pgs. 89-90.

On August 24, 2012, Petitioner saw Dr. Amin, M.D., at Rush Pain Center. PX 3, PX11, PX12. Petitioner reported to Dr. Amin that he had been diagnosed with CRPS of the left leg; Dr. Amin concurred with that diagnosis. Dr. Amin formulated his diagnosis that Petitioner was suffering from CRPS because he exhibited the hallmark signs and symptoms of the condition: changes in skin color, pain as well as swelling, and signs of thickened toe nails and skin of the left lower extremity. PX 3, pgs. 167-169. All of these symptoms were consistent with Dr.

Amin's diagnosis of CRPS. Dr. Amin formulated a plan to administer a series of lumbar sympathetic blocks and to begin physical therapy to improve Petitioner's range of motion and strength in the left leg.

On September 20, 2012, Dr. Amin administered a lumbar sympathetic block. PX 4, pg. 76. He performed a second lumbar sympathetic block on September 25, 2012. PX 3, pgs. 182-183. Subsequently, Petitioner experienced some improvement in his symptoms. On October 10, 2012, Dr. Amin noted that Respondent's claims handler was not approving physical therapy. Dr. Amin noticed that Petitioner had decreased swelling but continuing discoloration and pain. Petitioner exhibited severely limited range of motion with both flexion and extension as well as with temperatures differences in the left leg versus the right leg. Petitioner experienced significant weakness in the left leg. Dr. Amin started him on Lyrica and recommended that he proceed with a trial treatment involving a tunneled epidural catheter and pain pump combined with physical therapy. PX 2, pg. 183.

Respondent's workers' compensation claims handler continued to dispute the necessity of Dr. Amin's recommended treatment plan. Dr. Amin adamantly urged immediate approval of his treatment plan to improve the condition of Petitioner's leg and improve his chances of regaining functionality. PX 2, pg. 184. The dispute continued through March 27, 2013 at which time Arbitrator O'Malley issued his decision on Petitioner's motion and hearing pursuant to Section 19(b) of the Workers' Compensation Act. PX1. The hearing took place on January 15, 2013. Two months after Arbitrator O'Malley issued his decision, Respondent approved placement of the tunneled epidural catheter on May 28, 2013. On June 20, 2013, Dr. Amin placed the tunneled epidural catheter. PX 3, pg. 133.

One week later, on June 27, 2013, Dr. Amin noted a 90% improvement in leg symptoms and recommended beginning physical therapy. By July 16, 2013, Dr. Amin noted improvement in his range of motion and strength with good control of pain symptoms. Accordingly, Petitioner only required the use of a crutch for long-distance walking. After holding a six-week trial of the tunneled epidural catheter pump, Dr. Amin removed it and noted that Petitioner had improved. Petitioner performed physical therapy three times a week. Although he was improved, Petitioner was still unable to walk down stairs and experienced occasional shooting pains during physical therapy.

In September 2013, Dr. Amin obtained a repeat MRI of Petitioner's left knee at Parkside Imaging, Ltd. PX 3, pg. 158. Dr. Amin noted that the MRI showed bone marrow edema consistent with a bone bruise as a result of trauma. On September 16, 2013, Dr. Amin recommended Petitioner be re-evaluated by Dr. Cole for consideration of trial implantation of a spinal cord stimulator. On October 31, 2013, Petitioner saw Dr. Cole at Midwest Orthopaedics at Rush. Dr. Cole noted that Petitioner had continuing pain and swelling and that he had been treating for CRPS. Dr. Cole noted that Petitioner would be restricted to desk work only with no kneeling, squatting, pushing or pulling and was only capable of limited stair use. PX 2, pg. 88. Dr. Cole suggested that he continue physical therapy for strength, mobility and flexibility. On January 21, 2014, Dr. Amin noted that Dr. Cole was not planning any surgical intervention to repair Petitioner's knee injury because of the possibility of exacerbating the CRPS. PX 3, pg. 90, PX 12, pg. 29. Dr. Amin continued Petitioner on Lyrica and discussed with him the possibility of implanting a spinal cord stimulator.

On January 7, 2014, Petitioner underwent a Functional Capacity Examination ("FCE") at Accelerated Rehabilitation. PX 6, pgs. 156-163. The FCE indicated that Petitioner had an

increase in symptoms after lifting weights. Additionally, Dr. Amin noted that Petitioner has finished multiple courses of physical therapy with minimal to moderate relief. PX 3, pgs. 88-89. He noted that Petitioner's CRPS symptoms diminished his function and his ability to engage in everyday activities. Dr. Amin stated that due to his decreased function and mobility that caused difficulty with everyday activities and work duties, he recommended a trial implantation of a spinal cord stimulator. He found such treatment option to be medically necessary to improve Petitioner's symptoms. PX 3, pg. 89, PX 12, pg. 10.

On May 22, 2014, Dr. Amin implanted a spinal cord stimulator at the L5-S1 level of Petitioner's back. PX 4, pgs. 58-59. Petitioner described the spinal cord stimulator as a small box implanted under his skin in his low back with electrical leads installed in his spinal column. Petitioner demonstrated, during his testimony, a small device approximately the size and shape of a cellular telephone or television remote control with which he adjusts the stimulation level of the spinal cord stimulator in his back. When Petitioner experiences increased symptoms, he can adjust the spinal cord stimulator to lessen the symptoms. Petitioner can adjust stimulation to address symptoms in various areas of his leg.

On February 3, 2015, Petitioner was seen by Dr. Amin who noted that the spinal cord stimulator was working well and required some adjustments to address Petitioner's symptoms. Dr. Amin further noted that Petitioner was capable of sedentary work with no crawling, kneeling or crouching and advised light-duty activity to avoid aggravation of pain or potential worsening of the conditions related to Petitioner's CRPS. PX 3, pg. 84. On August 11, 2015, Dr. Amin noted that Petitioner was still experiencing pain and burning in the area of his knee that was controlled with Lyrica. Petitioner was contemplating a return to work in some capacity for Respondent. PX 3, pgs. 80-81.

On October 13, 2015, Petitioner returned to Dr. Amin at Rush Pain Center. He reported that his pain was at a level of 6/10. Such pain was exacerbated by walking and relieved by rest. Petitioner reported an onset of right hip pain. PX 3, pgs. 78-79. Dr. Amin attempted to re-program the spinal cord stimulator to address right hip pain but was unsuccessful. On October 27, 2015, Dr. Amin prescribed Voltaren gel, which Petitioner used to address some of his pain. Petitioner continued to take Lyrica and was continuing to report right hip and calf soreness. PX 3, pgs. 76-77. On November 7, 2015, Petitioner reported to Dr. Amin that his right hip was "giving out." Dr. Amin assessed Petitioner with sacroiliitis as a result of limping, which led to the inflammation of the nerves in Petitioner's right hip. PX 3, pgs. 74-75. On December 3, 2015, Dr. Amin injected Petitioner's right sacroiliac joint, which produced some improvement by December 15, 2015. PX 3, pg. 71, PX 4, pg. 137.

Dr. Amin discussed with Petitioner a nerve ablation and diagnostic medial branch block, which might address ongoing right sacroiliac joint symptoms and potentially address some of Petitioner's ongoing pain symptoms. Dr. Amin performed a diagnostic medial branch block on January 7, 2016. Petitioner reported an improvement in his symptoms in the right sacroiliac joint. He noticed that it positively affected some of his other symptoms. PX 4, pgs. 96-97. On March 15, 2016, Petitioner was in the process of trying to find an accommodated position with Respondent that was within his physical capabilities. In June of 2016, Petitioner reported to Dr. Amin that he was doing well taking Lyrica and, at that point, was not taking opioids to address his symptoms.

On September 13, 2016, Petitioner was seen by Dr. Amin. He noted that Petitioner was doing well due to the functioning of the spinal cord stimulator and medication. Treatment had reduced his symptoms to minor aching around the left knee that worsened with increased activity

and cold weather. Dr. Amin noted that on the current regimen, Petitioner was stable. PX 3, pg. 61.

Petitioner returned to light-duty work as a concrete acting foreman on February 2, 2017. Petitioner's work is discussed below.

On March 7, 2017, Petitioner returned to Dr. Amin and reported increased leg swelling and pain following his return to work. PX 3, pg. 59. Dr. Amin noted that Petitioner was taking one to two Norco tablets per day. On July 25, 2017, Dr. Amin noted that Petitioner experienced a worsening in left shin pain following a fall. Dr. Amin noted that Petitioner should continue his current medication regimen.

Petitioner was seen by Dr. Amin on October 3, 2017 and January 9, 2018 and reported that his pain was well controlled with adjustment to the spinal cord stimulator and that he was taking Lyrica occasionally for pain.

On July 24, 2018, Petitioner was seen by Dr. Amin and reported two occurrences of burning pain in his left leg that was not covered by his spinal cord stimulator. PX 3, pg. 5. This required Dr. Amin to change the programming of his device to make the pain more manageable. Dr. Amin programmed the device to optimize coverage in Petitioner's ankle and foot. Petitioner returned to Dr. Amin on March 12, 2019 and reported that his pain was well controlled with the spinal cord stimulator and that he also took Lyrica for pain. Petitioner reported that he used Norco on a few occasions when he was unable to successfully reprogram his spinal cord stimulator. PX 3, pg. 2. Dr. Amin refilled Petitioner's prescription medication and recommended a follow-up visit in six months. Dr. Amin testified that in the future, Petitioner's spinal cord stimulator would require replacement batteries and reprogramming. PX 12, pgs. 12-13.

On behalf of Respondent, anesthesiologist Howard Steven Konowitz, M.D., testified. He agreed that Petitioner has CRPS as a result of his December 2011 accident. He disagreed with Dr. Amin's recommendation for the tunneled epidural procedure. RX 2, pgs. 37-38, 52.

Petitioner's Post-Injury Work for Respondent

Petitioner returned to work with Respondent on February 13, 2017. Although, technically, Petitioner maintains the position of "cement laborer," he testified that his current job duties require no physical work. Petitioner is employed in the role of data entry record keeper for various cement laborer crews employed by Respondent in the northern half of the City of Chicago. A different cement laborer with similar job duties performs data entry tasks for cement laborer crews in the southern half of the City of Chicago.

Petitioner visits cement-finishing crews to input, into a laptop computer, their time sheets and work progress notes. Petitioner secured this accommodated position by requesting an accommodated job with Respondent, City of Chicago, with the help of Dr. Amin. Dr. Amin assisted Petitioner in filling out the required paperwork.

Petitioner testified that his daily activities include driving his car to a construction trailer where he processes faxed forms from the previous day. He collects faxed paperwork for each new work day and maps a route in his territory. He drives to meet crews in the field, completes paperwork and enters the results in a laptop computer that he carries with him. Petitioner testified that each day he visits six to seven crews from 7:00 a.m. to 3:30 p.m., Monday through Friday. Petitioner testified that the heaviest object he picks up or carries during the day is typically the laptop computer. This is the only physical activity he performs. He testified that he avoids walking in excavations and does not handle tools or materials.

Petitioner testified that, as far as he knows, the job he has been given was specifically created for him. The person assigned to the southern half of the City of Chicago territory performs similar tasks. Petitioner testified that the person assigned to the southern half of the City also has physical restrictions and is in an accommodated position because of those restrictions.

Petitioner testified that, given his physical restrictions and limitations, he is no longer capable of performing work as a cement laborer or a cement laborer foreman. He specifically testified that if he were not in the accommodated position he currently occupies, he would be unable to work as a cement laborer or foreman either for the Respondent or out of the union hall.

Petitioner testified that as a result of his injured left leg and symptoms in his right hip, he is unable to kneel, squat or twist using his left leg. Petitioner testified that he experiences pain daily, which increases with activity. Petitioner testified that he can address some of his symptoms with the spinal cord stimulator using the remote control but that he is significantly restricted in the physical activity he is now able to do as compared with before his 2011 work-related injury. He is unable to work in an unrestricted manner, which he was able to do before his on-the-job injury. Petitioner's condition and restrictions are consistent with the medical records of Doctors Cole and Amin, the physical therapy records, the FCE and the testimony of Dr. Amin.

Petitioner testified that he applies Voltaren gel frequently and takes Norco two times per month on average to address pain symptoms. Petitioner occasionally takes Tylenol to address symptoms and is taking Lyrica every day to control his symptoms.

Petitioner testified that prior to his work-related injury, he was an active hockey coach and frequently went snow skiing. He described himself as active and healthy. After his injury,

he was unable to use ice skates. Recently, Dr. Amin has allowed Petitioner to use ice skates and Petitioner has started to use them on a limited basis. Petitioner testified that he can no longer ski or perform many of the other activities to which he was accustomed in the past. Petitioner testified that the week before the hearing he had been forced to change a tire on his car when it had gone flat. He testified and demonstrated that he experienced significant difficulty in changing the tire because he was unable to kneel and had to keep his left leg straight the entire time.

No lay witness testified on behalf of Respondent.

Dr. Amin testified that the battery in the spinal cord stimulator requires replacement every few years. PX 12, pg. 12. Petitioner continues to take medication. In addition, Dr. Amin is occasionally required to evaluate the performance of the spinal cord stimulator and adjusts it through a laptop computer, which is a more sophisticated procedure than using the remote control. PX 12, pg. 13. Petitioner testified that he returns to see Dr. Amin frequently and will require ongoing medical care on a permanent basis.

The Arbitrator finds that Petitioner is credible.

CONCLUSIONS OF LAW:

In support of his decision with regard 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:

Pursuant to Section 8(a) and subject to Section 8.2 of the Act, Respondent shall pay the following unpaid medical bills: from Midwest Orthopaedics at Rush in the amount of $310.80, from Athletico in the amount of $573.00, and from ATI Physical Therapy in the amount of $8,720.28. PX8, PX9, PX10. The Arbitrator finds such treatment to be reasonable, necessary and causally related to the accident.

In support of his decision with regard to issue (L) "What is the nature and extent of the injury?", the Arbitrator finds as follows:

Section 19(e) of the Act, states, in relevant part, the following:

> Decisions rendered by the Commission and dissents, if any shall be published together by the Commission. The conclusions of law set out in such decisions shall be regarded as precedents by arbitrators for the purpose of achieving a more uniform administration of this Act.

In *Robert Trevino v. City of Chicago, Dept. of Fleets & Facilities Mgmt.*, 19 IWCC 0081, claimant, at the time of accident, was a 66-year-old ironworker who sustained an injury to his right knee that necessitated surgery. Claimant was released to return to work with restrictions. He conducted a self-directed job search since he could not return to work as an ironworker. Subsequently, respondent offered him an accommodated position as a supervisor which he accepted. He did not perform heavy lifting, climbing, balancing, or work on a scaffold. Claimant testified that he did not perform his full duties as an ironworker. Without the

accommodation, claimant would be unemployable as an ironworker and would not be able to obtain employment outside of respondent as an ironworker. Yet, respondent paid claimant ironworker wages. Claimant testified that he had planned on working until age 70, but due to his knee injury, voluntarily retired at age 68. He worked 6-1/2 months as a supervisor. Claimant offered evidence of a wage loss but waived his right to recover under Section 8(d)1. The Commission affirmed the Arbitrator's permanency award of 37.5%, person as a whole, pursuant to Section 8(d)2 of the Act.

In *Gerald Hackman v. County Tree Service, Inc., and IWBF*, 17 IWCC 0847, claimant, at the time of the accident, was a 48-year-old tree trimmer who sustained acute head, brain, and neck injuries for which he underwent a craniotomy and additional surgery. As a result, claimant had a seizure disorder, adjustment disorder, impaired memory, double vision, impaired equilibrium, and was restricted from driving. He suffered a loss of trade and changed jobs. Claimant offered evidence of a significant impairment of earnings. The Commission awarded claimant a loss of use of his person as a whole to the extent of 60%, pursuant to Section 8(d)2 of the Act.

Pursuant to Section 8.1b of the Act, for accidental injuries that occur on or after September 1, 2011, the following criteria are to be used in the determination of permanent partial disability:

(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. The Arbitrator therefore gives no weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals Petitioner was employed as a cement laborer foreman, to which he was unable to return post-accident. Once Petitioner had the spinal cord stimulator implanted, he was only able to work for Respondent in a significantly accommodated position. Petitioner's current position is less physically demanding to the point that it is nearly sedentary work. The heaviest object Petitioner handles on a day-to-day basis is a laptop computer. Petitioner does not handle any tools, does not operate any equipment, and does not move construction materials such as dirt, sand, gravel, or cement. He does not kneel, squat, twist or navigate through excavations. The Arbitrator gives major weight to this factor and finds that it would increase permanency.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 46 years old at the time of the accident and 54 at the time of the permanency hearing. The Arbitrator views Petitioner as a middle-aged worker who could conceivably remain in the workforce another 11 years. The Arbitrator gives moderate weight to this factor and finds that it would increase permanency.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earning capacity, the Arbitrator notes that the record reveals that while it is true Petitioner is employed by Respondent, he is no longer afforded the opportunity to work overtime hours. Petitioner testified that his pre-accident job offered the opportunity for overtime earnings. Yet, no quantified evidence of an

impairment of earnings was offered into evidence. The Arbitrator gives moderate weight to this factor and finds that it would slightly increase permanency.

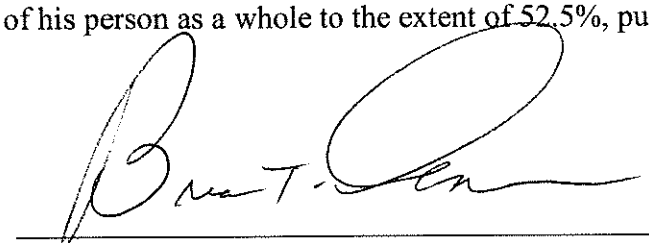
With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes the following:

On March 12, 2019, Dr. Amin noted that Petitioner is a 54-year-old male with CRPS on the left knee, which is well-controlled with a spinal cord stimulator. Per patient, pain is still well-controlled with current pain regimen and SCS. Dr. Amin further noted that Petitioner is currently on Lyrica, 150 BID, and that he still rarely uses Norco (he used it 1-2 x in the past six months during the polar vortex since he could not reprogram his device). PX3, pg. 2.

In his deposition of May 2, 2018, Dr. Amin testified that during the FCE, Petitioner tested at the medium physical demand level but that there was exacerbation of pain. It was a valid FCE that indicated he had reports of left knee pain, instability, and functional difficulty with kneeling and so, that activity was not recommended. It also indicated he had difficulty with crawling and crouching and so these activities were recommended on a minimal, occasional basis. Dr. Amin determined that Petitioner's work capabilities fall below the level at which he was tested and therefore found that he should do sedentary work. PX12, pgs. 19-21.

The Arbitrator gives major weight to this factor and finds that it would increase permanency.

Determination of permanent partial disability ("PPD") is not simply a calculation but an evaluation of the five factors. The Arbitrator has carefully considered all five factors. By applying §8.1b and by considering the relevance and weight of all five factors, the Arbitrator finds that as a result of the December 2, 2011 accident, Petitioner has sustained a permanent loss of use of his person as a whole to the extent of 52.5%, pursuant to Section 8(d)2 of the Act.



Brian T. Cronin
Arbitrator

6-15-2019
Date

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Wilbert Voss,
Petitioner,

vs.

Chicago Transit Authority,
Respondent.

19IWCC0704

NO: 17 WC 15753

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 15, 2019, 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.

There is no bond for the removal of this cause to the Circuit Court by Respondent pursuant to §19(f)(2) of the 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: DEC 24 2019
o12/5/19
DLS/rm
046

Deborah L. Simpson

Barbara N. Flores

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

19IWCC0704

VOSS, WILBERT
Employee/Petitioner

Case# **17WC015753**

CHICAGO TRANSIT AUTHORITY
Employer/Respondent

On 5/15/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.35% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4788 HETHERINGTON KARPEL & BOBBER
PETER C BOBBER
120 N LASALLE ST SUITE 2810
CHICAGO, IL 60602

0515 CHICAGO TRANSIT AUTHORITY
LAURA HARTIN
567 W LAKE ST 6TH FL
CHICAGO, IL 60661

19IWCC0704

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

Wilbert Voss
Employee/Petitioner

v.

Chicago Transit Authority
Employer/Respondent

Case # **17** WC **15753**

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 **Brian T. Cronin**, Arbitrator of the Commission, in the city of **Chicago**, on **3/15/2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] 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 _____

FINDINGS

On **2/27/2017**, Respondent ***was*** operating under and subject 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 $**94,954.60**; the average weekly wage was $**1,826.05**.

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

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

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

Respondent is entitled to a credit of $**14,608.44** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**14,608.44**.

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

ORDER

Respondent shall pay Petitioner $**119.37** for reasonable and necessary medical services, subject to the medical fee schedule, as provided in Section 8(a) and subject to Section 8.2 of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $**1,217.37**/week for **9-1/7** weeks, commencing **2/28/2017** through **5/2/2017**, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of $**14,608.44** for temporary total disability benefits that have been paid.

Respondent shall pay Petitioner permanent partial disability benefits of $**775.18**/week for **37.5** weeks, because the injuries sustained caused the **7.5%** 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

5/14/2019
Date

MAY 15 2019

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Wilbert Voss,	)	
	)	
Petitioner	)	
v.	)	
	)	Case No. 17 WC 15753
Chicago Transit Authority,	)	
	)	
Respondent.	)	

I. FINDINGS OF FACT

Petitioner, Wilbert Voss, was employed as a mechanic at the Chicago Transit Authority on February 27, 2017. Petitioner worked for the CTA for 23 years. On the date of accident, Petitioner was working on an air bag under the bus, under the right front wheel well. The air bag is a 12" x 10" rubber cylinder with a metal top and bottom, filled with 125 PSI of compressed air. Petitioner was working on the bus brake and the air bag unexpectedly exploded about a foot in front of his face. The force of the airbag explosion blew Petitioner's head and neck backwards and blew his body out of the wheel well and into his tool cart. Petitioner felt immediate pain in his neck, head, and ringing in his ears, but could not hear anything else.

Petitioner was taken to Concentra as a part of the formal procedure. Petitioner reported neck pain, stiffness, limited range of motion, mild visual disturbance, slight ringing in ears, and a mild headache. He was diagnosed with a neck strain/sprain, and post-concussive headache. He was referred for physical therapy. Petitioner was put on restricted sitting only duty. (PX 2). This could not be accommodated, and Petitioner was taken off work. The next day, Petitioner went to the Emergency Room at Franciscan Health Olympia Fields. He reported headaches, blurry vision, hyperextension of his neck, neck pain, ringing in his right ear, nausea, and dizziness. Petitioner underwent a CT scan of his head and neck, which were normal. He was diagnosed

with a concussion, cervical paraspinal muscle spasm and tinnitus. (PX 1). Petitioner continued going to physical therapy for his neck at Concentra. (PX 2).

On March 7, 2017, Petitioner attended a neurology appointment with Dr. Ro Young II, who is associated with Specialty Physicians of Illinois, LLC. Petitioner reported tinnitus, blurred vision, headaches, neck pain radiating into his shoulders, dizziness, forgetfulness, difficulty concentrating and photophobia. He was diagnosed with a concussion, post-concussive syndrome, and a cervical strain. He was referred for an MRI of his brain and neck. (PX 3). On March 15, 2017, Petitioner underwent an MRI of the brain (which was compared to the initial head CT scan). It revealed no evidence of acute intracranial process, a few scattered foci of high T2/FLAIR signal in the white matter, which may be related to mild chronic microvascular ischemic changes, migraines, and vasculitis. On the same date, Petitioner underwent an MRI of the cervical spine (also compared to the prior CT scan of the head and neck), which revealed mild to moderate degenerative changes of the cervical spine, most significant at C3-C4, mild intervertebral disc space narrowing at C3-C4, small posterior disc osteophyte complex causing mild central canal stenosis, and moderate neuroforaminal narrowing. (PX 1, PX 3).

Petitioner's last visit to Concentra was on March 24, 2017. The records indicate that he met his physical therapy goals for cervical impairment, but that his post-concussive symptoms of blurry vision and dizziness with functional activities prevented him from returning to work. (PX 2). On March 27, 2017, Petitioner returned to his neurologist, Dr. Young. He reported dizziness, blurred vision, and headaches. Dr. Young found that the MRI of the brain was negative, and he felt the cervical spine MRI only revealed degenerative changes. Dr. Young diagnosed Petitioner with post-concussive syndrome and a cervical strain, Petitioner was instructed to return in one

month. (PX 3). Petitioner's last visit to his neurologist, Dr. Young, was on April 21, 2017. Dr. Young noted that Petitioner's post-concussive syndrome and cervical strain were much better now, and that his symptoms were almost fully resolved. Petitioner was told he could return to work in one week (on May 1, 2017). Petitioner was instructed to return in three months. (PX 3). Petitioner returned to work with no restrictions on May 3, 2017.

Petitioner testified that he never returned to any of his treating doctors (despite the instructions to return three months after his last neurology appointment). He testified that he has no ongoing prescription medication related to his work injury, but that he takes Ibuprofen a couple times a month. Petitioner testified that he is continuing to work full duty with no restrictions or accommodations. He testified that if he is gets shoulder discomfort when he works overhead for 10 to 15 minutes, then he will switch to a new task. He also testified that he has regular soreness in his right shoulder and neck area since the accident. He has trouble sleeping: he tosses and turns at night. He no longer plays basketball because his shoulder bothers him too much. Petitioner also testified that he has periodic dizziness and headaches. Petitioner testified that he has blurred vision that comes and goes daily. He also testified that he has a low ringing in his ears all the time, but it is worse with loud noises.

II. CONCLUSIONS OF LAW

a. Were 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 Respondent agrees to pay the outstanding bill of $119.37 from Occupational Health Centers. (PX 4, ArbX 1). The Arbitrator awards the bill from Occupational Health Centers to be paid by Respondent, pursuant to Section 8(a) and subject to Section 8.2 of the Act.

b. What amount of compensation is due for temporary total disability?

The Parties agree that the Petitioner was entitled to temporary total disability payments from February 28, 2017 to May 2, 2017 (9 weeks). The Parties agree that the Respondent paid Petitioner temporary total disability benefits from February 28, 2017 to May 22, 2017, which represents a 20-day overpayment in the amount of $3,652.11. (ArbX 1).

c. What is the nature and extent of Petitioner's injury?

Pursuant to Section 8.1b of the Act, for accidental injuries that occur on or after September 1, 2011, the following criteria are to be used in the determination of permanent partial disability:

(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 or opinion was submitted into evidence. The Arbitrator therefore gives no weight to this factor and finds it would have no effect on permanency.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals Petitioner was a journeyman mechanic for Respondent. He works in the brake department and repairs all types of CTA vehicles, including buses. Following his recovery from the February 27, 2017 accident, he returned to his full duties in this position. Therefore, the Arbitrator gives moderate weight to this factor, and finds that it would increase permanency.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 45 years old at the time of the accident. As he is neither an older nor a younger worker, the Arbitrator gives minor weight to this factor and finds it would have a neutral effect on permanency.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earning capacity, the Arbitrator notes that no evidence was introduced to indicate that Petitioner's future earning capacity will be affected. Therefore, the Arbitrator gives minor weight to this factor and finds it would have a neutral effect on permanency.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes the following: Petitioner last saw Dr. Young, his treating neurologist, on April 21, 2017. At that time, Dr. Young noted that he had post-concussive syndrome and a cervical strain, that his symptoms are almost resolved, and that he is able to work in a week. In his review of systems, Dr. Young noted, neurologically, Petitioner was positive for dizziness, positive for headache, negative for weakness, negative for numbness, tingling and pain. With regard to his eyes, Petitioner was positive for blurred vision and negative for double vision. For his ears, Petitioner was negative for earache, negative for hearing problem, and negative for ringing in the ears. With regard to his muscles and joints, Petitioner was negative for pain and negative for swelling. Dr. Young instructed Petitioner to return in three months, but Petitioner did not. There is no evidence that after April 21, 2017, Petitioner sought medical care from any doctor for the related injuries. There is no evidence that Petitioner requested work accommodations from Respondent. The Arbitrator gives major weight to this factor and finds it would increase permanency.

Determination of permanent partial disability ("PPD") is not simply a calculation but is an evaluation of the 5 factors. The Arbitrator has carefully considered all 5 factors. By applying §8.1b and by considering the relevance and weight of all 5 factors, the Arbitrator finds that as a result of the February 27, 2017 accident, Petitioner has sustained a permanent loss of use of his person as a whole to the extent of 7.5%, pursuant to Section 8(d)2 of the Act.

Brian T. Cronin
Arbitrator

5/14/19
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 Choose reason	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☒ Modify up	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

CHRISTOPHER O'CONNOR,
Petitioner,
vs.

NO: 15 WC 24411

TRIMARK MARLINN,
Respondent.

19IWCC0705

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 issue(s) of causal connection, reasonable and necessary medical services, prospective medical care, and temporary total disability benefits, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings pursuant to *Thomas v. Industrial Commission*, 78 Ill. 2d 327 (1980).

The Arbitrator found Petitioner was not entitled to the spinal fusion surgery at L3-L4 and L4-L5 recommended by Dr. Anis Mekhail, based on his deposition testimony that the success rate is not very high. However, Dr. Mekhail testified that the success rate was approximately 70 percent. He also explained that success can be measured in terms of pain relief, and is also measured against the risk involved. Dr. Mekhail gave the example that a patient may opt for surgery with a 50 percent success rate when there is no downside risk. He stated that in lumbar spine surgery, for example, there is really no risk of paralysis from the waist down because there is no spinal cord involvement. The risks in the context of Petitioner's presentation would be the bone not healing, persistence of pain, or infection. Dr. Mekhail later added that, in general, 100 percent back pain relief would be uncommon. He testified that if a patient's pain is eight out of ten and surgery reduced that level of pain to a three out of ten, many people would be happy with that result.

Considering Dr. Mekhail's testimony as a whole, the Commission concludes Petitioner is entitled to the spinal fusion surgery recommended by Dr. Anis Mekhail, noting the surgeon's strong recommendation that Petitioner cease smoking in order to increase the opportunity for bones to heal.

4015003 1.84

19IWCC0705

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $330.48 per week for a period of 169 & 1/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay Petitioner's reasonable and necessary medical bills of: Athletico; Concentra; Parkview Orthopedics; Radiology and Nuclear Consultants; and Palos Community Hospital for January 13, 2016, May 9, 2015, and May 23, 2017, if previously unpaid and not written off, incurred by Petitioner from September 17, 2014 to October 19, 2018, pursuant to §§8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is liable for Petitioner's prospective medical care prescribed by Dr. Mekhail for the spine.

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 $75,000. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: DEC 26 2019
11/21/19
BNF/kcb
045

Barbara N. Flores

Deborah L. Simpson

Marc Parker

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

O'CONNOR, CHRISTOPHER Case# **15WC024411**

Employee/Petitioner

TRIMARK MARLINN

Employer/Respondent

19IWCC0705

On 12/3/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.47% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1747 SEIDMAN MARGULIS & FAIRMAN LLP
STEVEN J SEIDMAN
20 S CLARK ST SUITE 700
CHICAGO, IL 60603

0532 HOLECEK & ASSOCIATES
LAUREN ZIMMER
161 CLARK ST SUITE 800
CHICAGO, IL 60601

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Christopher O'Connor
Employee/Petitioner

v.

Trimark Marlinn
Employer/Respondent

Case # **15** WC **24411**

Consolidated cases: _____

19IWCC0705

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Thomas L. Ciecko**, Arbitrator of the Commission, in the city of **Chicago**, on **October 19, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ 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, **September 17, 2014**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**25,777.96**; the average weekly wage was $**495.73**.

On the date of accident, Petitioner was **34** years of age, ***single*** with **3** dependent children.

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

Respondent's credits have been reserved by the parties.

ORDER

Medical Benefits

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule to: Concentra; Parkview Orthopedics; Atletico; Radiology and Nuclear Consultants; and Palos Community Hospital for January 13, 2016, May 9, 2015, and May 23, 2017, if previously unpaid and not written off, incurred by Petitioner from September 17, 2014 to October 19, 2018, as provided in Sections 8(a) and 8.2 of the Act.

Temporary Total Disability

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from July 20, 2015 through October 19, 2018 at $330.48 per week.

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

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

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

Signature of Arbitrator

December 3, 2018
Date

ICArbDec19(b)

DEC 3 - 2018

Christopher O'Connor v. Trimark Marlinn, No. 15WC 24411

Preface

19IWCC0705

The parties proceeded to hearing October 19, 2018. The parties represented the hearing would be pursuant to Section 19(b) and 8(a) of the Act, even though no Petition had been filed. The parties placed the following issues in dispute: whether Petitioner's current condition of ill-being is causally connected to the injury; 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; is Petitioner entitled to any prospective medical care; is Petitioner entitled to temporary total disability. Arbitrator's Exhibit 1; Christopher O'Connor v. Trimark Holdings, LLC, No. 15 WC 24411 Transcript of 19(b) and 8(a) Proceedings on Arbitration at 4-7. This Arbitrator is referring to Respondent by the name placed on the Application for Adjustment of Claim. Arbitrator's Exhibit 2.

Findings of Fact

Christopher O'Connor (Petitioner), a 34 year old male, testified that on September 17, 2014, he was working at Trimark Marlinn (Respondent) in shipping and receiving, using a fork lift, loading trucks, putting stock away, and breaking down pallets. At the time, he had worked there for four to five years. He was putting stock away with a fork lift when product fell from a layer above. He got onto a pallet on the fork lift to retrieve the product. He caught his heel in some shrink wrap at the bottom of the pallet and fell back off the pallet on his lower and middle back onto a concrete floor. He felt pain when he landed. O'Connor at 10-15.

Petitioner testified he first sought medical treatment at Concentra Health Center. The records of Concentra Occupational Health Centers of Illinois show Petitioner was seen September 17, 2014, by Dr. Andrew Chet. Petitioner complained of back pain and was assessed with thoracic strain and lumbar strain. An x-ray was taken showing no acute fracture. Petitioner was told to take ibuprofen and given muscle rub cream. He was advised to use an ice and heat pack and to follow up as needed. He returned September 19, 2014, reporting improved symptoms. Petitioner told Dr. Chet he was back at work on regular duty and wanted to be released from care. He was. O'Connor at 16; Petitioner's Exhibit 2 (unpaginated). It is not clear when or why, but Petitioner testified he missed a week of work. Respondent offered no cross examination on this testimony. O'Connor at 17.

Petitioner further testified he saw Dr. Noorun Khan. The records of Dr. Khan show Petitioner saw Khan 16 days after the accident. He told Dr. Khan he fell backwards last week at work and complained of low back pain. Khan's assessment was "s/p fall", back pain and hematuria. He

recommended x-rays and medication. Khan put Petitioner on light duty, with no bending, stooping, or weight lifting. O'Connor at 17; Respondent's Exhibit 1 at 6-7.

Petitioner testified he was sent to Dr. Anis Mekhail by Dr. Khan. Although the records of Dr. Khan indicated he recommended Petitioner to Dr. Mekhail in May 2015, Mekhail testified by means of an evidence deposition, Petitioner was referred to him by Dr. Khan and he first saw Petitioner October 27, 2014. O'Connor at 17; Respondent's Exhibit 1 at 8; Petitioner's Exhibit 12 at 8.

Dr. Mekhail, a board certified, practicing orthopedic surgeon, testified when he first saw Petitioner on October 27, 2014, Petitioner complained of low back pain going down his leg. Petitioner was on light duty but could not tolerate the pain. Over the counter medication was not helping. Petitioner's physical examination was abnormal, but he was neurologically intact. Mekhail recommended an MRI, gave Petitioner prescription medication and kept him off work. Mekhail testified the MRI was done and revealed Petitioner had degenerative changes in the spine at multiple levels and a herniated disk at L1-2. In Mekhail's opinion, Petitioner had a back strain and the accident was the causative factor. In December 2014, Mekhail put Petitioner on light duty with a 25 pound weight restriction, refilled medication and continued physical therapy. Petitioner's Exhibit 12 at 7, 8, 9, 12; Petitioner's Exhibit 9 (unpaginated).

Dr. Mekhail saw Petitioner between January and July 2015. Mekhail released Petitioner to full duty February 23, 2015, but Petitioner was still on medication. Petitioner was placed at MMI March 23, 2015. However, on May 18, 2015, after Petitioner saw Mekhail with a new episode of low back pain, he was kept off work and given pain medication. By June 5, 2015, Petitioner was released to full duty. In July 2015, Petitioner complained of severe low back pain. Mekhail kept him off work and on medication. Mekhail recommended a lumbar discogram to determine if disc disease was causing the back pain. Petitioner's Exhibit 12 at 10-12, Petitioner's Exhibit 9 (unpaginated).

Petitioner submitted to an independent medical examination on August 7, 2015, by Dr. Frank Phillips, a board certified orthopedic surgeon. Phillips testified by means of an evidence deposition. Phillips reviewed the medical records of Petitioner and of diagnostic testing. He conducted a physical examination of Petitioner. Phillips noted degenerative changes and disc bulging with annular fissures in Petitioner's back. Phillips testified Petitioner's September 2014 injury aggravated his symptoms of underlying degenerative condition. Phillips did not agree with the recommendation of a discography and said Petitioner is not a candidate for fusion surgery. Phillips recommended physical therapy and medication. Petitioner's Exhibit 2 at 9-11, 30, 14-15; Petitioner's Exhibit 4.

Petitioner underwent a Functional Capacity Evaluation (FCE) on August 24, 2015. The evaluation referenced an injury on September 17, 2014. It noted Petitioner was a fork lift driver and diagnosed with lumbar strain. The evaluation found Petitioner functions at the medium physical demand level and the demand of his job is heavy physical demand level. The evaluation recommended a graduated work conditioning program and said Petitioner does not demonstrate the physical capabilities and tolerances to perform all the essential functions of his job.

Dr. Mekhail testified the evaluation showed Petitioner could not return to work. Dr. Phillips had no quarrel putting Petitioner at the medium level. Petitioner's Exhibit 12 at 18; Respondent's Exhibit 3 at 42.

Dr. Phillips opined in three subsequent addendums to his IME. In April 2016 he wrote Petitioner was not a surgical candidate and a discography was not indicated. He would allow Petitioner to work within the FCE and found him at MMI. Inexplicably, Phillips testified at the time he believed there was no reason Petitioner could not work unrestricted duty, even though he was not sure what work Petitioner did. In May 2016, Phillips wrote there was no objective spinal contraindication to Petitioner resuming unrestricted duty as it related to the injury in question. In November 2016, Phillips wrote Petitioner required no additional treatment to his lumbar spine as it related to his injury. Phillips also prepared an impairment rating finding a two percent assignment. Respondent's Exhibit 4; Respondent's Exhibit 2 at 22, 28.

The records of Dr. Mekhail indicate Petitioner continued to treat with him through April 2017. Petitioner testified he still treats with Mekhail. Mekhail's records reveal consistent complaints of low back pain. Mekhail testified Petitioner has exhausted conservative treatment and can work with restrictions. He believes Petitioner has a degenerative disc disease that was aggravated by his work injury, with recurrent flare ups. He thinks surgery in the form of L3-L5 fusion is an option. The alternative to surgery is home exercise, pain control and work with restrictions. Petitioner's Exhibit 9; O'Connor at 18; Petitioner's Exhibit 10, 18, 19.

Petitioner's medical records also indicate complaints of low back pain in visits to Dr. Kahn in September 2016 and November 2017; as well as emergency room visits to Palos Community Hospital in May 2015, January 2016, and May 2017. Petitioner's Exhibit 1 at 10, 12; Petitioner's Exhibit 6 (unpaginated).

Petitioner testified he has not worked since July 20, 2015. He was on light duty with Respondent, failed a drug test on was terminated. He has applied for shipping and receiving jobs over the internet. Petitioner testified that at home he does housework, laundry, dishes and yardwork. He takes care of his two children, seven and nine, and does crafts. He takes Advil for his back once or twice a day. O'Connor at 24, 25, 26, 37, 23, 35, 22.

Conclusions of Law

Disputed issue **F** is, is Petitioner's current condition of ill-being causally related to the injury. A claimant must establish, among other things, that the condition of ill-being is causally connected to a work related injury. The injury need not be the sole causative factor in the resulting condition. Elgin Board of Education School District U-46 v. Illinois Workers' Compensation Commission, 409 Ill. App. 3d 943, 948-49 (2011).

Petitioner's current condition is degenerative disc disease aggravated by the fall on

September 7, 2014, with recurrent flare ups as stated by Dr. Mekhail. Petitioner's Exhibit 10 at 18, 20. That opinion closely parallels that of Dr. Phillips, who described the condition as a lumbar sprain/strain with underlying degeneration with symptoms aggravated and was a consequence of the injury on September 17, 2014. Respondent's Exhibit 3 at 17, 23, 28.

Prior good health followed by a change immediately following an accident allows an inference that a subsequent condition of ill-being is a result of the accident. Navistar International Transportation Co. v. Industrial Commission, 315 Ill. App. 3d 1197, 1205 (2000). Petitioner testified that prior to September 17, 2014, he had no treatment to his lower back. His pain began at the time of the fall. O'Connor 12, 16.

Relying on the testimony of Petitioner, and the testimony of Dr. Mekhail and Dr. Phillips who are essentially in agreement on the issue, as noted by Dr. Mekhail, I find as a conclusion of law, Petitioner's current condition of ill-being is causally related to the accident. Petitioner's Exhibit 12 at 17, 21.

Disputed issue **J** were the medical services that were provided to Petitioner reasonable and necessary; and has Respondent paid all appropriate charges for all reasonable and necessary medical services. An employer is liable for all necessary medical services and all necessary medical and hospital services thereafter incurred that are reasonably required to cure or relieve one from the effects of the accidental injury. 820 ILCS 305/8(a).

Causation having been found, a review of the medical records of Concentra, Dr. Khan, and Dr. Mekhail, as well as certain dates of treatment from Palos Community Hospital, appear to reflect diagnosis of Petitioner's condition and attempts to relieve his symptoms or cure his condition. There is no evidence the medical services were unusual or not customary treatment based on Petitioner's complaints and history as articulated to medical providers. As Dr. Mekhail noted, Petitioner's treatment was conservative. With the exception of a discogram, no evidence challenged the reasonableness or necessity of the services done by the aforementioned medical providers. A close reading of the opinions of Dr. Mekhail and Dr. Phillips suggest a distinction without a difference. In any event, it was done and proved of value to Dr. Mekhail. Petitioner's Exhibit 12 at 19-21, 28; Respondent's Exhibit 2 at 14, 33.

I find as a conclusion of law, the medical services provided to Petitioner from September 17, 2014, to the date of hearing by Concentra; Parkview Orthopedics; Athletico; and Radiology and Nuclear Consultants to be reasonable and necessary. Although no testimony or context was offered on the treatment rendered by Palos Community Hospital, based on a review of the records, I find the medical services provided to Petitioner on January 13, 2016, May 9, 2015, and May 23, 2017, to be reasonable and necessary. I further find the Respondent has not paid all appropriate charges for all reasonable and necessary medical services.

Disputed issue **K** is, is Petitioner entitled to any prospective medical care.

Petitioner testified he has been recommended for fusion surgery at L3-4 and L4-L5 and wants the surgery. O'Connor at 31. Dr. Mekhail testified surgery at L3 to 5 is an option, as Petitioner has exhausted conservative treatment. He testified the success rate is not high, usually a patient's

pain does not go away. Mekhail said smoking increases the risk of the bone not healing and he urged Petitioner to stop smoking. Mekhail testified an alternative to surgery is home exercise, pain control, and work with restrictions. Dr. Khan noted he discussed smoking cessation with Petitioner in detail and Petitioner indicated he was not ready to quit. O'Connor at 31; Petitioner's Exhibit 10 at 19, 30, 33, 18; Respondent's Exhibit 1 at 12.

Dr. Phillips testified Petitioner is not a candidate for fusion surgery, as fusion surgery is performed on persons with instability, significant spinal deformities, and advanced disc degeneration. He said with degeneration, fusion patients do poorly. He testified fusion surgery for back pain has mixed results and with Petitioner's clinical evaluation, the chances of success would be abysmal. Respondent's Exhibit 3 at 18,11; Respondent's Exhibit 2 at 15, 20.

Petitioner can function at a medium demand level. He testified he is actively looking for work and had been working prior to July 20, 2015. He testified to doing housework, yardwork and child care in addition to doing crafts. He takes over the counter medication.

I find as a conclusion of law, Petitioner is not entitled to fusion surgery. I find it not reasonable or necessary and would provide no real benefit to Petitioner. I rely on the testimony of Dr. Phillips and Dr. Mekhail and note the reluctance of Petitioner to stop smoking, which impacts on outcome of any surgery. I also note the present condition of Petitioner and his physical abilities.

I do note Petitioner's testimony that he still sees Dr. Mikhail, and given Mikhail's testimony on alternative treatment, further treatment by Mikhail is reasonable and necessary.

Disputed issue **L** is, what temporary benefits are in dispute. Here it is temporary total disability. Arbitrator's Exhibit 1. To be entitled to a temporary total disability award under the Act, an injured worker must prove not only he did not work but that he was unable to work. Ingalls Memorial Hospital v. Industrial Commission, 241 Ill. App3d 710 (1993). Such award exists from the time the injury incapacitates him from work until such time as he is recovered or restored as the permanent character of the injury will permit. Mount Olive Coal Company v. Industrial Commission,295 Ill. 429 (1920). Even when an employee is terminated, he is entitled to temporary total disability until he reaches MMI. See Interstate Scaffolding, Inc. v. Illinois Workers' Compensation Commission, 236 Ill. 2d 132 (2010).

Here the disputed entitlement beginning date is July 20, 2015. At that time Petitioner was being seen by Dr. Mekhail, who had him off work, having noted Petitioner was in significant distress, could barely move his back, and the pain was affecting the quality of life. Petitioner's Exhibit 9.

When Dr. Phillips examined Petitioner on August 7, 2015, he only anticipated Petitioner would be at MMI sometime in the future. He did not place Petitioner at MMI. Dr. Phillips placed Petitioner at MMI, April 1, 2016, yet allowed a return to work within the limitations of the FCE. Respondent's Exhibit 4. Dr. Mekhail agreed Petitioner could work with restrictions. Petitioner's Exhibit 9; Petitioner's Exhibit 10 at 25.

Having reviewed the testimony of Dr. Phillips and Dr. Mekhail, I find the opinions of

Dr. Mekhail more persuasive. I do so based on Mekhail's extensive treatment of Petitioner. Phillips testified Petitioner was able to return to regular duty but did not know what kind of work Petitioner did. Phillips seemed to focus entirely on Petitioner not being a surgical candidate and his dismissal of the use of a discogram.

I find as a conclusion of law Petitioner is not recovered or restored as the permanent character of his injury will permit and is still in need of medical care, though not fusion surgery, and is entitled to temporary total disability benefits from July 20, 2015, through October19, 2018, at the rate of $330.48 per week. Although capable of performing medium demand work, the unrebutted evidence shows none is readily available to Petitioner.

Arbitrator

12/3/18

Date

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jackie Stueve Jr.,

Petitioner,

vs. NO: 17 WC 14668

State of IL/ Menard C.C. ,

Respondent.

19IWCC0706

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 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. 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 6, 2018, 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.

19IWCC0706

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

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

No county, city, town, township incorporated village, school district, body politic or municipal corporation is required to file a bond to secure the payment of the award and the cost of the proceedings in the court to authorize the court to issue such summons. 820 ILCS 305/19(f)(2). Based upon the named Respondent herein, no bond is set by the Commission. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: DEC 30 2019
o12/19/19
BNF/mw
045

Barbara N. Flores

Deborah L. Simpson

Marc Parker

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

STUEVE JR, JACKIE Case# **17WC014668**

Employee/Petitioner

STATE OF IL/MENARD CC

Employer/Respondent

19IWCC0706

On 6/6/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.07% 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:

0969 RICH RICH & COOKSEY PC
THOMAS C RICH
6 EXECUTIVE DR SUITE 3
FAIRVIEW HTS, IL 62208

0558 ASSISTANT ATTORNEY GENERAL
AARON L WRIGHT
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0498 STATE OF ILLINOIS
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CHICAGO, IL 60601-3227

1350 CENTRAL MANAGEMENT SERVICES
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SPRINGFIELD, IL 62794-9208

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

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

JUN 6 - 2018

RONALD A. RASCIA, SECRETARY
Illinois Workers' Compensation Commission

STATE OF ILLINOIS)
)SS.
COUNTY OF WILLIAMSON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Jackie Stueve, Jr.
Employee/Petitioner

v.

State of IL/Menard C.C.
Employer/Respondent

Case # 17 WC 14668

Consolidated cases: n/a

19IWCC0706

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Herrin, on April 10, 2018. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS 19IWCC0706

On the date of accident, February 27, 2017, Respondent was operating under and subject 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 $62,933.27; the average weekly wage was $1,210.25.

On the date of accident, Petitioner was 38 years of age, married with 1 dependent child(ren).

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

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

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

ORDER

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibit 1, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit of amounts paid for medical benefits that have been paid and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall authorize and pay for reasonable and necessary prospective medical treatment as recommended by Petitioner's treating physician, Dr. Nathan Mall.

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

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

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

William R. Gallagher, Arbitrator
ICArbDec19(b)

June 3, 2018
Date

JUN 6 - 2018

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged he sustained a repetitive trauma injury arising out of and in the course of his employment for Respondent. The Application alleged a date of accident (manifestation) of February 27, 2017, and that Petitioner sustained repetitive trauma to his right and left hands/wrists and right and left arms/elbows (Arbitrator's Exhibit 2). This case was tried in a 19(b) proceeding and Petitioner sought an order for payment of medical bills as well as prospective medical treatment. Respondent disputed liability on the basis of accident and causal relationship in regard to Petitioner's bilateral cubital tunnel syndrome. Respondent admitted liability in regard to Petitioner's bilateral carpal tunnel syndrome (Arbitrator's Exhibit 1).

Petitioner became employed by Respondent in August, 2009, and worked as a correctional officer. Petitioner testified in detail regarding his job duties which included rapping bars, locking/unlocking doors with Folger Adams keys, cuffing/uncuffing inmates, performing shakedowns and restraining combative inmates.

Petitioner described the bar rapping as his using a 14 inch long steel rod and raking it across the bars in the gallery to make certain that the inmates had not tried to cut through them. Petitioner performed this task at the beginning of each shift. In regard to his use of the Folger Adams keys, Petitioner stated they would many times get stuck and have to be forcibly turned to unlock the doors.

Petitioner also testified that when the facility went on lockdown, the movement of the inmates was even more restricted than normal. When the facility was on lockdown, Petitioner stated he would use a gallery crank which was old and extremely difficult to operate.

Petitioner reviewed a Job Analysis of his position prepared by Corvel at the request of Respondent; a Post Description of the Duties of Cell House Officers prepared by Respondent; and a Demands of the Job form prepared by Respondent. Petitioner acknowledged that the information contained in the preceding documents was accurate. Further, Petitioner also testified he watched a DVD of other correctional officers performing various job duties which included bar rapping and using Folger Adams keys. Petitioner likewise agreed that this was an accurate depiction of his job duties as well (Petitioner's Exhibits 10, 11, 12 and 15).

All of the various preceding job duties of Petitioner required the active and repetitive use of both upper extremities. Petitioner testified that, over time, he began to experience symptoms of numbness and aching in both of his hands. Petitioner stated he frequently had the symptoms in both of his hands after he finished rapping the bars.

At trial, Petitioner testified he was 6 feet tall and weighed 300 pounds, but did not have diabetes, gout or hypothyroidism. Petitioner did state he had hypertension, but it was controlled with medication.

Petitioner initially sought medical treatment on January 23, 2017, from Dr. Joseph Molnar, his family physician. At that time, Petitioner complained of numbness/tingling in both arms. Dr. Molnar opined Petitioner had parasthesias in both hands, prescribed medication and ordered EMG/nerve conduction studies (Petitioner's Exhibit 3).

On February 21, 2017, Petitioner was seen by Dr. James Goldring, who performed EMG/nerve conduction studies. The diagnostic tests were positive for bilateral carpal tunnel syndrome, more on the right than left. However, the tests did not reveal any abnormalities in regard to both ulnar nerves (Petitioner's Exhibit 4).

Petitioner was subsequently treated by Dr. Nathan Mall, an orthopedic surgeon, who initially saw Petitioner on March 10, 2017. Dr. Mall noted Petitioner had bilateral numbness/tingling in both the median and ulnar distribution which Petitioner specifically associated with bar rapping and key turning while at work. Dr. Mall's findings on examination were consistent with bilateral carpal tunnel and cubital tunnel syndrome. Dr. Mall noted that the EMG/nerve conduction studies revealed Petitioner had bilateral carpal tunnel syndrome, but were negative for cubital tunnel syndrome. He ordered another set of EMG/nerve conduction studies to be performed and referred Petitioner to Dr. Daniel Phillips (Petitioner's Exhibit 5).

When Dr. Mall saw Petitioner on that initial visit, he noted Petitioner had high blood pressure and was obese and that these were both risk factors for the development of carpal tunnel and cubital tunnel syndrome. However, Dr. Mall stated that Petitioner's bar rapping and key turning were factors in the development of both conditions. He also stated that Petitioner had cubital tunnel syndrome, and even if the new EMG/nerve conduction studies did not reveal ulnar neuropathy, Petitioner's hand symptoms were indicative of both nerve compression syndromes (Petitioner's Exhibit 5).

Dr. Phillips saw Petitioner on April 6, 2017, and performed EMG/nerve conduction studies on Petitioner's right upper extremity. The diagnostic tests were negative for right ulnar neuropathy, but positive for right median neuropathy (Petitioner's Exhibit 6).

Dr. Phillips again saw Petitioner on May 4, 2017, and performed EMG/nerve conduction studies on Petitioner's left upper extremity. The diagnostic tests were positive for a mild left ulnar neuropathy and positive for left median neuropathy (Petitioner's Exhibit 6).

Dr. Mall saw Petitioner on April 6, 2017, and reviewed the EMG/nerve conduction studies that had been performed by Dr. Phillips on that same day. While he noted the diagnostic studies were negative for right ulnar nerve compression, he again opined Petitioner clearly had cubital tunnel syndrome. He recommended Petitioner undergo both a carpal tunnel release and cubital tunnel decompression/transposition surgery (Petitioner's Exhibit 5).

At the direction of Respondent, Petitioner was examined by Dr. Anthony Sudekum, a hand surgeon, on August 22, 2017. In connection with his examination of Petitioner, Dr. Sudekum reviewed medical records and information regarding Petitioner's job duties provided to him by Respondent. Dr. Sudekum opined Petitioner had mild to moderate bilateral carpal tunnel

syndrome, but that Petitioner did not have ulnar neuropathy on either side. He based this latter opinion upon the lack of any findings on his clinical examination (Respondent's Exhibit 3).

In regard to causality, Dr. Sudekum noted Petitioner had a number of other risk factors, specifically, Petitioner's age, morbid obesity, hypertension, fluid retention, smoking, arthritis and a history of diabetes. However, Dr. Sudekum also opined Petitioner's employment activities were a "...minor contributing factor" to the development of Petitioner's bilateral carpal tunnel syndrome. Although Dr. Sudekum did not diagnose Petitioner with cubital tunnel syndrome, he opined Petitioner's employment activities did not contribute to ulnar neuropathy on either side (Respondent's Exhibit 3).

Dr. Mall subsequently performed surgery on February 15, 2018, and the procedure consisted of a left carpal tunnel release and left elbow ulnar nerve decompression and transposition. On March 1, 2018, Dr. Mall performed surgery which consisted of a right carpal tunnel release and right elbow ulnar nerve decompression and transposition (Petitioner's Exhibit 7).

Dr. Mall was deposed on October 23, 2017, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Mall's testimony was consistent with his medical records and he reaffirmed the opinions contained therein. Dr. Mall testified that he diagnosed Petitioner with bilateral carpal tunnel and cubital tunnel syndrome for which he recommended surgery consisting of a carpal tunnel release and ulnar nerve transposition. In regard to the bilateral cubital tunnel syndrome, Dr. Mall made that diagnosis based upon his findings on examination. While he acknowledged that the diagnostic tests showed some compression of the ulnar nerve on the left, but not on the right, he testified that compression of elbow nerves is not always seen on nerve conduction studies. Dr. Mall specifically stated that on examination when he pushed on the ulnar nerve, Petitioner had immediate symptoms in the ulnar distribution (Petitioner's Exhibit 9; pp 9-11).

In regard to causality, Dr. Mall testified that he reviewed data regarding Petitioner's job duties and opined that Petitioner's upper extremity conditions were related to Petitioner's work activities. Dr. Mall did acknowledge Petitioner had other risk factors for the development of the conditions, specifically, obesity and hypertension (Petitioner's Exhibit 9; pp 10-16).

On cross-examination, Dr. Mall agreed that diabetes can also be a contributing factor to the development of carpal tunnel and cubital tunnel syndrome. However, he did not believe that smoking was such a contributing factor (Petitioner's Exhibit 9; pp 18-19).

Dr. Sudekum was deposed on January 25, 2018, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Sudekum's testimony was consistent with his medical report and he reaffirmed the opinions contained therein, specifically, that Petitioner had mild/moderate carpal tunnel syndrome, but Petitioner did not have cubital tunnel syndrome on either side. Dr. Sudekum testified Petitioner had no findings on examination indicative of cubital tunnel syndrome. In regard to causality, Dr. Sudekum testified that Petitioner's work activities were a minor contributing factor to the development of Petitioner's bilateral carpal tunnel syndrome (Respondent's Exhibit 4; pp 22, 28-30).

At trial, Petitioner testified he is still being seen by Dr. Mall and had an appointment to be evaluated by him the following day. Petitioner stated he was continuing to work light duty, was doing home exercises but was not at MMI.

Conclusions of Law

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

The Arbitrator concludes Petitioner sustained a repetitive trauma injury arising out of and in the course of his employment for Respondent that manifested itself on February 27, 2017, and that his current condition of ill-being, specifically, his bilateral carpal tunnel syndrome and bilateral cubital tunnel syndrome is causally related to same.

In support of this conclusion the Arbitrator notes the following:

There was no dispute that Petitioner's bilateral carpal tunnel syndrome was causally related to Petitioner's work activities because, at trial, Respondent stipulated that it was related. Further, Petitioner's treating physician, Dr. Mall, opined it was related and Respondent's Section 12 examiner, Dr. Sudekum, opined that Petitioner's bilateral carpal tunnel syndrome was, at least, caused in part by Petitioner's work activities.

Dr. Mall's findings on examination were positive for bilateral cubital tunnel syndrome. Even though the EMG/nerve conduction studies were positive for left ulnar neuropathy, but negative for right ulnar neuropathy, Dr. Mall testified that individuals can have cubital tunnel syndrome even when the diagnostic tests are negative. Further, on examination, when Dr. Mall pressed the ulnar nerve, it immediately caused symptoms in the ulnar distribution.

While Dr. Sudekum stated there were no positive findings on examination indicative of cubital tunnel syndrome, Dr. Mall consistently found cubital tunnel syndrome based upon his findings on examination and he subsequently performed corrective surgery.

Based upon the preceding, the Arbitrator finds the opinion of Dr. Mall to be more persuasive than that of Dr. Sudekum.

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 services as identified in Petitioner's Exhibit 1, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit of amounts paid for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

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

The Arbitrator concludes Petitioner is entitled to prospective reasonable and necessary medical treatment, recommended by Petitioner's treating physician, Dr. Nathan Mall.

In support of this conclusion the Arbitrator notes the following:

Petitioner is still being seen and treated by Dr. Mall and is not yet at MMI.

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 down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

TRAVIS SCRANTON,

Petitioner,

vs. NO: 16 WC 025836

STATE OF ILLINOIS/IDOT,

Respondent.

19IWCC0707

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, 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 was employed as a ferry pilot by the Illinois Department of Transportation. On May 17, 2016 Petitioner was descending the stairs from the pilothouse leading to the deck of the ferry when he experienced a "pop" in his left knee. Petitioner went to the emergency department at Alton Memorial Hospital immediately following the accident. He underwent an MRI in June 2016 and subsequently had an arthroscopic debridement of the left medial meniscus, femoral chondroplasty, and chondroplasty of the of the medial facet of the patella, performed by Dr. Stirton on September 7, 2016. Petitioner testified at hearing that prior to the May 17, 2016 accident he did not have any symptoms in the left knee other than occasional stiffness.

By history Petitioner had sustained a previous work- related injury to his right knee in 2014 which required arthroscopic surgery. Petitioner testified that he had recovered from the right knee injury but acknowledged that subsequent to the surgery he had a cortisone injection in the right knee. The medical records pertaining to the right knee injury were not tendered into evidence.

19MCC0707

19IWCC0707

Dr. Stilton ordered a course of physical therapy following the left knee arthroscopy. During physical therapy Petitioner complained of bilateral knee pain. Petitioner saw Dr. Stirton and expressed complaints of bilateral knee pain. Dr. Stirton administered steroid injections in both knees on November 30, 2016. At hearing, Petitioner testified that the pain in his right knee began shortly after the May 17, 2016 injury to his left knee because he was favoring his left knee.

Petitioner continued to have ongoing pain in his left knee and Dr. Stirton performed a second arthroscopic procedure on March 29, 2017 that involved shaving the posterior horn of the medial meniscus, chondroplasty of the patellofemoral joint, and removal of debris. Petitioner's complaints of bilateral knee pain continued and Dr. Stirton performed a total knee replacement of the right knee on August 9, 2017. Following this surgery Dr. Stirton ordered additional physical therapy and continued Petitioner's off work status which had been in effect since the May 17, 2016 accident.

The Arbitrator found that Petitioner's current condition of ill-being in his both his left and right knees were causally connected to the accident of May 17, 2016. He awarded medical expenses related to both knees, and the loss of use of 40% of the person as whole based upon that conclusion. The Commission views the evidence related to Petitioner's condition of ill-being in his right knee differently.

Dr. Stirton and Respondent's Section 12 examiner Dr. Lehman offered conflicting opinions on the issue of causal connection. The Commission notes that Petitioner had pre-existing pathology in the right knee that was significant enough to require surgical intervention followed by the need for a cortisone injection following surgery to treat residual pain. Dr. Lehman submitted a Section 12 report and testified that the current condition of ill-being in neither the left or right knees were related to the May 17, 2016 work injury but rather were related to pre-existing degenerative arthritis. The Commission disagrees with the finding of the Arbitrator as it relates to causal connection in the right knee and finds that, in light of Petitioner's medical history related to the right knee, the testimony of Dr. Lehman is more persuasive than Dr. Stirton's opinion. The Commission therefore vacates the finding of causal connection as it relates to Petitioner's right knee.

The Commission views the evidence differently with respect to Section 8.1(b) factor (v).

(v) evidence of disability corroborated by the treating medical records

In analyzing the evidence of disability, the Arbitrator determined that Petitioner underwent a total knee replacement of the right knee that was causally connected to the work injury to his left knee sustained on May 16, 2016. The Arbitrator made an award of 40% of the person as a whole pursuant to Section 8(d)2 of the Act premised on Petitioner's disability arising from injuries to both lower extremities. Petitioner testified at hearing that he sustained a prior work-related injury to his right knee in 2014 that required surgery followed by a cortisone injection. Petitioner had significant pre-existing degenerative arthritis in the right knee with varus osteoarthritis and near bone on bone evident in x-rays. The Commission finds Dr. Lehman's opinion that there was no causal connection with respect to the right knee persuasive.

JSTOR

19IWCC0707

Petitioner underwent two arthroscopic procedures on his left leg. The Commission finds that an award of 30% loss of use of the left leg pursuant to Section 8(e) of the Act to be the appropriate award.

Having weighed the evidence and analyzed the Section 8.1b (b) factors, the Commission find Petitioner sustained a 30% loss of use of the left leg under Section 8(e) of the Act.

Based upon the foregoing analysis the Commission vacates the award of medical expenses related to Petitioner's right knee. Having determined that there is no causal connection as to the right knee the Commission vacates the Arbitrator's award of 40% loss of use of the person as whole pursuant to Section 8(e) of the Act. The Commission finds that Petitioner sustained the loss of use of 30% of the left leg pursuant to Section 8(e) of the Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $1,003.37 per week for a period of 125 1/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $755.22 per week for a period of 64.5 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the loss of use of 30% of the left leg. The award of 40% loss of use of the person as a whole pursuant to Section 8(d)2 of the Act is hereby vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner medical expenses related to treatment of the left leg under §8(a) and 8.2 of the Act. The award of medical expenses related to treatment of Petitioner's right leg is hereby vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of benefits to Petitioner for permanent partial disability of the loss of use of 40% of the person as a whole pursuant to Section 8(d) 2 of the Act is hereby vacated.

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

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

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is entitled to a credit of amounts paid under Section 8(j) of the Act.

JAMCOPY

19IWCC0707

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: DEC 3 1 2019
MJS/msb
O: 11/6/19
44

Stephen J. Mathis

D Douglas McCarthy
Douglas McCarthy

L Elizabeth Coppoletti
L. Elizabeth Coppoletti

Microfilm

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SCRANTON, TRAVIS
Employee/Petitioner

Case# **16WC025836**

STATE OF ILLINOIS-IDOT
Employer/Respondent

19IWCC0707

On 3/26/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.41% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0487 SMITH MENDENHALL SELBY ET AL
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ALTON, IL 62002

0502 STATE EMPLOYEES RETIREMENT
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0498 STATE OF ILLINOIS
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CHICAGO, IL 60601-3227

1430 CMS BUREAU OF RISK MANAGEMENT
WORKERS' COMPENSATION MANGER
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

MAR 26 2019

Brendan O'Rourke, Assistant Secretary
Illinois Workers' Compensation Commission

19IWCC0707

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

Travis Scranton
Employee/Petitioner

v.

State of Illinois - IDOT
Employer/Respondent

Case # 16 WC 25836

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 William R. Gallagher, Arbitrator of the Commission, in the city of Collinsville, on February 25, 2019. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On May 17, 2016, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $78,262.50; the average weekly wage was $1,505.05.

On the date of accident, Petitioner was 49 years of age, married with 1 dependent child(ren).

Petitioner has received all reasonable and necessary medical services.

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

Respondent shall be given a credit of $37,412.82 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $37,412.82.

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

Respondent shall pay Petitioner temporary total disability benefits of $1,003.37 per week for 125 1/7 weeks commencing June 1, 2016, through August 23, 2018, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $755.22 per week for 200 weeks because the injury sustained caused the 40% loss of use 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.

William R. Gallagher, Arbitrator

March 23, 2019
Date

MAR 2 6 2019

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged he sustained an accidental injury arising out of and in the course of his employment by Respondent on May 17, 2016. According to the Application, Petitioner "slipped down steps of ferry" and sustained an injury to his left knee (Arbitrator's Exhibit 2). Respondent disputed liability on the basis of accident and causal relationship (Arbitrator's Exhibit 1).

Petitioner worked for Respondent as a ferry pilot on the Brussels Ferry which transported cars across the Illinois River. The ferry could transport approximately 19 cars at the time. Petitioner described pilothouse as being an area of approximately seven feet by nine feet which was elevated 19 feet above the surface of the deck.

When Petitioner was in the pilothouse, he was seated while operating the controls. Because of the space limitation, Petitioner could not extend his legs and typically sat with his knees flexed with his lower legs and feet beneath the seat. Petitioner would usually sit in this position two to four hours at a time. Petitioner stated that he would experience pain/stiffness in his knees when he would get up after having been in that flexed knee position.

Petitioner had to access the pilothouse by using the stairs which lead from the deck of the ferry to the pilothouse. Petitioner testified the height of the steps varied and some were higher than others. At trial, Petitioner's counsel tendered into evidence photographs of the steps. Each step had a measuring tape adjacent to it. The Arbitrator reviewed the photographs and noted that the steps did vary in height from eight inches to 12 inches (Petitioner's Exhibit 5).

At trial, Petitioner testified he had been sitting in the pilothouse for approximately two hours and he was going to take a break in the lunchroom which is on land. As Petitioner was in the process of descending the stairs, he experienced a "pop" in his left knee. Petitioner was not certain which step he was on, but stated he did not fall because he caught himself using the hand rail. The accident was reported to Respondent immediately after it occurred.

Petitioner testified that prior to the accident he did not have any left knee symptoms other than a little bit of stiffness. However, Petitioner previously sustained an injury to the right knee which required arthroscopic surgery. The right knee injury was also work-related and occurred sometime in 2014. Petitioner recovered from that prior surgery, but stated he had received one cortisone shot afterward. None of the medical records regarding the prior right knee surgery were tendered into evidence at trial.

Subsequent to the accident of May 17, 2016, Petitioner was seen at the ER of Alton Memorial Hospital. At that time, Petitioner complained of left knee pain and stated he injured his left knee at work that same day while walking down steps (Petitioner's Exhibit 3).

Petitioner was evaluated by Dr. David Stirton on May 27, 2016. Dr. Stirton prescribed medication and ordered an MRI scan. He also authorized Petitioner to be off work (Petitioner's Exhibit 2).

The MRI was performed on June 23, 2016. According to the radiologist, the MRI revealed marrow edema in the subarticular aspect of the medial proximal tibia, degenerative changes within the posterior horn of the medial meniscus, a small tear in the medial aspect of the posterior horn of the medial meniscus, joint effusion and some fluid in the infrapatellar bursa (Petitioner's Exhibit 3).

Dr. Stirton saw Petitioner on June 23, 2016, and reviewed the MRI. He opined it revealed a tear of the medial meniscus and continued to authorize Petitioner to remain off work (Petitioner's Exhibit 2).

Dr. Stirton performed arthroscopic surgery on Petitioner's left knee on September 7, 2016. The surgical procedure consisted of debridement of the medial meniscus, femoral chondroplasty and chondroplasty of the medial facet of the patella (Petitioner's Exhibit 2).

Dr. Stirton continued to treat Petitioner following surgery and ordered physical therapy. While in physical therapy, Petitioner complained of pain in both the left and right knees. When Dr. Stirton saw Petitioner on November 30, 2016, Petitioner complained of bilateral knee pain. At that time, Dr. Stirton administered steroid injections to both knees (Petitioner's Exhibit 2). At trial, Petitioner testified he began favoring the left leg after the injury and experienced right knee symptoms shortly thereafter.

Dr. Stirton continued to treat Petitioner and authorized him to remain off work. When Dr. Stirton saw Petitioner on February 16, 2017, he opined that it was "not likely" Petitioner would be able to return to work at full duty (Petitioner's Exhibit 2).

Petitioner continued to experience both left and right knee pain. Because of Petitioner's ongoing left knee symptoms, Dr. Stirton performed another arthroscopic surgery on Petitioner's left knee on March 29, 2017. The surgical procedure consisted of shaving of the posterior horn of the medial meniscus, chondroplasty of the patellofemoral joint and removal of debris/fluid (Petitioner's Exhibit 2).

Because of Petitioner's continuing right knee symptoms, Dr. Stirton performed a right total knee replacement surgery on August 9, 2017. Following surgery, Dr. Stirton ordered physical therapy and continued to authorize Petitioner to remain off work (Petitioner's Exhibit 2).

At the request of Petitioner's counsel, Shane Callahan, a kinesiologist, reviewed the photographs of the steps to the pilothouse. Callahan's CV and reports were tendered into evidence at trial. Callahan opined the increased height of the steps resulted in a knee flexion increase of four percent (4%) to 12%, a torque increase to the knee joint of five percent (5%) to 15% and an absorbed power increase to the knee joint of 10% to 30% (Petitioner's Exhibit 4).

Dr. Stirton was deposed on December 15, 2017, and his deposition testimony was received into evidence at trial. Prior to being deposed, Dr. Stirton reviewed Callahan's report as well as the photographs of the steps leading to the pilothouse. Dr. Stirton testified he performed two arthroscopic surgeries on Petitioner's left knee and a total knee replacement surgery on the right

knee. Dr. Stirton also noted Petitioner complained of right knee pain when he was recovering from left knee surgery (Petitioner's Exhibit 1; pp 6-10).

In regard to causality, Dr. Stirton testified he reviewed Callahan's report and he considered his opinion to be "worthwhile." Petitioner's counsel then asked Dr. Stirton a hypothetical question which included Petitioner having a history of degenerative arthritis in his knee, the fact that he had his knee in a flexed position for two to four hours while operating the ferry and the irregular height of the steps Petitioner was required to descend. Dr. Stirton opined the preceding could be causative factors in regard to Petitioner's left knee injury. Specifically, Dr. Stirton noted that having the knee joint immobilized in a high degree of flexion for a long period of time made the joint more susceptible to injury. He also stated the heightened steps also presented at an increased risk or loading in the knee (Petitioner's Exhibit 1; pp 10-13).

In regard to Petitioner's right knee condition, Dr. Stirton testified Petitioner was asymptomatic prior to the accident. Because of the immobilization of the left knee following surgery, the right knee became symptomatic and aggravated (Petitioner's Exhibit 1; pp 13-14).

At the direction of Respondent, Petitioner was examined by Dr. Richard Lehman, an orthopedic surgeon, on February 6, 2018. In connection with his examination of Petitioner, Dr. Lehman reviewed medical records provided to him by Respondent. In regard to Petitioner's left knee, Dr. Lehman opined Petitioner had a tear of the meniscus, but the condition was related to pre-existing degenerative arthritis. In regard to Petitioner's right knee, Dr. Lehman opined the right knee condition was also related to pre-existing degenerative arthritis. He also opined Petitioner could return to work without restrictions other than no squatting and no kneeling (Respondent's Exhibit 1; Deposition Exhibit 2).

Dr. Lehman was deposed on July 19, 2018, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Lehman's testimony was consistent with his medical report and he reaffirmed the opinions contained therein. Dr. Lehman testified Petitioner had pre-existing degenerative arthritis in both knees which was not related to the accident of May 17, 2016. In regard to the irregular height of the steps, Dr. Lehman testified the increased stress on the knee was absorbed by the knee cap, not the meniscus. In regard to Petitioner having to remain seated for a long period of time with his knees in a flexed position, Dr. Lehman agreed this would be uncomfortable, but that it would not predispose the knee to an injury because it put no rotational stress on the knee. Dr. Lehman also testified Petitioner's right knee had pre-existing degenerative arthritis and the total knee replacement was not because of overcompensation due to left knee pain (Respondent's Exhibit 1; pp 10-20).

Petitioner continued to be seen by Dr. Stirton for his bilateral knee condition. Dr. Stirton evaluated Petitioner on August 23, 2018, primarily for his right knee condition. At that time, he noted Petitioner had a strenuous job which required difficult positions of his leg and knee (Petitioner's Exhibit 2).

Dr. Stirton saw Petitioner on November 6, 2018, primarily for his left knee condition. At that time, he administered a cortisone injection in Petitioner's left knee (Petitioner's Exhibit 2).

Dr. Stirton prepared a report dated January 14, 2019, wherein he opined Petitioner had permanent restrictions of no climbing ladders, limited bending and no heavy lifting because of his knee condition. He also noted Petitioner could not return to work because the restrictions would not permit him to perform his normal job duties (Petitioner's Exhibit 7).

At trial, Petitioner testified he continues to have pain in both knees and has not returned to work. Petitioner did not obtain an evaluation by a vocational rehabilitation specialist and was not seeking an award of permanent and total disability.

Conclusions of Law

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

The Arbitrator concludes Petitioner sustained an accidental injury arising out of and in the course of his employment by Respondent on May 17, 2016.

In support of this conclusion the Arbitrator notes the following:

Petitioner's testimony that he was required to sit with his knees in a flexed position with his feet underneath the seat for a two to four hour time period while operating the controls to the ferry was unrebutted.

Petitioner testified he would experience pain/stiffness in his knees when he got up from the flexed position.

The evidence clearly revealed that the steps Petitioner had to go up/down varied in height from eight inches to 12 inches.

For Petitioner to prove that he sustained an accidental injury arising out of and in the course of his employment by Respondent, he must show that he was subjected to a risk of injury to a greater degree than that of the general public, Caterpillar Tractor Co. v. Industrial Commission, 541 N.E.2d 665 (Ill. 1989).

The Arbitrator finds that Petitioner having to sit for two to four hours with his knees flexed to where his feet were underneath the seat and his having to go up/down stairs that would vary in height from eight inches to 12 inches constituted a risk of injury to a greater degree than that of the general public.

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

The Arbitrator concludes Petitioner's current condition of ill-being in regard to his left knee and right knee is causally related to the accident of May 17, 2016.

In support of this conclusion the Arbitrator notes the following:

While Petitioner had pre-existing degenerative arthritis of both knees and a prior surgery on the right knee, he was able to work full duty as a ferry pilot prior to the accident of May 17, 2016.

As noted in disputed issue (C), Petitioner's testimony regarding the circumstances of the accident was unrebutted.

Prior to the accident, Petitioner only had some stiffness in the left knee, but other than that he had no left knee symptoms. In regard to the right knee, Petitioner previously underwent arthroscopic surgery, but had not received treatment for his right knee for a considerable period of time prior to the accident.

Petitioner's treating physician, Dr. Stirton, opined that Petitioner's left knee condition was related to the accident of May 17, 2016, and his right knee condition was because of Petitioner's favoring his left knee subsequent to surgery. Dr. Stirton also had the benefit of Callahan's report.

The Arbitrator was not persuaded by Dr. Lehman's opinion that Petitioner's left and right knee conditions were not related to the accident of May 17, 2016, but were related to the pre-existing degenerative arthritis.

Based upon the preceding, the Arbitrator finds the opinion of Dr. Stirton to be more persuasive than that of Dr. Lehman in regard to causality.

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 Respondent is liable for payment of the medical bills incurred therewith.

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibit 6 as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit of amounts paid for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

In support of this conclusion the Arbitrator notes the following:

There was no dispute that the medical treatment provided to Petitioner was reasonable and necessary.

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

The Arbitrator concludes Petitioner is entitled to temporary total disability benefits of 125 1/7 weeks, commencing June 1, 2016, through August 23, 2018.

In support of this conclusion the Arbitrator notes the following:

Petitioner was receiving medical treatment for his left and right knee conditions and was authorized to be off work. The Arbitrator finds Petitioner reached MMI as of August 23, 2018.

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

The Arbitrator concludes Petitioner has sustained permanent partial disability to the extent of 40% loss of use of the person as a whole.

In support of this conclusion the Arbitrator notes the following:

Neither Petitioner nor Respondent tendered an AMA impairment rating. The Arbitrator gives this factor no weight.

At the time of the accident, Petitioner worked as a pilot of a ferry. As noted herein, Petitioner was not able to return to work because of the restrictions imposed by his treating physician, Dr. Stirton. The Arbitrator gives this factor significant weight.

Petitioner was 49 years old at the time of the accident and will have to live with the effects of this injury for the remainder of his natural life. The Arbitrator gives this factor moderate weight.

Petitioner chose not to seek other employment or vocational rehabilitation services. Accordingly, the Arbitrator cannot determine what, if any, effect the injury had on Petitioner's future earning capacity. The Arbitrator gives this factor no weight.

As a result of the accident, Petitioner underwent two arthroscopic surgeries on the left knee and a total knee replacement on the right knee. Petitioner also has degenerative arthritis in both knees. Dr. Stirton has imposed restrictions which preclude Petitioner from returning to work as a ferry pilot. The Arbitrator gives this factor significant weight.

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Maureen P. Carroll,

Petitioner,

vs. No. 17 WC 05449

City of Chicago,

Respondent.

19IWCC0708

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 issue of 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.

Petitioner, a right hand dominant streetlight repair person, testified that she worked for Respondent for 24 years. On January 3, 2017, while attempting to repair a circuit, Petitioner injured her right shoulder as she was opening a manhole cover. Ultimately, Petitioner was diagnosed with a rotator cuff tear and underwent surgery on May 10, 2017. Following a full-duty release, Petitioner returned to her regular job as a streetlight repair person in November of 2017, at the same rate of pay. Petitioner generally uses a bucket lift to perform her job, but occasionally needs to climb a ladder or use a line belt and hooks method of climbing.

The medical records in evidence show that on May 10, 2017, Dr. William Heller performed an arthroscopic repair of the rotator cuff, subacromial decompression, and extensive debridement of the glenohumeral joint. Postoperatively, he diagnosed a rotator cuff tear and long head biceps tenosynovitis and capsulitis. Petitioner's postoperative recovery was uneventful, and she progressively improved with physical therapy. The final physical therapy note, dated October 27, 2017, states the following assessment: "Pt demonstrating ability to

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perform work simulated tasks with wts ranging from 20-30#. Pt with some mechanical break down upon fatigue but is able to complete sets of 30 repetitions with exercises. Improvements of shoulder strength and ROM noted generally with some tightness to IR and EX due to post-tx session fatigue. Pt has surpassed the realm of skilled PT tx and is recommended for work conditioning program to further prepare her R UE for safe return to work duties." On November 7, 2017, Petitioner reported to Dr. Heller she was ready to return to work and requested a full duty discharge. Physical examination findings were as follows: "[T]he shoulder has no swelling. No deformity. Full active range of motion including forward flexion and abduction to 170. Internal/external rotation 80 degrees each. Good overhead strength. No scapular winging or compensation. No pain or weakness to isolated testing of supraspinatus or infraspinatus tendons." Dr. Heller found Petitioner "has done quite well" and released her to return to work full duty.

At the time of the arbitration hearing, Petitioner was 64 years old. Petitioner described her current condition as follows: "[E]very once in a while because of working outside and everything, like the dampness with the rain lately. And sometimes, like the last couple of months I've noticed that *** it will throb once in a while if I sleep on it or just for no reason." The range of motion in the shoulder is "okay," "pretty close" to preinjury level, "but not quite." Petitioner "definitely" feels a loss of strength, without noticeable atrophy. Petitioner reiterated the shoulder occasionally hurts or throbs. The shoulder condition affects the way Petitioner performs her job, but does not affect her activities of daily living.

In determining permanent partial disability, the Commission considers the five factors enumerated in section 8.1b(b) of the Workers' Compensation Act (the Act): "(i) the reported level of impairment pursuant to subsection (a); (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. No single enumerated factor shall be the sole determinant of disability." 820 ILCS 305/8.1b(b).

Regarding factor (i), the Commission notes no impairment rating has been submitted into evidence. The Commission therefore gives no weight to this factor.

Regarding factor (ii), the Commission notes Petitioner is a streetlight repair person, which is a physically demanding job. Petitioner generally uses a bucket lift to perform her job, but occasionally needs to climb a ladder or use a line belt and hooks method of climbing. The Commission notes the injury was to the dominant, right shoulder. Petitioner has returned to work full duty. The residual pain and loss of strength affect the way Petitioner performs her job. The Commission gives considerable weight to this factor.

Regarding factor (iii), the Commission notes Petitioner was 64 years old at the time of the arbitration hearing. The Commission gives less weight to this factor because Petitioner has recovered well from her injury and has a shorter work life ahead of her.

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Regarding factor (iv), the Commission notes no decrease of earning capacity. The Commission gives no weight to this factor.

Regarding factor (v), the Commission again notes Petitioner has recovered well from her injury, but suffers from residual pain and loss of strength, which affect the way she performs her job, but not the activities of daily living. The Commission gives some weight to this factor.

Having carefully considered and weighed the foregoing factors, the Commission believes the proper measure of disability is 10 percent of the person as a whole.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 11, 2019, is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $775.18 per week for a period of 50 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the permanent disability to the extent of 10 percent of the person as a whole.

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

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

DEC 31 2019

DATED:
d-12/10/2019
SM/sk
44

Stephen Mathis

L. Elizabeth Coppoletti

Douglas McCarthy

T8IMCC0308

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CARROLL, MAUREEN P
Employee/Petitioner

Case# **17WC005449**

CITY OF CHICAGO
Employer/Respondent

19IWCC0708

On 7/11/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.07% 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:

1404 BARRY A KETTER PC
221 E LAKE ST
SUITE 202
ADDISON, IL 60101

0010 CITY OF CHICAGO LAW DEPT
DONALD CHITTICK
30 N LASALLE ST SUITE 800
CHICAGO, IL 60602

STATE OF ILLINOIS)SS.

COUNTY OF Cook)

19IWCC0708

☐ 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

Maureen P. Carroll
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # **17** WC **5449**

Consolidated cases: _____

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Thomas L. Ciecko**, Arbitrator of the Commission, in the city of **Chicago**, on **May 2, 2019**. A record was made and the parties did not request a decision with finding of fact and conclusions of law. By stipulation, the parties agree:

On the date of accident, **January 3, 2017**, 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 $**100,263.94**, and the average weekly wage was $**1928.15**.

At the time of injury, Petitioner was **62** years of age, ***single*** with **0** dependent children.

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

Respondent shall be given a credit of $**51,052.72** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**51,052.72**.

After reviewing all of the evidence presented, this Arbitrator hereby makes findings regarding the nature and extent of the injury. I conclude the Petitioner suffered an injury to her right shoulder; three months of conservative treatment failed and Petitioner underwent surgery consisting of arthroscopic repair of right shoulder rotator cuff, arthroscopic subacromial decompression of the right shoulder, and right shoulder glenohumeral joint arthroscopy with extensive debridement; and extensive physical therapy. She returned to work full duty with no restrictions. Here permanent partial disability is established using the criteria found in 820 ILCS 305/8.1b. As to the level of permanent partial disability, this Arbitrator finds as follows.

With regard to subsection (i) of Section 8.1b(b) this Arbitrator notes that no permanent partial disability impairment report or opinion was submitted into evidence. I give this factor no weight in determining the level of disability.

With regard to subsection (ii) of Section 8.1b(b) the occupation of the employee, the record shows she was a streetlight repairman and returned to that occupation without restriction after being released from medical care November 7, 2017. I give this factor no weight in determining the level of disability.

With regard to subsection (iii) of Section 8.1b(b) the parties have stipulated Petitioner was 62 years old at the time of the injury. She will not heal as quickly at that age and I give this factor weight in determining the level of disability.

Regarding subsection (iv) of Section 8.1b(b) Petitioner's future earning capacity, Petitioner testified she returned to work at the same wages as before the accident. I give this factor no weight in determining the level of disability.

With regard to subsection (v) of Section 8.1b(b) evidence of disability corroborated by the treating medical records, Petitioner testified she has lost some strength since the accident, but the injury has no effect on her daily life. I give some weight to this factor in determining the level of disability.

ORDER

Permanent partial disability

Based on the factors in Section 8.1b(b) and the record taken as a whole, this Arbitrator finds Petitioner sustained permanent partial disability to the extent of 5% (25 weeks at $775.18 per week) loss of a person as a whole pursuant to Section 8(d)2 of the Act.

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

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

Signature of Arbitrator

7-11-19
Date

ICArbDecN&E p.2

JUL 11 2019

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

Melanie D. Brooks,

Petitioner,

vs.

No. 13 WC 28262

Western Illinois University,

19IWCC0709

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petitions for Review having been filed by the parties herein and proper notice given, the Commission, after considering the issues of accident, permanent disability and credit, and being advised of the facts and law, affirms and adopts with correction the Decision of the Arbitrator, which is attached hereto and made a part hereof.

With regard to the issue of credit, the Commission notes the Arbitrator awarded credit for the temporary total disability benefits paid, without correspondingly noting the parties' stipulation of Respondent's liability for the temporary total disability benefits. During the oral argument, the parties stipulated all temporary total disability benefits have been paid. As temporary total disability was not at issue, the Commission strikes the Arbitrator's award of credit therefor.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 2, 2018, is hereby corrected, 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.

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19IWCC0709

IT IS FURTHER ORDERED BY THE COMMISSION that, except as stated above, 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: DEC 31 2019
o-12/10/2019
SM/sk
44

Stephen Mathis

L. Elizabeth Coppoletti

Douglas McCarthy

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BROOKS, MELANIE D
Employee/Petitioner

Case# **13WC028262**

19IWCC0709

WESTERN ILLINOIS UNIVERSITY
Employer/Respondent

On 4/2/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.89% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0834 KANOSKI BRESNEY
CHARLES N EDMISTON
129 S CONGRESS ST
RUSHVILLE, IL 62681

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

0558 ASSISTANT ATTORNEY GENERAL
JOSEPH L MOORE
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

0904 STATE UNIVERSITY RETIREMT SYS
PO BOX 2710 STATION A
CHAMPAIGN, IL 61825

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

APR 2 - 2018

GERALD A RASCIA, Acting Secretary
Illinois Workers' Compensation Commission

19IWCC0709

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

Melanie D. Brooks
Employee/Petitioner

v.

Western Illinois University
Employer/Respondent

Case # **13** WC **28262**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Peoria**, on **February 21, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **June 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.

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

In the year preceding the injury, Petitioner earned **$43,115.75**; the average weekly wage was **$829.15**.

On the date of accident, Petitioner was **57** years of age, ***single*** with **0** dependent children.

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

Respondent shall be given a credit of **$122,425.70** for TTD, **$0** for TPD, **$0** for maintenance, **$0** in non-occupational indemnity disability benefits and **$0** for other benefits, for a total credit of **$122,425.70.**

Respondent is entitled to a credit for medical bills paid in the amount of **$IF ANY** through its group medical plan for which credit may be allowed under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner the sum of **$497.49**/week for a further period of **175 weeks,** as provided in Section 8(d)2 of the Act, because the injuries sustained caused **35% loss of use of the person-as-a-whole.**

Respondent shall be given a credit of **$122,425.70** for TTD, **$0** for TPD, **$0** for maintenance, **$0** in non-occupational indemnity disability benefits and **$0** for other benefits, for a total credit of **$122,425.70.**

Respondent is entitled to a credit for medical bills paid in the amount of **$IF ANY** through its group medical plan for which credit may be allowed under Section 8(j) of the Act.

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

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

Signature of Arbitrator

3/26/18
Date

APR 2 - 2018

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Melanie D. Brooks
Employee/Petitioner

Case # **13** WC **28262**

v.

Consolidated cases: **N/A**

Western Illinois University
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that she works for Respondent's Physical Plant doing janitorial work. She testified that part of her job duties included cleaning the windows of campus buildings. She testified that on June 26, 2013, she was engaged in her duties as a janitor at Western Illinois University with four other employees washing windows on the outside of Olson Residence Hall. She testified that in order to access one of the windows, she had to climb over a railing at the entrance of the building and down onto the ground. She testified that she was then required to climb back up over a "ledge", which was a metal railing about 30 inches high at the top of the raised concrete entryway, carrying her supplies. She testified that as she climbed back over the railing, swinging her legs over the railing one at a time while holding onto the top of the railing, she was put into a bent-over position and that when she raised up, she struck the back and top of her head on a wall-mounted telephone booth that was attached to a concrete post next to the entry of the building. She testified that the telephone booth was wider than the post and projected out away from the building and was constructed of metal.

Petitioner testified that she experienced immediate sharp pain in the back of her head and felt dazed. She testified that the accident happened near the end of her shift and that she went to the breakroom and put ice on her head to try to relieve the pain. She testified that she filled out an accident report and went home after her shift and during the night continued to feel severe pain and experienced nausea, as well as pain into her neck and shoulders. She testified that she got up during the night and was sick to her stomach two or three times. She testified that the following day, a co-worker noticed that one of her pupils was larger than the other and advised her to report her ongoing complaints to her supervisor and advised she see her family physician, Dr. Stortzum.

Petitioner testified that she ultimately underwent a three-level cervical fusion followed by physical therapy. She testified that she returned to work following her medical treatment that was within her work restrictions. She testified that she is now earning more money per hour than prior to her injury. She testified that her arms now have limited mobility and that she has difficulty turning her head side-to-side and looking up. She testified that she has headaches every couple of days. She testified that she suffered from migraines prior to her injury. She testified that she has weakness in her arms. She testified that she is now 62 years old. She testified that she does not currently take any medication for her injury, but that she uses a heating pad nightly.

On cross examination, Petitioner described her work restrictions as 30 pounds of lifting as the heaviest, 7 pounds of lifting that can be done repeatedly and 17 pounds of lifting that can be done

intermittently. She testified that she is able to do her job. She testified that she was a daily smoker. She agreed that she has a B-12 deficiency which has side effects which included numbness and tingling of the hands and feet. She also agreed that her doctor informed her that a B-12 deficiency could cause headaches, fatigue and dizziness. She testified that she had headaches prior to her injury, but that her headaches were now more frequent. She testified that she underwent two FCE tests, with the first test being invalid due to inconsistent test results.

On cross examination, Petitioner testified that none of the equipment that she was using the day of the incident was defective. She testified that she did not know of any defect in the telephone booth. She testified that she did not trip on anything prior to her hitting her head on the telephone booth. She testified that the weather was good and that it was not raining when she was injured. She further testified that she was not in a hurry when she was injured.

On cross examination, Petitioner testified that she would typically wash the windows by the entrance to Olson once a year. She testified that her supervisor did not instruct her how to wash the windows or where to stand to wash the windows.

The medical records of Family Practice Associates were entered into evidence at the time of arbitration as Petitioner's Exhibit 1. The records reflect that Petitioner was seen on June 27, 2013, at which time it was noted that she hit the top of her head at work the day before, that it affected the left side of her head and her left eye and that she had left shoulder pain. It was noted that Petitioner hit her left posterior parietal head on a steel box, that she did not lose consciousness and that she felt dazed for a bit. It was noted that Petitioner's left eye felt swollen, that she was fatigued and that her left upper extremity felt a little weaker than the right. The assessment was noted to be that of contusion to the head causing neck muscle strain/spasm as well as very mild concussion. Petitioner was advised of the need for increased rest for the next couple of days and the need to avoid any excessive strenuous activity such as pushing, pulling or lifting as well as to avoid excessive heat for the next 2-3 days. It was noted that Petitioner was given a note excusing her from work through June 30th but that after that since her symptoms were mild, she could return without limitations. (PX1).

The records of Family Practice Associates reflect that Petitioner was seen on July 1, 2013, at which time it was noted that she complained of being sick to her stomach, that she had neck pain and headaches and that she hit her head at work on Thursday and had had a lot of pain since. The assessment was noted to be that of concussion with post-concussive syndrome and left neck trapezius strain secondary to recent head contusion. Petitioner was advised to try Phenergan for nausea and to use Ibuprofen for pain and inflammation. Petitioner was also recommended to use topical heat to the left posterior neck. It was noted that Petitioner was given a note excusing work absence that day and that she was to call tomorrow as to her progress. The records reflect that on July 2, 2013, Petitioner called indicating that she was still with left neck and shoulder pain that was causing a headache and that she was wondering about physical therapy and if she should return to work. The phone note entry dated July 9, 2013 noted that Petitioner called indicating that the physical therapist recommended that she be off work for two weeks. (PX1).

The records of Family Practice Associates reflect that Petitioner was seen on July 23, 2013, at which time it was noted that she had persistent neck and shoulder pain, among other issues. It was noted that Petitioner was not responding to physical therapy as hoped, that minimal activities were making it worse, that she was not using much Vicodin and that she was using Flexeril without much relief. The assessment was noted to be that of persistent neck muscle pain likely due to strain and spasm and detrusor instability. Petitioner was given a script for Skelaxen for muscle spasm, asked to remain off physical therapy for the next 4-5 days and to undergo cervical spine x-rays. At the time of the July 29, 2013 visit, it was noted that Petitioner was feeling weak in her neck and shoulders, that the pain was better with the new medication but that she felt like a zombie and that she wanted to do more strength exercises and go back to physical therapy. The assessment was noted to be that of neck muscle strain and spasm, improving.

Petitioner was instructed to continue the muscle relaxants and to return to physical therapy. At the time of the August 6, 2013 visit, it was noted that Petitioner was complaining of headaches, that she was taking the muscle relaxants as directed and that she had re-started physical therapy. It was noted that Petitioner was doing less and less activity because of the fear of making her symptoms worse. The assessment was noted to be that of persistent neck muscle strain and spasm. It was noted that due to the plateau of improvement and that since Petitioner had reproducible tender spots on the left column, they would consider trigger point injections along with continued physical therapy. Petitioner underwent trigger point injections on that date. (PX1).

The records of Family Practice Associates reflect that Petitioner was seen on August 15, 2013, at which time it was noted that she wanted to see about going to a neurologist and that she stated that physical therapy was making her do too much. It was noted that Petitioner was frustrated with the lack of progress and that she noted that any time she tried to do anything even moderately strenuous her upper back and neck caused severe pain and a headache that could last up to 24 hours. The assessment was noted to be that of persistent neck and upper back pain (cervicalgia). Petitioner was recommended to discontinue the Skelaxen and remain off the Flexeril. It was noted that due to the lack of progress, it was felt that further consultation likely with neurology would be beneficial. At the time of the August 23, 2013 visit, it was noted that Petitioner was complaining of neck pain. The assessment was noted to be that of persistent neck and upper back pain (cervicalgia). It was noted that contact would be had with Petitioner's work comp caseworker to get the name of an in-network neurologist. It was noted that if a neurology referral were to take greater than 2-3 weeks, they would consider another course of physical therapy in a different office. (PX1).

Included within the records of Family Practice Associates was a note from Illinois CancerCare dated August 1, 2013, at which time it was noted that Petitioner had been struggling with intermittent migraine headaches and had certainly been tired, that she was working one job at 35 hours a week and felt that she needed a second one for income and that no other major new difficulties or problems had come up. It was noted that Petitioner had been on Elavil for control of her migraines but that she was advised to stop that several years ago. It was also noted that Petitioner had a fall hitting her head several weeks ago and was evaluated, that it was felt that she had whiplash but that over the last two weeks she had had no headaches at all, that she had a migraine lasting one day two weeks ago and no headaches a week before that and that the current headache only began two hours ago. The assessment was noted to be that of (1) carcinoma of the breast, unremarkable; (2) migraine headaches. It was noted that Petitioner would be given a few doses of Vicodin and would follow-up with her primary care physician. It was noted that there were no findings to suggest that this was a chronic process different from the intermittent migraines that she had had over the years and that she had had no signs or symptoms to suggest that the head trauma several weeks ago had had any relationship to the discomfort. (PX1).

The records of Family Practice Associates reflect that Petitioner was seen on October 28, 2013, at which time it was noted that she was seen in follow-up for her neck and back pain. It was noted that Petitioner had seen Dr. Fortin on October 15, 2013, had multiple trigger point injections and that she had begun to see some improvement. It was noted that Petitioner was still with daily pain in the right posterior neck that radiated to the right occiput. The assessment was noted to be that of persistent neck pain with component of cervicalgia, occipital neuralgia and likely myofascial component. It was noted that Petitioner had seen some improvement after the injections by Dr. Fortin but that she was still having a fair amount of discomfort. It was noted that Petitioner was advised to continue with physical therapy. At the time of the November 25, 2013 visit, it was noted that Petitioner was getting persistent headaches and that she was not feeling better or worse after physical therapy. The assessment was noted to be that of (1) ongoing neck pain, currently in process of evaluation with neurology; (2) anxiety/depression with recent addition of Bupropion. Petitioner was prescribed medications and it was noted that an EMG was scheduled. (PX1).

The medical records of McDonough District Hospital were entered into evidence at the time of arbitration as Petitioner's Exhibit 2. The records reflect that Petitioner was seen on September 25, 2015 with a sore throat, head congestion and chest tightness. The impression was noted to be that of viral pharyngitis. At the time of the June 6, 2015 visit, it was noted that Petitioner stated that both thighs had been hurting but the prior Monday her pain increased in her left groin and had continued getting more painful. It was noted that Petitioner denied any trauma to the area but reported that she had been walking a lot. The impression was noted to be that of acute myofascial strain, malaise and fatigue. At the time of the December 8, 2013 visit, it was noted that Petitioner had had hot coffee drip onto her left hand and wrist. The impression was noted to be that of a 2nd degree burn to the left hand. (PX2).

The records of McDonough District Hospital reflect that Petitioner underwent physical therapy for the timeframe of October 15, 2012 through December 5, 2012 for the diagnosis of neck/shoulder muscle spasm. The "Personal Data Information_- Rehabilitation Services" form dated October 15, 2012 noted that Petitioner had migraines very often, that they seemed to start on the right side of her neck/shoulder and that they had started years ago. It was noted that Petitioner's goals for therapy were to establish ways to eliminate the headaches. The records further reflect that Petitioner underwent physical therapy for persistent back/neck muscle strain/spasm for the timeframe of September 24, 2013 through February 27, 2014. It was noted that Petitioner had multiple cancellations and no-shows during her scheduled course of treatment. (PX2).

The records of McDonough District Hospital reflect that Petitioner underwent an MRI of the cervical spine on November 9, 2013, which was interpreted as revealing (1) multilevel disc disease most marked at C4-C5 through C6-C7; there is mass effect on the left nerve root at C4-C5 from a focal protruding disk to the far left; (2) focal far right protruding disk at C6-C7 with mild mass effect on the right nerve root. The records reflect that Petitioner underwent x-rays of the cervical spine July 23, 2013, which were interpreted as revealing no significant neuroforaminal narrowing; no fracture or listhesis; degenerative intervertebral disc space narrowing at C4 through C6. The records reflect that Petitioner underwent additional physical therapy and work conditioning during the timeframe of August 7, 2015 through March 15, 2016. It was noted that Petitioner had multiple cancellations and no-shows during her scheduled course of treatment. (PX2).

The medical records of Springfield Clinic were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The records reflect that Petitioner was seen by Dr. Stortzum on September 25, 2015 for an extreme sore throat and swollen glands. The assessment was noted to be that of fever and acute sinusitis. At the time of the visit with nurse practitioner Elvia Washington on September 24, 2015, it was noted that Petitioner was seen for her 12-week post-operative visit. It was noted that Petitioner stated that she was getting a lot of headaches, that she was also getting tingling in both hands, that she felt weak and that she would like more physical therapy. It was noted that Petitioner advised that she could not go back to work. The assessment was noted to be that of cervicalgia; cervical spinal stenosis; spondylosis of cervical region without myelopathy or radiculopathy; cervical radiculopathy. Petitioner was recommended to do daily work conditioning and to continue muscle relaxers and anti-inflammatory over-the-counter pain medication as needed. At the time of the visit with Dr. Stortzum on September 10, 2015, it was noted that Petitioner was complaining of a headache, pressure behind the right eye, neck pain and nausea. It was noted that Petitioner's headaches had been low grade for several days but starting about five hours ago, the intensity suddenly worsened. It was noted that Petitioner had been using Methocarbamol but was not sure that it was giving much relief and that she had just started physical therapy again about three weeks prior. The assessment was noted to be that of migraine headache; occipital neuralgia; anxiety. It was noted that Petitioner was encouraged to contact Dr. MacGregor's office to see if they wanted her to change her Methoocarbamol since she felt it was not giving much relief versus any further evaluation for her ongoing neck discomfort. It was noted that Dr. Stortzum believed that some of this was related to recent stressors and headache. (PX3).

The records of Springfield Clinic reflect that Petitioner was seen by Dr. MacGregor on July 23, 2015, at which time it was noted that she stated that she was uncomfortable/tense all the time, that she had been having headaches every now and then, that she had been having tense muscles in the neck and shoulders, that she stated that she had been wearing the collar 24/7, that she had numbness and tingling in the left hand and that she needed refills on pain medications and the muscle relaxer. The assessment was noted to be that of spondylosis of the cervical region without myelopathy or radiculopathy; cervical radiculopathy; cervical spinal stenosis. It was noted that Petitioner may wean out of the collar and that she was to begin a course of physical therapy. At the time of the July 6, 2015 visit with Dr. Stortzum, it was noted that Petitioner had had a migraine and vomiting the day before and that she still had a mild headache and nausea. It was noted that Petitioner was also having increasing left ear and jaw pain in the last 2-3 days and that she had been wearing a neck immobilizing brace since her cervical spine surgery. It was noted that Petitioner had recently had her first migraine-type headache since surgery, that in the past they had had her keep a small supply of Phenergan available as she usually experienced a fair amount of nausea and that she had vomited on that date. The assessment was noted to be that of otalgia of the left ear; nausea with vomiting. It was noted that the ear pain was not from infection and may be related to mild TMJ, maybe secondary to her neck brace usage. Petitioner was instructed to use Tylenol or Motrin and possibly consult her dentist. (PX3).

The records of Springfield Clinic reflect that Petitioner was seen by Nursing on June 23, 2015, at which time she stated that she was having difficulty swallowing. Petitioner was instructed to continue her pain medications as needed and that in regard to her swallowing difficulty, it was pretty common after cervical surgery and was related to post-operative swelling. At the time of the May 18, 2015 visit with Dr. MacGregor, it was noted that Petitioner stated that she was about the same as last time, that she had tenderness in the back of the neck and right shoulder and that she had numbness and tingling in her hands. The assessment was noted to be that of cervical radiculopathy; cervical spinal stenosis; and spondylosis of the cervical region without myelopathy or radiculopathy. The records reflect that on April 30, 2015, Petitioner was seen by Dr. Stortzum for medical clearance for a planned anterior cervical fusion of C4 through C7 by Dr. MacGregor. It was noted that Petitioner's symptoms began in June 2013 with a work-related injury and that she had tried multiple conservative measures, which she had failed. It was noted that since that time, Petitioner had also had worsening of her underlying headache issue. The assessment was noted to be that of cervical spinal stenosis; cervical radiculopathy; hypothyroidism; COPD; breast cancer, left. (PX3).

The records of Springfield Clinic reflect that Petitioner called the Springfield Clinic Telenurse on March 12, 2015, at which time it was noted that she reported a headache for the last two days and that she had not noticed her right eye was bloodshot until coming to see her daughter that evening, who told her to call. It was noted that Petitioner did not remember doing anything strenuous to cause the eye to turn red and that she did sneeze, but did not think that it was enough to cause the eye to get bloodshot. It was noted that Petitioner was instructed that if her eye pain was more than mild, she should be seen for that that night and that if her pain was tolerable after taking over-the-counter Tylenol or Ibuprofen, she should call her primary care physician's office in the morning to get an appointment. The records reflect that Petitioner underwent a pre-operative history and physical by Dr. Stortzum on February 12, 2015 for a planned anterior cervical fusion of C4 through C7 by Dr. MacGregor on February 20, 2015. It was noted that Petitioner's symptoms began in June 2013 with a work-related injury and that she had tried multiple conservative measures, which she had failed. It was also noted that since that time, Petitioner had also had worsening of her underlying headache issue. The assessment was noted to be that of spondylosis of the cervical region without myelopathy or radiculopathy; hypothyroidism; COPD; migraine headache; anxiety; cervical radiculopathy; cervical spinal stenosis. (PX3).

The records of Springfield Clinic reflect that Petitioner was seen by Dr. Stortzum on January 16, 2015, at which time it was noted that she had left knee pain and swelling for at least three weeks and that she had also been experiencing pain from the hip area to the left leg and foot. It was noted that there was no trauma at the onset of symptoms. Petitioner was instructed to undergo x-rays of the left hip and knee for further evaluation. At the time of the nurse practitioner visit on October 9, 2014, it was noted that Petitioner reported that on June 26, 2013 she was at work and bent over and that as she came up, she hit the top of her head on the bottom of a phone booth encasement. It was noted that Petitioner stated that she jarred her neck and head, that she reported neck pain, numbness and tingling in both arms and hands and that she had tenderness in the back of her neck and on the right-side shoulder. It was noted that Petitioner was concerned with the lack of use in her hands, that she could no longer do her normal daily activities and that she had decreased range of motion in her neck. The assessment was noted to be that of cervical radiculopathy; cervical spinal stenosis; cervical spondylosis. It was noted that Petitioner was offered anterior cervical discectomy and fusion C3-4, C4-5 and C5-6 and that she had failed all conservative treatments up to that point. It was noted that it was not thought that epidural steroid injections would be beneficial. (PX3).

The records of Springfield Clinic reflect that Petitioner was seen by Dr. Fortin on March 18, 2014, at which time it was noted that she needed some disability support forms filled out, that she was complaining of night sweats, that she had a rash on her arms after an EMG and that she had headaches and shoulder pain. The assessment was noted to be that of cervical radiculopathy; carpal tunnel syndrome. Petitioner was recommended to undergo physical therapy and a consultation with Dr. MacGregor in view of the EMG demonstrating a bilateral C6 radiculopathy and MRI demonstrating a protruding disc at C6-7. The records reflect that on February 28, 2014, Petitioner underwent EMG/NCV, at which time it was noted that she was a 58-year-old female, status post right median nerve release in the remote past not performed on the left, who had neck pain with radiation into both arms. The impression was noted to be that of (1) bilateral C6 radiculopathies, subacute to chronic in nature with evidence of reinnervation; (2) bilateral median neuropathies at the wrists, mild to moderate on the right, severe on the left, with neuropraxia seen bilaterally much worse on the left with sensory axonotmesis solely on the left. It was noted that a neurosurgical consultation would be arranged with Dr. MacGregor for purposes of evaluation of the carpal tunnel syndrome and cervical radiculopathies. (PX3).

The records of Springfield Clinic reflect that Petitioner underwent cervical spine x-rays on September 24, 2015, which were interpreted as revealing no interval change as compared to July 23, 2015. The history was noted to be that three-month post-operative follow-up; complaints of pain both sides of neck with numbness and tingling down both arms and headaches. The interpretive report for cervical spine x-rays performed on July 23, 2015 noted that the films were interpreted as revealing stable anterior cervical fusion of C4-C7 with stable hardware alignment. (PX3).

The records of Springfield Clinic reflect that Petitioner was seen by Dr. Fortin on November 19, 2013, at which time it was noted that the previous trigger point injections and occipital nerve blocks worked minimally and only for 1-2 weeks. It was noted that NSAIDs had not helped the pain and that the MRI demonstrated degenerative joint disease at C5-6 and C6-7 with a herniated nucleus pulposus. The assessment was noted to be that of cervicalgia; cervical radiculopathy. Petitioner was recommended to undergo an EMG/NCV of the upper extremities. At the time of the October 15, 2013 consultation with Dr. Fortin, it was noted that Petitioner was seen for evaluation of neck and bilateral shoulder pain and also headaches. It was noted that Petitioner had a history of neck and occipital pain with radiation to her shoulders as well as slowly worsening lumbar pain. It was noted that Petitioner was bending over and then standing up, hitting her head on the back of a ledge while at work and that she immediately felt stunned and dazed when this occurred in June of 2013. It was noted that Petitioner initially was disoriented, light-headed and then began having pain and that the next day, she was noted to have asymmetric pupils. It was noted that Petitioner had a history of migraines since age 12, that she had had four severe headaches since

June and that she had been off work since June. It was noted that physical therapy had helped and that a steroid injection and muscle relaxers had helped a bit. The assessment was noted to be that of common migraine (without aura) with intractable migraine; cervicalgia; occipital neuralgia. Petitioner was recommended to undergo bilateral occipital nerve blocks and trigger point injections, which were performed. (PX3).

The records of Springfield Clinic reflect that Petitioner was seen by Dr. Stortzum on May 13, 2016, at which time it was noted that she had complaints of headache, neck pain, and head and chest congestion, among other issues. The assessment was noted to be that of acute sinusitis; seborrheic keratosis, inflamed, left shoulder and mid-back bra line. The records reflect that Petitioner underwent an EMG/nerve conduction study of the upper extremities on May 9, 2016. The impression was noted to be that of (1) bilateral carpal tunnel syndrome, mild on the right and moderately severe on the left; (2) no evidence of ulnar or radial neuropathy; (3) no evidence of cervical radiculopathy. The records reflect that Petitioner was seen by nurse practitioner Elvia Washington on May 9, 2016, at which time it was noted that she stated that she was still having headaches, that she was still having the numbness and tingling in her hands bilaterally and that she reported that her endurance was not that great. It was noted that Petitioner continued to smoke. The assessment was noted to be that of carpal tunnel syndrome; cervical radiculopathy; cervical spinal stenosis; spondylosis of cervical region without myelopathy or radiculopathy. It was noted that Petitioner consented for left carpal tunnel release but that no surgical date would be given until she contacted the office pertaining to getting it approved by her insurance company. At the time of the March 25, 2016 visit with nurse practitioner Melissa Pounders, it was noted that Petitioner stated that a week ago she was sitting in her recliner, that she dropped something and reached over the arm of the chair and that she felt something pull/pop in her right-side ribcage. It was noted that the pain was fairly constant but increased in severity with certain twisting movements and that it felt muscular in nature. The assessment was noted to be that of a muscle strain. Petitioner was given prescriptions for a muscle relaxant and pain medication. (PX3).

The records of Springfield Clinic reflect that Petitioner was seen on June 20, 2017 for pain in the lower abdomen of unknown etiology. At the time of the May 16, 2017 visit with Dr. Stortzum, it was noted that Petitioner had been out of work for four years, that her neck surgery was two years ago, that Dr. MacGregor left town and that Petitioner's job asked for an FCE to give her some permanent restrictions. It was noted that Dr. Stortzum noted that he would only give restrictions based off the FCE. It was noted that the FCE indicated that Petitioner's effort was inconsistent but that they felt she could at least do a Medium demand vocation. It was noted that Petitioner asked about range of motion of her neck and that she indicated that she could not fully extend it like she used to be able to do. It was noted that Petitioner was undoubtedly as good as she was ever going to get concerning her neck pain. The assessment was noted to be that of chronic neck pain. At the time of the May 2, 2017 visit, it was noted that Petitioner presented for suture removal from a biopsy on the right side of the nose done the week before. The assessment was noted to be that of melanocytic nevus of face. At the time of the April 25, 2017 visit, Petitioner presented for a punch biopsy of a mole lesion on the right side of the bridge of the nose. (PX3).

The records of Springfield Clinic reflect that Petitioner was seen by Dr. Stortzum on April 10, 2017, at which time it was noted, among other things, that she felt like her heart was racing all of the time and that she felt short of breath moreso than normal. At the time of the January 23, 2017 visit, it was noted that Petitioner reported more headaches in the past week and that she noted that there was a lot of facial pain and pressure. The assessment was noted to be that of allergic rhinitis; depression; hypothyroidism; chronic sinusitis; right otitis media. Petitioner was given a script for antibiotics and Prednisone. At the time of the October 12, 2016 visit, it was noted that Petitioner had a loose tooth and that she thought it was causing her an infection as well as a complaint of significant productive cough with thick green sputum. The assessment was noted to be that of acute bronchitis; acute sinusitis. At the time of the September 21, 2016 visit, it was noted that Petitioner had complaints of a significant sore throat, nasal congestion and cough. The

assessment was noted to be that of allergic rhinitis; acute URI. Petitioner was encouraged over-the-counter supportive and symptomatic care. (PX3).

The records of Springfield Clinic reflect that Petitioner was seen on August 30, 2016, at which time it was noted that she had concerns over increased swelling and tightness in the feet, among other issues. The assessment was noted to be that of dyspnea on exertion; lower extremity edema; COPD. At the time of the July 11, 2016 visit, it was noted that Petitioner presented with a complaint of numbness and tingling and a heavy feeling in her bilateral feet, legs, arms and hands, that it had been present for approximately three months and that it had been intermittent in nature. It was noted that Petitioner's foot symptoms began when she started physical therapy. It was noted that Petitioner had had cervical surgery and that she stated that the symptoms she was currently having in her upper extremities were different than the cervical radiculopathy she was having prior. The assessment was noted to be that of paresthesias/numbness. Petitioner was ordered to undergo labs to look for any deficiencies that may be causing paresthesias. (PX3).

The records of Springfield Clinic reflect that Petitioner was seen on February 18, 2016, at which time it was noted that on February 12, 2016 she was diagnosed with radiation dermatitis and skin ulceration having recently completed radiation therapy. It was noted that there was good wound healing at that time. At the time of the February 12, 2016 visit, it was noted that Petitioner had just completed a course of radiation therapy on February 1, 2016. The assessment was noted to be that of radiation dermatitis. Petitioner was referred to the MDH Wound Clinic. At the time of the February 11, 2016 visit with Dr. MacGregor, it was noted that Petitioner stated that she was doing fine and had intermittent pain. It was noted that Petitioner noted that she had good and bad days in terms of pain severity, that she stated that she completed physical therapy but was getting headaches after physical therapy and that she complained of pain, numbness and tingling in her hands bilaterally. It was noted that Petitioner reported that she had not had carpal tunnel surgery at that point and that she stated that she recently underwent radiation treatment for right-sided breast cancer and suffered a severe radiation burn. The assessment was noted to be that of cervical radiculopathy; cervical spinal stenosis; spondylosis of the cervical region without myelopathy or radiculopathy. Petitioner was given a work note for upper extremity work restrictions, was recommended to undergo an EMG of the left upper extremity and to consider an EMG of the right upper extremity, and was recommended carpal tunnel syndrome release surgery. (PX3).

The records of Springfield Clinic reflect that Petitioner was seen on December 29, 2015 for left knee pain and swelling, that she thought she injured it in therapy the week before and that she also wanted a flu shot. It was noted that Petitioner was currently going through physical therapy for work hardening therapy. It was noted that Petitioner had also noticed that she was getting more headaches due to strain on her neck and shoulder muscles due to this and her sister's recent progressive health issues. The assessment was noted to be that of knee pain and need for influenza vaccination. It was noted that a call was placed to physical therapy and that they would try to reduce the weight load on Petitioner's squatting exercises and modified activity as tolerated but still keep on course for getting her ready to return to work. At the time of the November 24, 2015 visit with Dr. Stortzum, it was noted that Petitioner was having issues with a cough and nasal congestion. It was noted that Petitioner had a frontal headache and that she was also achy across the upper back and posterior neck. The assessment was noted to be that of acute left otitis media and acute frontal sinusitis and current every day smoker. Petitioner was prescribed antibiotics. (PX3).

The medical records of Memorial Medical Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. The Discharge Summary dated June 11, 2015 noted that Petitioner was admitted on June 9, 2015 for anterior cervical discectomy and fusion at C4-5, C5-6 and C6-7 for cervical stenosis and radiculopathy and that she underwent a normal fusion without any problems or complications. The Operative Report noted that Petitioner underwent anterior cervical decompression with arthrodesis, placement of machined interbody fusion device and plating at C45, C56, C67 by Dr.

MacGregor for pre- and post-operative diagnoses of cervical spinal stenosis, cervical spondylosis and cervical radiculopathy. (PX4).

The medical records of Orthopedic Center of Illinois were entered into evidence at the time of arbitration as Petitioner's Exhibit 5. The records reflect that Petitioner underwent an FCE on September 12, 2017, at which time it was noted that she provided excellent effort throughout the testing process, that during the dynamic lifting she was cooperative but limited by her maximum safe effort and that she appropriately qualified at a Medium Physical Demand Classification. It was noted that lifts over five times per day at the Medium level would place Petitioner at significant medical risk and that, as a result, the safe recommended PDC was that of Medium with occasional lifting of 28 pounds, frequent lifting of 17.5 pounds and constant lifting of 7 pounds. (PX5).

The medical records of Orthopedic Group at Springfield Clinic were entered into evidence at the time of arbitration as Petitioner's Exhibit 6. The records reflect that Dr. William Payne issued a "To Whom It May Concern" letter indicating that in his opinion, the new FCE should be considered a valid and reliable result; that he did not think that Petitioner should undergo any further work hardening and strengthening; that the new restrictions should be permanent and that Petitioner was at maximum medical improvement; and that permanent restrictions as of September 29, 2017 were that of Medium Demand Level job, lifts over five times per day at recommended demand levels; not recommended floor to knuckle, safe recommended occasional 28 pounds, frequent 17.5 pounds, constant 7 pounds. (PX6).

The Medical Bills Exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibit 7.

The December 11, 2017 IME Report of Dr. Timothy Payne was entered into evidence at the time of arbitration as Petitioner's Exhibit 8. The report reflects that Petitioner was seen for an IME on December 11, 2017. It was noted that Petitioner stated that she underwent surgery, that she was a poor historian, that she stated that she had a 3-level fusion anteriorly and that she subsequently underwent therapy for an additional three months. It was noted that Petitioner was released to go back to work in October of 2017 and that she was currently released for light duty where she was mopping, cleaning toilets and cleaning rooms. It was noted that Petitioner stated that her neck was stiff, that she had weakness and tingling involving both arms, that she complained of stiffness around the neck, that she still had some headaches and that she complained of notch tightness in the left and right paracervical area. It was noted that Petitioner was not taking any medication except for applying Icy Hot ointment to the neck. (PX8).

The report reflects that Petitioner's exam and history indicated that she had degenerative changes of the cervical spine, particularly C4-5, C5-6 and C6-7. It was noted that Petitioner was a candidate for cervical fusion because she failed conservative treatment and that the aggravation was the result of the contusion to her head, aggravating the underlying cervical spondylosis, resulting in symptoms of cervical radiculitis. It was noted that medical treatment to date had been reasonable and necessary. It was noted that Petitioner should maintain a home exercise program but may work as she had been doing without restrictions and that she did not require further diagnostic studies. It was noted that Petitioner could perform her duty but should avoid repetitive overhead lifting activities and that she had reached maximum medical improvement. (PX8).

The CMS Workers' Compensation Packet was entered into evidence at the time of arbitration as Respondent's Exhibit 1.

The IME Report of Dr. Timothy Payne was entered into evidence at the time of arbitration as Respondent's Exhibit 2. The report reflects that Dr. Payne saw Petitioner on May 29, 2014, at which time she gave a history of an injury occurring to her head and neck on June 26, 2013. It was noted that Petitioner

was washing windows in front of a building, that she was putting supplies into a cart and that as she came up, she hit her head on a shelf. It was noted that Petitioner complained of pain involving her neck, that it was greater on the right than the left side, that she complained of stiffness with motion of the cervical spine, that she had pain in the upper back and complained of trigger point-type pain or knots involving the upper back near the midline, that she complained of numbness and tingling involving her hands and that she noted that the numbness and tingling had been ongoing for a couple of months. (RX2).

The report reflects that Dr. Payne opined that Petitioner sustained a contusion to the neck and cervical spine, which resulted in the onset of cervical radiculitis. It was noted that the cervical spine arthritic changes pre-existed the injury but that the condition was exacerbated by her injury. It was noted that the carpal tunnel syndrome seemed to be an incidental finding but that it was noted in notes of post-treatment for her neck and head that she had weakness in her hands, that the complained of weakness in her hands was objectively supported by the findings on EMG but that it was impossible to determine whether the weakness was secondary to her cervical radiculitis or from her carpal tunnel syndrome. It was noted that the carpal tunnel syndrome was not related to her work-related injury of June 26, 2013. (RX2).

The report reflects that Dr. Payne opined that Petitioner had not reached maximum medical improvement, that she required further treatment for the cervical spine and that she would benefit from pain management with assessment of a possible epidural injection to control the cervical spine complaints and that, if the symptoms were not controlled with the epidural injection, she may require neurosurgical evaluation regarding her cervical spine. It was noted that Petitioner was not able to work full duty as a janitor/cleaning person due to her ongoing complaints of neck and arm pain and that she could work modified duty with restrictions to include no overhead lifting, infrequent lifting to shoulder level and no repetitive turning of the neck. (RX2).

The FCE Report dated April 18, 2017 was entered into evidence at the time of arbitration as Respondent's Exhibit 3. The records reflect that the overall classification of effort was invalid due to Petitioner performing inconsistently during a repeated measures protocol and that she met the material handling demands of Medium demand vocation per the Dictionary of Occupational Titles. It was noted that Petitioner failed to give maximum voluntary effort during the FCE and that it was undeterminable as to maximum lifting capabilities and/or other functional capabilities. (RX3).

A Picture of Olson Hall was entered into evidence at the time of arbitration as Respondent's Exhibit 4.

CONCLUSIONS OF LAW

With respect to disputed issue (C), the Arbitrator finds that Petitioner met her burden of proof in establishing that she sustained accidental injuries that arose out of and in the course of her employment with Respondent on June 26, 2013.

To obtain compensation under the Illinois Workers' Compensation Act, a claimant must show by a preponderance of the evidence that he has suffered a disabling injury arising out of and in the course of his employment. 820 ILCS 305/2; *Metropolitan Water Reclamation District of Greater Chicago v. Illinois Workers' Compensation Comm'n*, 407 Ill. App. 3d 1010, 1013 (2011); *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill. 2d 52, 57 (1989). However, the fact that an injury arose "in the course of" the employment is not sufficient to impose liability, for to be compensable, the injury must also "arise out of" the employment. *Id.* at 58.

The "arising out of" component refers to an origin or cause of the injury that must be in some risk connected with or incident to the employment, so as to create a causal connection between the employment and the accidental injury. *Id.* There are three categories of risk to which an employee may be exposed: (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. *Springfield Urban League v. Illinois Workers' Compensation Comm'n*, 2103 IL App (4th) 120219WC, ¶ 27; *Young v. Illinois Workers' Compensation Comm'n*, 2014 IL App (4th) 130392WC. Injuries resulting from a neutral risk are not generally compensable and do not arise out of the employment unless the employee was exposed to the risk to a greater degree than the general public. *Id.*

The "in the course of" component refers to the time, place and circumstances under which the accident occurred. *Illinois Bell Telephone Co. v. Industrial Comm'n*, 131 Ill. 2d 478, 483 (1989). If an injury occurs within the time period of employment, at a place where the employee can reasonably be expected to be in the performance of her duties, and while she is performing those duties or doing something incidental thereto, the injuries are deemed to have been received in the course of the employment. *Caterpillar Tractor Co.*, 129 Ill. 2d at 58. "Injuries 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, or within a reasonable time before and after work, are generally deemed to have been received in the course of the employment." *Johnson v. Illinois Workers' Compensation Comm'n*, 2011 IL App (2d) 100418WC, ¶21.

In the case at hand, the Arbitrator notes that Respondent has argued that no evidence was presented at trial that any hazard existed or that there was a defect of any kind, that the outdoor telephone booth was a neutral risk that had no particular employment or personal characteristics such as those that the general public is commonly exposed to and that Petitioner admitted that she was familiar with the area at issue. The Arbitrator notes, however, that Petitioner was required to climb over a railing while handing supplies to her co-workers, which placed her in an awkward, bent-over position next to a wall-mounted telephone booth that was hanging out over her as she maneuvered herself over the railing, and that her employment activities placed her in this awkward and precarious position leading to her having hit her head and having suffered injury. Although the area was admittedly open to the general public, the Arbitrator notes that the general public would generally not be expected to be climbing over the railing or have their attention diverted by handing supplies to others in the area.

As a result thereof, the Arbitrator finds that Petitioner met her burden of proof in establishing that she sustained accidental injuries that arose out of and in the course of her employment with Respondent on June 26, 2013.

With respect to disputed issue (L) pertaining to the nature and extent of Petitioner's injury, and consistent with 820 ILCS 305/8.1b, permanent partial disability shall be established using the following criteria: (i) the reported level of impairment pursuant to subsection (a) of Section 8.1b of the Act; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. 820 ILCS 305/8.1b. No single enumerated factor shall be the sole determinant of disability. *Id.*

With respect to Subsection (i) of Section 8.1b(b), the Arbitrator notes that no AMA rating was offered by either party in this matter. As a result thereof, the Arbitrator gives no weight to this factor.

With respect to Subsection (ii) of Section 8.1b(b), the Arbitrator notes that Petitioner continues to work for Respondent. The Arbitrator finds that the nature and demands of her position will likely have some affect on her permanent partial disability and, as such, the Arbitrator places greater weight on this factor when making the permanency determination.

With respect to Subsection (iii) of Section 8.1b(b), Petitioner was 57 years old on her date of accident. Given the age of Petitioner and the fact that she has been placed under permanent restrictions by Dr. Stortzum, the Arbitrator places greater weight on this factor when making the permanency determination.

With respect to Subsection (iv) of Section 8.1b(b), the Arbitrator notes that Petitioner has returned to work in a light duty capacity at her previous position, but there was the suggestion at the time of arbitration that Respondent may be unable to provide work within her restrictions in the summer months, which would thereby result in a reduction in her annual earnings. The Arbitrator places some weight on this factor when making the permanency determination.

With respect to Subsection (v) of Section 8.1b(b), the Arbitrator notes that Petitioner testified that her arms now have limited mobility and that she has difficulty turning her head side-to-side and looking up. Petitioner testified that she has headaches every couple of days. Petitioner testified that she has weakness in her arms. Petitioner further testified that she does not currently take any medication for her injury, but that she uses a heating pad nightly. At the time of the February 11, 2016 visit with Dr. MacGregor, it was noted that Petitioner stated that she was doing fine and had intermittent pain. It was noted that Petitioner noted that she had good and bad days in terms of pain severity, that she stated that she completed physical therapy but was getting headaches after physical therapy and that she complained of pain, numbness and tingling in her hands bilaterally. (PX3). The Arbitrator concludes that Petitioner's evidence of disability at the time of arbitration, namely her continued complaints and purported limitations, were corroborated by her treating records at the conclusion of her treatment with Dr. MacGregor. The Arbitrator accordingly places greater weight on this factor in determining permanency.

The Arbitrator notes that the determination of permanent partial disability benefits is not simply a calculation, but an evaluation of all of the factors as stated in the Act in which consideration is not given to any single factor as the sole determinant. Based on the above factors and the record in its entirety, the Arbitrator concludes that Petitioner sustained permanent partial disability to the extent of 35% loss of use of the person-as-a-whole under 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

Ricardo Salinas,

Petitioner,

vs. NO. 15 WC 41424

McDonald's,

Respondent.

19IWCC0710

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §8a 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 care and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 12, 2018 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.

19IMCC0210

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

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

No bond is required for the 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: DEC 31 2019

Stephen J. Mathis

SJM/sj
o-12/18/2019
44

Deborah Simpson

DISSENT

The Arbitrator found that Petitioner's September 16, 2015 accident resulted in a lumbar strain only. The Arbitrator further found that Petitioner reached maximum medical improvement in November 2015 and that his L4-L5 herniation and recommended fusion was not causally related.

I find that under the chain-of-events analysis, Petitioner's current condition is causally related to his September 16, 2015 accident and I would order the Respondent to provide and pay for prospective medical treatment.

Petitioner was a 41-year old maintenance worker at McDonald's with no prior history of back problems. On the above date, he slipped on a ladder and injured his low back. He reported the incident immediately to the store manager and was advised to go the doctor. Petitioner presented to Silver Cross Hospital that day complaining of an electrical type pain in the low back radiating primarily to the left side. Petitioner thereafter began to work light duty; however, he stated that he performed most of his regular duties.

Petitioner then underwent physical therapy with some relief. An MRI performed on December 7, 2015 showed a right-sided herniated disc at L4-L5 and a broad-based disc bulge/protrusion at L5-SI. Petitioner was then seen by Dr. Richard Koutsky, an orthopedist, on December 23, 2015 with complaints of pain down the left leg. The examination revealed a decreased pin prick sensation on the left, a positive straight leg raise on the left, tenderness and spasms to palpation, and limited range of motion. Dr. Koutsky reviewed the MRI and noted that

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it demonstrated a central disc herniation and extruded fragmented at L4-L5 with stenosis and nerve root impingement. Dr. Koutsky diagnosed Petitioner with left radiculopathy at L4-L5 and an extruded herniated disc.

From January 2016 through August 2016, Petitioner engaged in continuous conservative treatment including physical therapy and injections. In September 2016, Petitioner returned to regular duty and noticed an increase in his symptoms. Petitioner returned to Dr. Koutsky on September 15, 2016 and reported that his symptoms recurred severely. Petitioner was then seen by Dr. Sean Salehi, a neurosurgeon, on October 24, 2016. Dr. Salehi reviewed the MRI and noted that it revealed a moderate central to right paracentral herniated disc at L4-L5 with significant, right more than left, lateral recessed stenosis and moderate bilateral facet arthropathy at L4-L5. Dr. Salehi noted that Petitioner had mechanical back pain secondary to a permanent aggravation of disc disease at L4-L5 and an annular tear at L4-L5 due to a disc herniation causally related to the work injury. Dr. Salehi recommended an L4-L5 transforaminal lumbar interbody fusion as Petitioner failed conservative treatment.

Dr. Jay Levin performed a Section 12 exam on January 27, 2016. Though he found significant strength deficits and sensory changes, he opined that the Petitioner suffered a strain only which should have resolved in 4 to 6 weeks.

Petitioner worked at the Respondent's facility from the date of accident through May 5, 2017. He then went to work at another McDonald's.

I believe there is causation using the chain of events analysis. Respondent argues that the Petitioner may have injured his back after he left the job, and that the pain location changed from the right to the left leg throughout the period of treatment. The record establishes that Petitioner underwent treatment on a regular basis following the accident. The MRI revealed a moderate central to right paracentral herniated disc at L4-L5 with significant, right more than left, lateral recessed stenosis and moderate bilateral facet arthropathy at L4-L5. While Petitioner improved with treatment, his condition never fully healed following the accident. Petitioner then experienced a severe recurrence of his symptoms upon his return to regular duty. Petitioner was still working for the Respondent when the diagnosis and surgical recommendation was made.

The Majority and the Arbitrator relied on the opinion of Dr. Levin. I believe Dr. Levin's opinion is not persuasive. Dr. Levin's examination noted positive findings. His opinion that Petitioner sustained a strain only is contradicted by the record. Clearly the Petitioner did not have a strain, which resolved itself within a short period of time. Therefore, I would find causal connection and award the lumbar fusion as recommended by Dr. Salehi.

D. Douglas McCarthy

0170CC91E1

# ILLINOIS WORKERS' COMPENSATION COMMISSION
# NOTICE OF ARBITRATOR DECISION
8(a)

SALINAS, RICARDO
Employee/Petitioner

Case# **15WC041424**

McDONALDS
Employer/Respondent

19IWCC0710

On 10/12/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.38% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1427 BERG & BERG
STEPHEN M WAUCK
2100 W 35TH ST
CHICAGO, IL 60609

2461 NYHAN BAMBRICK KINZIE & LOWRY
DANIEL UGASTE
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

19IWCC0710

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 SECTION 8(a)

RICARDO SALINAS,
Employee/Petitioner

Case # **15 WC 41424**

v.

Consolidated cases: **DNA**

MCDONALDS,
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 **PAUL SEAL**, Arbitrator of the Commission, in the city of **CHICAGO**, on **July 25, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ 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, **09/16/2015**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did*** 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 $**20,924.28**; the average weekly wage was $**402.39**.

On the date of accident, Petitioner was **42** years of age, ***married*** with **1** dependent children.

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

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

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

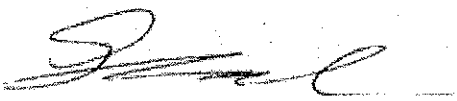
ORDER

Prospective medical treatment and bills are denied after the petitioner's MMI date of November 2015.

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

October 11, 2018
Date

ICArbDec19(b)

OCT 12 2018

FINDINGS OF FACT

The petitioner testified through an interpreter. On direct examination he testified that on September 16, 2015, he had worked for McDonald's in Orland Park, for approximately six years and, while working at this McDonald's, he also worked at other McDonald's restaurants on a part-time basis. The petitioner was a maintenance man. His first job at the respondent's Orland Park location was in the kitchen - but, he was promoted to maintenance. His duties included cleaning and maintaining the refrigerators and other equipment, as well as basic maintenance.

On September 16, 2015, the petitioner was placing boxes for storage in a room above the bathrooms. While stepping up on a ladder, a box he was lifting was about to slip. He managed to hold onto the box and the ladder moved. Nothing fell, and the petitioner did not fall, but he felt pain in his back.

The petitioner testified that he reported the incident to the store manager. She told him that if he needed to go to the doctor to feel free to do so. Later that same day, he went to Silver Cross Hospital. He stated that he had electricity-like pain in his low back. He took medication, which he stated helped but not completely.

On October 2, 2015, the petitioner sought medical treatment at La Clinica. He received physical therapy and eventually was sent for MRI. From La Clinica he was referred to Dr. Koutsky at Elmhurst Orthopedics. Dr. Koutsky recommended injections in his back. He referred the petitioner to Dr. Husain who performed a series of three injections. The petitioner testified that these did not help very much.

Following the injections, the petitioner did not feel the same pain as he had on the date of accident. He testified that it was more intense. Specifically, it bothered him a lot more during activities. These included sleeping, moving side to side, and when he was bathing.

The petitioner testified that he returned to Dr. Koutsky following the injections and the doctor recommended surgery. The petitioner then saw Dr. Salehi for a second opinion. He also recommended surgery and the petitioner wants to have the surgery performed by Dr. Salehi. When asked if he was taking pain medication, the petitioner responded that he is taking Advil when the pain is very intense - at night and when he goes to sleep. When asked by his attorney more specifically how often he takes the Advil, he stated a couple of times a week.

The petitioner testified that he currently is working, but only one job now. Before the accident, he had a full-time job and a part-time job. He no longer works for the respondent McDonald's in Orland Park - but only works for the McDonald's in Lockport. He performs three days of maintenance there and the rest of the time he spends working in the kitchen.

The petitioner testified on cross-examination that he went to Silver Cross Hospital in Joliet following his accident and he lives in Joliet. He further described the pain he was experiencing in his back at that time as a sharp pain, like a shock or electricity. He described it as a great deal of pain. He did not recall being asked his symptoms when he was at the hospital. He did not recall telling them that he had experienced prior episodes of back pain on rare occasions. He testified that he did not

have any prior injuries to his back. He stated that he went to Silver Cross in Joliet is because it is the only place he knew that was close by.

The petitioner testified that he went to La Clinica approximately two weeks later. He stated that Silver Cross gave him medication for two weeks. He testifed that La Clinica is located at 5738 South Pulaski Road in Chicago and he drove himself there. The petitioner testified that all his treatment has been in Cook County except for Dr. Koutsky, who is in Elmhurst. The petitioner drove himself to all his appointments.

The petitioner testified that he continued working both his full-time and part-time jobs following the accident. He admitted that he had to fill out a new application to work for SueCo on November 22, 2015, because ownership of the McDonald's had changed. When asked if SueCo's records show that he had worked for them from December of 2015, through December of 2017, without restrictions; the petitioner testified that would be inaccurate. He has restrictions and they know it.

The respondent called Ms. Kelly Glaeser. Ms. Glaeser has been employed by the respondent for almost 19 years. She works for the owners, the Freemans, and her current position is that of supervisor. As of July 25th, she will have been in that position for one year. Prior to this position, she was a general manager at the store at 159th and Wolf Road in Orland Park. She held that position for four years and her duties included basic operation of that location. This included running service and taking care of everything in the store. She also did scheduling. If someone had work restrictions, they brought them to her. In addition to her supervisory role, she also worked the store, which meant that she actually participated in the preparation of food and the

activities at the store.

She testified that she knew the petitioner because he had worked for her, including in September of 2015. She was his boss until the time he left. If she was present at the time, he reported directly to her. Otherwise, he would report other managers.

She was aware of the petitioner's September 16, 2015, accident because he told her about it right after it occurred. She stated that she had additional conversations with him about his injury at later dates. Eventually, the petitioner began coming to work with notes, which were restrictions from doctors. The restrictions were honored through a modification of his prior position.

Ms. Glaeser testified that she had other conversations with the petitioner concerning his injuries. On October 26, 2016, Ms. Glaeser and the owner, Bob Freeman, had a conversation with the petitioner about how he was feeling. The petitioner stated that he was fine, his back was fine, the doctors wanted him to get surgery but he did not want it because he did not need it.

She testified that she did not notice anything unusual about his activities, any pain behaviors, while he was working light duty. He did bring a back brace with him to work and would bring it inside with him. However, it sat in their crew room on their table. She noticed this on a couple of occasions. She stated that the petitioner's last day of work was May 5, 2017.

Robert Freeman testified for the respondent. He testified that he owned McDonald's restaurants, including the one in Orland Park that was the subject of the testimony that day. He stated that he was aware of the petitioner's accident and was informed of it that day. He also kept informed of the petitioner's condition because he saw the doctor's notes that came in.

Mr. Freeman testified that when the petitioner was under restrictions they were followed 100%. He noticed on occasion that the petitioner would lift something that he should not, and he would have to tell him not to lift that while on restrictions. Mr. Freeman stated that he never had to use an interpreter to communicate with the petitioner.

Mr. Freeman also confirmed the conversation that the petitioner had with him and Ms. Glaeser on October 26, 2016, about not wanting to go for further treatment and feeling better. Mr. Freeman confirmed that RX7 documented what was told to them.

Mr. Freeman also testified that he learned later that the petitioner worked at another McDonald's - including work for the Corey's - for approximately a year to a year and a half prior to the time that he resigned from the respondent's location.

Sometime shortly before the petitioner resigned his employment with the respondent, Mr. Freeman learned that he was doing grill work and maintenance work at the Corey's McDonald's without restrictions. Mr. Freeman also testified that he had a conversation with another owner by the name of Sue, whose last name he could not recall because she had remarried. When he asked about the work that the petitioner was doing at Sue's McDonald's, the supervisor had to call him back. It was either the

store manager or the general manager who confirmed that the petitioner was working for them at the time without any restrictions.

When asked on cross-examination about the physical nature of work at McDonald's, Mr. Freeman testified that the job of a maintenance worker involves heavy lifting. Again, Mr. Freeman stated that when the petitioner was working with restrictions for him they would often have to stop him from working beyond his restrictions. He stated that the petitioner generally was a good employee and a hard worker.

The petitioner testified in rebuttal that he did not wear the back brace because he was not able to work with it on. If he wore it while working, he could not breathe. Also, the doctor told him that he did not have to wear it all the time, only when he had pain.

MEDICAL

On September 16, 2015, the petitioner injured his low back while lifting a box at work. He initially sought care at Silver Cross Hospital in Joliet, where he told them that his preferred language was English and described his symptoms as "achy." He told them that he had prior episodes on rare occasions. With the exception of tenderness in the left lumbar area, his examination was normal. The petitioner was diagnosed with a lumbar strain and was referred to Dr. Mohammad Kahn, since he had no family physician. He was to be seen the following day.

The petitioner was seen two weeks later at La Clinica, a chiropractic and physical therapy practice located in Chicago, Illinois. The first visit was on October 2, 2015. He testified that he sought treatment there at the recommendation of a co-worker. The petitioner worked full duty up until this date. Once seen at La Clinica, he was given restrictions and placed on light duty beginning October 2nd.

The petitioner continued at La Clinica. On October 29, 2015, the petitioner told the doctor that he was having mild lower back pain - but, his condition was a lot better. He denied any numbness or tingling into his lower extremities. He stated that work did not affect his condition but bending still caused mild pain. He was not taking any pain medication. The doctor released him to full duty on that date.

The petitioner underwent MRI on December 7, 2015. The radiologist interpreted it as showing a right-sided herniated disc at L4-5 and a broad-based disc bulge/protrusion at L5-S1. The remainder of the spine appeared unremarkable. Three days later the petitioner underwent an EMG. The radiologist interpreted findings that he thought might be ascribed to early left-sided lumbosacral radiculopathy, as well as findings consistent with anterior tarsal tunnel syndrome.

The petitioner continued under the care of physicians at La Clinica. On December 23, 2015, he saw Dr. Richard Koutsky at the recommendation of Dr. Jao. Examination revealed decreased pin prick sensation on the left, as well as positive left-sided straight leg raising tests. There was some tenderness and spasm noted to palpation and limited range of motion. Dr. Koutsky interpreted the MRI to show a central disc herniation and extruded fragmented L4-5 with stenosis and nerve root

impingement. Dr. Koutsky diagnosed a left L4-5 radiculopathy and extruded herniated disc. Trigger point injections were given.

The petitioner attended physical therapy at La Clinica on January 14, 2016, and he reported his pain level at 2/10 and that he was tolerating working full time without increased pain. On January 27, 2016, the petitioner was examined under section 12 of the Act by Dr. Jay Levin at Adult and Pediatric Orthopedics at the request of the respondent. Dr. Levin took a complete history, reviewed the medical records as well as the MRI and the EMG. Dr. Levin noted several non-anatomical findings. He reviewed the MRI study, which he indicated showed a central disc herniation at L4-5 as well as several degenerative conditions at the remaining lumbar levels to the sacrum. Dr. Levin thought that the MRI findings were consistent with the petitioner's age. He opined that the petitioner suffered a lumbar strain which appeared to have healed within four to six weeks of the injury. He indicated that it was appropriate for the petitioner to return to his full duty capacity, which he did within seven to ten days from his accident. He did not think that any further medical care was necessary for the petitioner.

The petitioner continued treatment at both La Clinica and with Dr. Koutsky. He last was seen at La Clinica in July of 2016. On August 11, 2016, Dr. Koutsky noted that the petitioner was anxious to return to work in a full duty capacity and that his therapy and injections were complete. Dr. Koutsky released him to return to full duty work and asked him to follow up in one month. The petitioner returned on September 15, 2016, and Dr. Koutsky noted that the petitioner's symptoms had recurred severely. Dr. Koutsky referred the petitioner to Dr. Geoffrey Dixon for a neurosurgical opinion.

In October of 2016, the petitioner was seen by Dr. Sean Salehi of Neurosurgical Surgery and Spine Surgery in Westchester, Illinois. Dr. Koutsky last found unchanged neurological examination with positive straight leg raising test on the left. Dr. Salehi's examination did not note this – but, it did reveal decreased sensation in the left calf and foot. Dr. Salehi reviewed the MRI studies and noted the findings at L4-5 – but, he interpreted these findings as showing a right paracentral herniated disc with significant right more than left recessed stenosis. Dr. Salehi recommended a spinal fusion. The petitioner saw Dr. Salehi last in November of 2017. Dr. Salehi continued to recommend a fusion.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Mr. Freeman, owner of the respondent McDonald's restaurant, testified that his discussions with the petitioner's other employers indicated that the petitioner worked at those other McDonald's restaurants, for other owners, without restrictions. While the petitioner denied this, stating that "he has restrictions and they know it," the records of his other employer, SueCo, do not support his testimony and corroborate Mr. Freeman's. (RX6) The evidence shows that the petitioner worked unrestricted the entire time at the other McDonald's for both the Coreys and SueCo.

The petitioner testified that immediately following the incident he felt electric like pain that later was a lot of pain or great pain. His records from Silver Cross Hospital the day of the accident indicate that the petitioner reported an achy-type pain. The petitioner testified that he currently is in pain severe enough that he wants to proceed with surgery. He takes only Advil a couple of times a week. The arbitrator did

not observe the petitioner show any discomfort or pain behaviors during his several hour arbitration hearing which included his testimony and that of two other live witnesses.

In addition, the petitioner testified with the assistance of an interpreter. The respondent's witnesses both testified that they never had any difficulty communicating in English with the petitioner. The arbitrator realizes that the petitioner might have been nervous at hearing and preferred the comfort of an interpreter assisting him. Nevertheless, the arbitrator observed the petitioner repeatedly begin to answer counsels' questions with gestures, head nods and verbally, even before the question was finished let alone had the interpreter translated it.

The respondent's examiner under section 12 of the act, Dr. Levin, noted a disc herniation on MRI study, as did the other doctors. Dr. Levin did not note any findings indicating that the disc caused a surgical condition and he did not find any additional care warranted. Dr. Levin's findings and opinions are supported by the facts that the petitioner continued working without restrictions for McDonald's restaurants other than the respondent's, the petitioner's testimony that he takes Advil for pain a few times per week, his sporadic complaints of pain and subjective responses to clinical testing by his doctors, and the absence of any sign of discomfort during a hearing that lasted several hours.

When last Dr. Koutsky saw the petitioner, he released him from care to return to work full duty. The petitioner then returned a month later with such dramatic change that Dr. Koutsky referred him. This coincided with Dr. Levin's section 12 examination.

At that time, Dr. Koutsky noted a herniated disc with primarily left-sided radiculopathy that he later termed as bilateral radiculopathy and a positive SLR test on the left during the time of his treatment of the petitioner. Dr. Salehi noted straight leg raising causing back pain only and MRI which showed primarily right-sided problems with only mechanical back pain, no radiculopathy.

CAUSAL CONNECTION

The Arbitrator finds that on September 16, 2015, the petitioner sustained an accident arising out of an in the course of his employment with the respondent for which compensation is payable. He sustained a lumbar strain injury.

Although all doctors found that the petitioner's MRI showed a disc herniation, as noted above, Drs. Koutsky and Salehi contradicted each other as to whether it was a right sided disc or one causing problems on the left and whether any radiculopathy resulted from this disc pathology. In turn, this evidence supports Dr. Levin's opinion that the disc is not causing any problems requiring treatment. Additionally, the records from LaClinica, in which the petitioner reported that he had minimal pain, as well as the petitioner's ability to continue work without restrictions, all support Dr. Levin's opinions regarding the petitioner's ability to return to full unrestricted duty with no further treatment. Dr. Levin opined that the petitioner would reach MMI within six weeks.

MEDICAL

The petitioner submitted medical bills into evidence for payment. Based on the above finding on causation and the related finding that the petitioner reached MMI by early November 2015, the Arbitrator denies all bills submitted, as being incurred for treatment after the petitioner reached MMI.

Finally, based on the above findings on causation and maximum medical improvement, the Arbitrator denies the petitioner's request for prospective medical care.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Elizabeth McAlexander,

Petitioner,

vs.

NO: 12 WC 31793
14 WC 21613

Mt. Vernon School District #80,

Respondent.

19IWCC0711

DECISION AND OPINION ON REVIEW

Timely Petitions for Review having been filed by both 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, Section 19(d) of the Act, permanent disability and Respondent's credit and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The underlying claim arises out of an accident[1] involving Petitioner's right ankle on March 13, 2012. Petitioner claimed that she was injured when, hurrying to a class, she tripped on stripping between carpet and tile. Petitioner tumbled forward landing on her hands and knees with her ankles and feet turned underneath her. Several witnesses testified regarding the school and condition of the flooring. The Arbitrator ultimately found that the stripping was higher than the carpet and tile and that Petitioner did sustain an injury arising out of and in the course of her employment with Respondent on March 13, 2012 as a result. He determined that Petitioner suffered a right ankle sprain which aggravated her pre-existing arthritis and accelerated her need

1 The parties' request for hearing form at arbitration included both case numbers, but only referenced the March 13, 2012 accident claimed in Case No. 13 WC 31793. At the hearing, Petitioner testified that she suffered a second accident affecting the right ankle on November 12, 2012 (as claimed in Case No. 14 WC 21613). The Arbitrator did not reach any conclusions in his decision related to the second claimed accident. Neither party appealed the lack of findings or conclusions in the arbitration decision for the consolidated cases related to the latter November 12, 2012 accident claim.

for a right ankle fusion performed on April 5, 2013. However, the Arbitrator concluded that Petitioner was noncompliant with treatment after her surgery severing causal connection effective April 16, 2013 pursuant to Section 19(d) of the Act. He awarded benefits commensurate with his conclusions of law. Thereafter, Petitioner and Respondent filed cross petitions for review of the arbitration decision filed on July 5, 2018.

I. FINDINGS OF FACT

A. Background

Petitioner was employed by Respondent as an Individual Aide at the time of her March 13, 2012 accident. In this position she taught special education students one-on-one ensuring their work was completed and that the students had the proper books and made it to their classes. If the child was disabled, Petitioner would have to feed him or her, change diapers, and lift the child from the floor to a chair and vice versa. Petitioner would also accompany students on field trips. Depending on what school she was assigned to, she may have to traverse three flights of stairs. Petitioner worked 23 years for Respondent.

Prior to her employment with Respondent, Petitioner had obtained a high school diploma, an associate in arts degree from Rend Lake College, and took several nursing classes. Her degree and nursing classes were completed in the 1970's. Petitioner also held several waitress jobs, nurse's aide jobs at two hospitals, and worked at a day care center.

Petitioner owns a computer but testified that she only used it for social media and searching the internet. She has no training in Microsoft or Excel and does not consider herself to be a good typist. While working for Respondent, Petitioner used a computer when working with 6th and 7th grade students.

B. Accident

On March 13, 2012, Petitioner was at Casey Middle School. She was walking to the science building where her student was located. Just inside the doors of the science building was a transition from carpet to tile flooring. A transition strip was used to separate the carpet and tile. While hurrying back to her child's class, Petitioner tripped on the strip, tumbled forward and landed on her hands and knees with her ankles and feet turned underneath her. Petitioner felt pain in her hands, wrists, knees and ankles. She was not carrying anything at the time.

Petitioner testified that she reported the injury to the Nurse, Lisa Tucker. Petitioner knew there would be a video recording of her fall because there was a camera at the end of the hall recording everything that came through the area. She requested to see a playback of the incident on video, which was granted by the substitute secretary. The video was requested by Petitioner's Counsel but was never provided.

Petitioner had pain and swelling in her feet and ankles prior to the accident. However, she testified that her right ankle became more swollen and painful following the accident.

19IWCC0711

C. Pre-injury Medical Treatment

Prior to the accident, Petitioner sought right ankle treatment with Dr. Gunzel in February of 2011 due to neuropathy and swelling in her feet and arthritic ankles. Petitioner also testified regarding prior treatment with a pain doctor, Dr. Juergens, for her feet on one occasion in February 2012.

On February 4, 2011, Petitioner presented to Dr. Gunzel for bilateral foot and right ankle pain, gradually worsening. She informed Dr. Gunzel that she had been diagnosed with osteoarthritis approximately 10 years ago. Petitioner's diagnosis included pain in the joint involving the ankle and foot, and osteoarthritis localized primarily involving the ankle and foot.

On May 20, 2011, Petitioner indicated to Dr. Gunzel that her foot pain had not improved. She received bilateral injections at the tarsal sinus and was placed on restrictions of no walking more than one block or standing over 20 minutes at a time. At this time her diagnoses included degenerative joint disease, unspecified inflammatory or toxic neuropathy, metatarsalgia bilateral, hallux limitus left, valgus bilateral and bunion deformity bilateral.

On December 9, 2011, Petitioner informed Dr. Gunzel that her condition was worsening. Another injection was performed, and shoe selection was discussed to minimize discomfort. Petitioner was told to follow up in four weeks. However, Petitioner cancelled her January 6, 2012 visit and her records were sent to Dr. Juergens.

On February 29, 2012, Petitioner's complaints to Dr. Juergens included pain in her neck, bilateral shoulders, bilateral hands, low back and bilateral feet. She was able to stand on her heels and toes bilaterally. Petitioner was diagnosed with unspecified hereditary or idiopathic peripheral neuropathy, prescribed medication and recommended to follow-up with a neurologist.

An October 2012 report by Section 12 examiner Dr. Schmidt later indicated that Petitioner denied any trauma or injury to her right ankle prior to March 2012.

D. Post-injury Treatment, Section 12 Examinations and Employment

On March 13, 2012, Petitioner presented at the Good Samaritan Hospital emergency room ("ER") with complaints of injury to her knees bilaterally and right ankle and foot. Abrasions were noted on the left knee and ankle and there was tenderness and swelling to her right foot and ankle. Bilateral knee x-rays revealed moderate osteoarthritic changes of the left knee. Right ankle x-rays revealed extensive soft tissue swelling and osteochondral defect and impacted fracture of the talus of indeterminate age and etiology, a healed displaced fracture of the anterior aspect of the tibia of indeterminate age, degenerative changes of the tarsal bones, and enthesophyte at the insertion of the plantar aponeurosis in the calcaneus. Right foot x-rays revealed a question of bony demineralization and osteonecrosis of the talus, and arthritic changes at the first metatarsophalangeal joint. Prescription medication was provided, and Petitioner was given an ace bandage and crutches. She was taken off work for three days.

Petitioner then presented to Dr. Freehill at the Orthopedic Center of Southern Illinois on

March 27, 2012. She indicated that she had tripped over loose stripping on the floor and fell on both knees, both hands and her feet were bent underneath her. Petitioner had significant swelling over her lateral ankle ligaments. After a physical exam and review of x-rays, she was diagnosed with an acute right ankle sprain with evidence of old injury. Physical therapy was ordered and pain medication and a lace up brace were prescribed after Petitioner indicated she did not want a CAM walker boot. Petitioner was placed on light duty and was to avoid prolonged standing and walking.

On May 1, 2012, Dr. Freehill diagnosed Petitioner with a right ankle sprain with persistent pain and swelling. He was concerned about the swelling and possible osteonecrosis of the talus. Petitioner was also concerned that her cervical fusion with hardware would interfere with an MRI, thus she was sent for continued therapy while on light duty restrictions instead. The prescribed therapy at Physical Rehab Center in May and June of 2012 was unsuccessful and ultimately put on hold pending a follow up with Dr. Freehill due to Petitioner's persistent ankle pain. However, she was able to complete her work that school year.

On June 12, 2012, Dr. Freehill still noted a large amount of swelling over the lateral ankle ligaments, with tenderness over the ankle, ankle ligaments and tightness in the achilles tendon. Therapy was discontinued, and Petitioner was referred to an ankle specialist.

Petitioner also testified that she returned to work for the school year, but was working with a high functioning, older autistic child who did not require much physical aid. Petitioner still had pain and swelling and kept her ankle propped up on a chair during the school day.

Upon Dr. Freehill's recommendation, Petitioner underwent a right ankle MRI on September 17, 2012. On September 28, 2012 Dr. Freehill noted that the MRI revealed evidence of central collapse of the central and lateral talar articular cortex, degenerative changes of the anterior and posterior tibia and tibiotalar joint effusion with loose bodies. Petitioner was again referred to a foot and ankle specialist.

Petitioner underwent a Section 12 examination at Respondent's request with Dr. Schmidt, an orthopedic surgeon, on October 22, 2012. Petitioner complained of a painful and swollen right ankle and indicated difficulty with prolonged standing, walking and driving. A physical exam showed the circumference of her right ankle at the malleolar to be 31cm, while it was 29cm on the left side. Petitioner was unable to do a double-limb heel rise. Dr. Schmidt reviewed Petitioner's x-rays and diagnosed osteochondral lesion, osteonecrosis of the talus and osteoarthritis of the ankle. Dr. Schmidt agreed that Petitioner's current condition was related to the accident in question and recommended a CT scan. Dr. Schmidt further opined that Petitioner would likely require an ankle replacement.

Dr. Schmidt offered deposition testimony on December 20, 2017. He testified that Petitioner told him she spent 85% of her day lying down. He stated that his objective findings supported Petitioner's objective complaints, and that Petitioner had not reached maximum medical improvement ("MMI") at that time. Dr. Schmidt testified that his causal connection opinion was due to an absence of previous trauma to Petitioner's ankle. He stated Petitioner's osteochondral lesion and osteoarthritis were long-standing but had been accentuated by the

19IWCC0711

accident in question.

Petitioner suffered a second accident[2] affecting the right ankle on November 12, 2012. Petitioner testified that at the end of a class period some students were horse-playing. One student was then pushed into Petitioner's right ankle and kicked it. Petitioner felt pain and reported it to the Assistant Principal. Petitioner testified that she underwent x-rays at Good Samaritan and followed up with Dr. Freehill, who referred her to Dr. Klein at Washington University.

On November 21, 2012, Petitioner presented to another orthopedic surgeon, Dr. Aubuchon, for a second opinion. He noted significant right ankle swelling along with significant grinding with flexion and extension of the ankle. He diagnosed end stage arthritis of the ankle and recommended an ankle fusion and restricted Petitioner to sedentary work through December 1, 2012.

Petitioner testified that her student moved over Christmas Break of that school year. Upon returning in January, Petitioner was assigned to a child at the Early Childhood Center. This child was wheelchair-bound and could not speak. The child was the size of a 5 or 6-year-old, and Petitioner was tasked with lifting her regularly. Petitioner worked with the child for three days before deciding her ankle was too painful to assist this child. Petitioner spoke with the Superintendent about being assigned a new child, but none was available. Subsequently, Petitioner did not receive temporary total disability ("TTD") benefits, was denied disability benefits through the school district and ultimately went on FMLA. She did not receive payment, however, as she had no sick time available.

On January 18, 2013, Petitioner returned to Dr. Freehill who noted her persistent pain. He diagnosed right ankle arthritis and talar collapse and recommended an ankle fusion. Petitioner was placed on light duty and referred to Dr. Klein.

Petitioner underwent a second Section 12 examination at Respondent's request with Dr. Schmidt on February 4, 2013. Dr. Schmidt noted the November 12, 2012 injury, but maintained his prior causal connection opinions as unchanged.

Petitioner then began treatment with Dr. Klein on February 12, 2013. Severe pain and swelling were noted in her right ankle and a physical exam revealed a severely antalgic gait as well as Petitioner having difficulty bearing weight on her right foot. Dr. Klein reviewed x-rays and diagnosed severe right ankle arthritis, right ankle valgus deformity and idiopathic peripheral neuropathy. He also recommended a CT scan and explained to Petitioner that if she were to undergo surgery, she would be required to use a cast and boot. Dr. Klein cautioned against surgery if Petitioner did not think she would be able to adhere to post-operative restrictions.

The CT scan performed on February 28, 2013 revealed a large osteochondral lesion of the lateral right talar dome with articular collapse involving 2/3 of the talar articular surface, severe secondary right tibiotalar and tibiofibular joint osteoarthritis and mild right posterior

[2] The Arbitrator made no ruling relative to this accident in his Decision and the accident was not raised as an issue on appeal to the Commission.

19IWCC0711

subtalar joint osteoarthritis.

On February 28, 2013, Petitioner also presented to Dr. Klein who noted Petitioner's difficulty with wearing a walking boot in the past, as well as Petitioner's concern about surgical recovery. Dr. Klein indicated that post surgically Petitioner would be non-weight bearing in a cast for six weeks, followed by four weeks in a weight-bearing cast. After that, Petitioner would be allowed to bear weight in a walking boot.

On March 28, 2013, Petitioner returned to Dr. Klein for a pre-operative follow-up and was apprised of the risks and benefits of surgery. Dr. Klein recommended that Petitioner practice non-weight bearing at home prior to surgery.

Regarding her employment, Petitioner testified that she decided to retire effective April 10, 2013. She sent an e-mail to that effect on April 2, 2013, three days prior to her scheduled surgery date. Prior to e-mailing her resignation, Petitioner testified that she phoned the school district and informed them that she did not want to retire, but she had to due to financial reasons. She has not been employed since. Had she continued her employment, Petitioner explained that she would have been taken off work for at least six months to recover.

On April 5, 2013, Petitioner underwent surgery. Specifically, Dr. Klein performed a right ankle complex arthrodesis with interposition wedge allograft and a right iliac crest bone graft. The post-operative diagnosis was right ankle arthritis, right ankle valgus deformity, and obesity.

Post-operatively, Petitioner saw Dr. Klein on April 16, 2013. She reported that she was "doing her best" to non-weight bear. Dr. Klein noted it sounded like "she is putting her foot on the ground several times" and she reiterated the importance of non-weight bearing to give her the best chance for success. Petitioner was placed in a short leg non-weight bearing cast.

At the hearing, Petitioner denied putting full weight on her foot and testified that she was only putting her foot down to rest it due to the heaviness of her cast. Petitioner acknowledged that Dr. Klein was adamant about how she was to protect her ankle after undergoing surgery. She testified that there would be occasions where she put her foot down, but only to balance, which she explained Dr. Klein allowed. She testified that she did not walk on it and testified that the surgery decreased, but did not eliminate, her pain and swelling. She also testified that she followed post-operative orders not to walk on her ankle and she explained that she hopped around on her left foot using a walker.

The medical records reflect that on May 16, 2013, Petitioner again followed up with Dr. Klein who noted that it sounded like Petitioner had been walking on her foot somewhat. Dr. Klein noted the lengthy prior discussions with Petitioner about post-surgical restrictions, including the recommendation that Petitioner refuse surgery if she was not willing to avoid weight bearing. Dr. Klein again stressed the importance of Petitioner complying with post-surgical restrictions in order to have a successful recovery. Notwithstanding, no evidence of hardware loosening or failure was present in Petitioner's x-rays. Petitioner was placed in a short weight-bearing cast and told that she could place weight on the extremity. She explained to

Petitioner that she could weight bear but should stop walking if painful. Dr. Klein remained concerned with Petitioner's ability to comply and warned that Petitioner risked a non-union, which could lead to chronic pain.

On June 13, 2013, Petitioner still had clinical pain and had been weight bearing in the cast. An x-ray revealed stable hardware and a progressive fusion of the ankle joint line. Dr. Klein wanted to ease Petitioner into using a walking boot and noted that her radiographs looked good. Dr. Klein also allowed Petitioner to weight bear as tolerated in her boot and instructed not to walk without it. Dr. Klein further noted that Petitioner's "previous cast became somewhat loose because of calf atrophy. That may be why the ankle has been so sore." If she had discomfort, Petitioner was also advised to use her crutches and walker to keep weight off her foot.

On June 20, 2013, Petitioner presented to the Good Samaritan emergency room with right ankle pain status post fusion. A nurse practitioner noted the mechanism of injury that Petitioner "stepped wrong, possible twist." She also noted that Petitioner had a "(recent fracture repair, cast taken off about 1 week ago)." Petitioner's right ankle was swollen and tender, and she reported pain with ambulation in the boot. When she went in for x-rays, Petitioner was "wearing a boot [reporting p]ain shooting from ankle off leg." X-rays revealed an oblique fracture with mild displacement of the distal fibula. Petitioner was released from the emergency room with medication and follow up care instructions.

A telephone note from Dr. Klein's office on June 24, 2013 indicated Petitioner called requesting pain medication after being diagnosed with a fibular fracture the previous week. Dr. Klein believed the fracture was actually an osteotomy that was done during surgery. The following day during her scheduled appointment with Dr. Klein's nurse practitioner, Petitioner complained of increased pain at the right lateral ankle. Contrary to the fracture diagnosis at the emergency room, Petitioner's x-rays revealed no new fracture. She was placed in a short leg non-weight bearing cast.

On July 11, 2013, Petitioner reported to Dr. Klein that she was having good days and bad days with complaints of moderate swelling and tenderness to palpation around her ankle. Dr. Klein noted that Petitioner "came in a couple of weeks ago complaining of a lot of pain. I'm not sure what caused it." Dr. Klein was concerned that Petitioner was developing non-union due to her pain complaints. A CT scan was recommended.

On August 1, 2013, Dr. Klein reviewed Petitioner's CT scan taken August 1, 2013, which revealed a non-union of the right ankle arthrodesis, non-union of the distal fibular osteotomy, and mild subtular osteoarthritis. A bone stimulator was ordered. In a telephone note from that day, Dr. Klein restated Petitioner's post-surgical history and restrictions and told Petitioner that her arthrodesis had not healed. Dr. Klein did not restrict Petitioner from bearing weight and placed her in a boot allowing her to bear weight as tolerated. Dr. Klein allowed Petitioner to remove it to bathe and shower and indicated that she did not need to wear it to sleep.

On August 23, 2013, Petitioner returned to the emergency room at Good Samaritan after falling in her kitchen two weeks prior with worsened pain since then. Ankle x-rays revealed no

changes.

19IWCC0711

On September 26, 2013, Petitioner underwent x-rays. Dr. Klein noted early signs of non-union in Petitioner's ankle joint. Petitioner was to transition to a solid molded AFO at the ankle to help her get back into a shoe and out of a boot. Bone stimulator usage was to continue.

As of January 16, 2014, x-rays revealed evidence of a non-union including a broken screw and a loose screw and plate fixation of the talus. A CT scan several months later on April 2, 2014 confirmed the non-union. On April 4, 2014 Petitioner was told that a revision surgery was the next step. Petitioner requested time to consider her options.

Petitioner testified that Dr. Klein informed her that her ankle was not healing properly and discussed possible additional surgery. Petitioner testified that she was given the option to forego surgery and simply deal with the symptoms. She ultimately decided to forego another surgery.

Petitioner presented then presented for an independent medical examination ("IME") with Dr. Krause on June 30, 2014, which was scheduled at her attorney's request. Dr. Krause, an orthopedic surgeon, opined that without evidence to the contrary he did not dispute the causation opinions by Drs. Schmidt and Freehill, indicating Petitioner's need for a right ankle fusion was causally related to her March 2012 accident. Dr. Krause noted a non-union of Petitioner's ankle but did not recommend another surgery at that time and placed Petitioner at MMI. Dr. Krause opined that Petitioner could work at a sedentary capacity with intermittent standing.

At a deposition on June 2, 2017, Dr. Krause acknowledged that Petitioner did not tell him about any significant problems with her ankle prior to the accident. Had she done so, Dr. Krause's opinions could have changed regarding causal connection. However, he ultimately acknowledged the possibility that the accident in question accelerated Petitioner's need for the surgery performed by Dr. Klein. Dr. Krause testified that, despite his opinions regarding treatment, Petitioner probably could not stand 8-10 hours daily.

Dr. Krause also noted that Petitioner's eventual post-surgical non-union was most commonly caused by smoking. He mentioned other common causes including premature weight-bearing and a big piece of allograft bone inserted (which Petitioner had). Notwithstanding other common or possible causes, Dr. Krause testified that Petitioner could have been at risk for a non-union regardless of weight-bearing although he opined that premature weight-bearing contributed to Petitioner's non-union in some way. Dr. Krause also testified relative to Petitioner's complaint of a twisted ankle after being placed in a boot in June of 2013. He opined that this injury suggested Petitioner was not wearing her boot at the time, as instructed by Dr. Klein.

In an October 10, 2016 addendum report, Dr. Krause noted his review of additional records dating back to 2010 but indicated that they did not provide any significant additional information. His opinions from the June 2014 IME remained unchanged.

In a July 24, 2017 addendum report, Dr. Schmidt noted his review of additional medical

records received from Respondent's counsel. Therein, he opined that, although Petitioner had right ankle difficulty prior to the accident in question, he believed her condition did deteriorate due to the accident in question. As evidence, he noted that prior to the accident on February 29, 2012 Dr. Juergens indicated that Petitioner was able to lift on her toes. Conversely, during Dr. Schmidt's first examination of Petitioner on October 22, 2012, she was unable to do the same.

In his addendum report, Dr. Schmidt noted that Petitioner had been weight-bearing post-operatively in direct contradiction to Dr. Klein's recommendations. He also opined that Petitioner's non-compliance "would directly relate to her developing a non-union, especially what appears as an atrophic non-union as described in the further notes." He stated it was imperative that the ankle be non-stressed so that proper healing can take place. In his deposition, Dr. Schmidt confirmed his opinion that early weight-bearing and non-compliance would be a contributing factor to a non-union.

Notwithstanding, Dr. Schmidt admitted in his deposition that it was possible for a person to have a non-union even if they did not bear weight on a fusion. He also acknowledged that staying off a foot is very difficult for an ankle surgery patient to do, especially when that patient also has neuropathy. Dr. Schmidt also testified that he was not informed by Petitioner of her pre-accident treatment with Dr. Gunzel but testified that he likely treated Petitioner's right ankle arthritis. Ultimately, Dr. Schmidt maintained his causal connection opinion that the accident accelerated Petitioner's need for surgery, which remained unchanged.

E. Accident Investigation and Work Accommodations – Ms. Clark, Ms. McGreer, Mr. Green and Ms. Herzing

Petitioner testified that on August 9, 2012, she returned to the school so her co-employee Terri Clark could take several photographs of the stripping, which was loose where it met the tile. PX 16, Tr. 36. Petitioner testified the carpet was still in the same condition as it was at the time of accident. She stuck a ruler underneath the stripping to show how loose it was and explained that one could only see the raised area of carpet by bending down, not standing over it. She testified that the photos are not of good quality and make it seem as though the ruler is propped up. Petitioner stated that it only seems that the ruler is propped up due to the incline of the floor. She further testified that by the time the new school year started the stripping had been repaired.

Petitioner called Terri Clark as a witness. Ms. Clark is now retired, but previously served as Respondent's Committee Liaison. In 2012 she was the president of the Mt. Vernon Association of Classified Employees, the support staff union for the district.

Contemporaneous to the accident in question Ms. Clark heard about Petitioner's incident. In August 2012 Petitioner called her, and Ms. Clark suggested she take photos. Ms. Clark accompanied Petitioner to the school and took photos of the accident location. Ms. Clark testified that she could tell the carpet was loose where it joined the tile. The tack strip was not adhered to the carpet, which is why they were able to slide a ruler underneath it.

Respondent called Mary McGreer as a witness. Ms. McGreer is the Principal at Casey

Middle School and was so employed on the dates in question. Ms. McGreer was notified of Petitioner's March 2012 accident by the school nurse. She did not see Petitioner that day.

Ms. McGreer testified that the hallway where Petitioner's trip and fall took place is open to the general school population, staff and faculty. Groups of 75 students would traverse the hallway, as well as classes of 6th, 7th and 8th grade students, between 12 and 18 students per class. Visiting parents also had hallway access.

Ms. McGreer also completed an accident report on March 21, 2012 including a handwritten attachment from Petitioner describing the accident. Petitioner testified that the handwritten portion was drafted on the date of accident, so she would not forget any details, and she acknowledged that the report did not mention any defects on the floor, but she attributed this to drafting the note prior to going back and inspecting the floor later on the date of accident. Ms. McGreer testified that she examined the hallway and noted that the stripping was not loose. She stated that the hallway does have an incline, and after the incline the carpet continues for quite a while before the stripping and change to tile. Had there been any work repair orders between the accident date and March 21, 2012, Ms. McGreer would have signed it.

During the summer after the March 2012 accident, the school underwent some construction. Everything was pulled out of every classroom and placed in the hallway so that rooms could be cleaned including desks, chairs, and filing cabinets. In the process, she acknowledged that it is possible that damage could have been done to the hallway. Ms. McGreer was shown a photo of the hallway from May of 2012 and did not see any defect in the carpet. She testified that custodians maintain the hallway and, when a repair is necessary, she completes a work order and maintenance is called. Ms. McGreer testified that she is very paranoid about safety, so she inspects her school closely. However, she acknowledged that if there were small, inexpensive repairs necessary over the summer she would not be notified, and no work order would be necessary.

Ms. McGreer further testified that, as a first-year principal in 2012 and a self-proclaimed techie, she believed the school video system was grainy and antiquated. The system has since been updated, but at the time the server had a small memory, so recordings would only stay for 2-3 days. The cameras were motion-sensored so the more traffic went through, the quicker the memory would get used up. Ms. McGreer did not view the video and stated that if the substitute secretary alluded to by Petitioner showed Petitioner the video of the fall, that would be against Ms. McGreer's instructions. She only wanted herself and her usual secretary looking at video.

Ms. McGreer was also apprised of the November 12, 2012 incident by her assistant principal, as Ms. McGreer was away at meetings on the alleged date. She was unaware of any requests for professional accommodations made by Petitioner.

Respondent also called Michael Green as a witness. Mr. Green served as Respondent's Superintendent from July 1, 2011 through June 30, 2015. Prior to that he served as the Casey Middle School principal from 2006 to 2011. He testified that Petitioner was a very good employee.

One or two days after the incident, Mr. Green visited the school and had the head of maintenance show him the incident location. Mr. Green examined the location and noted that it appeared normal to him. Upon viewing Ms. Clark's photo of the hallway, Mr. Green stated that it did not look anything like that when he inspected the location. Mr. Green testified that the hallway in question was open to students, staff and faculty, as well as parents and other individuals who were authorized admission into the school.

When Mr. Green returned to work after spring break in 2013 he spoke with Petitioner who informed him that she was going to retire. He testified that Petitioner did not mention her reasons, however. After retiring Petitioner never contacted Mr. Green about employment that could accommodate her restrictions. Mr. Green testified that it would be difficult for Respondent to accommodate a person with Petitioner's restrictions due to the steps in the schools.

When Petitioner determined that she was physically unable to work with her newly assigned student in January 2013, Mr. Green testified that she did not ask him to assign her a new student. Mr. Green stated that such a request would definitely have been looked into.

In contrast, Petitioner testified that she had two meetings with Mr. Green regarding child assignment (one prior to Christmas break and one after), and she was told that there were no alternative children available. Petitioner acknowledged being told that there could be an opportunity to aid a new child, but no timeline could be placed on it. She reiterated that she did inform Mr. Green that she did not want to retire, but that it was her last resort due to financial needs.

Respondent called Nancy Herzing as a witness. Ms. Herzing was employed by Respondent through May 2017 as its Director of Business and is now retired. She performed all initial paperwork for workers' compensation claims and received Petitioner's papers for two claims, as well as retirement papers at some point. It was her understanding that Petitioner's retirement was voluntary.

F. Vocational Rehabilitation

On September 24, 2014, Petitioner presented to Stephen Dolan for a vocational evaluation. Petitioner had a cane and stated that she used it outside of the house. During the assessment Mr. Dolan noted that, after one hour and fifteen minutes, Petitioner had to elevate her right leg to waist level on another chair where she kept it elevated for the remainder of the evaluation.

Vocational testing revealed Petitioner had good word recognition and sentence comprehension and could spell above the high school level. Her math was at a ninth-grade level and her reading and spelling were in line with her education. A depression screening indicated a moderate depression level. Mr. Dolan opined that Petitioner had no specific vocational skills for a sedentary job, or a sedentary job that would allow intermittent standing. Mr. Dolan also noted Dr. Krause's restrictions placed on Petitioner of working in a sitting capacity with intermittent standing. These restrictions in conjunction with Petitioner's age, academic skills, work history and treating records from Dr. Klein led Mr. Dolan to conclude that there was no reasonably

stable labor market for Petitioner.

At his deposition on June 20, 2017, Mr. Dolan indicated he had been a vocational rehabilitation counselor since 1972. He testified that Petitioner informed him that if she did not elevate her leg during the evaluation, her ankle would turn red. Mr. Dolan found this to be credible. He testified that Petitioner indicated she could only stand for five minutes before experiencing increased pain, could only walk five to ten minutes, stooping increased her pain, and she could not crouch or kneel. Mr. Dolan testified that Petitioner informed him that she avoided stairs and was otherwise dependent on handrails, and she had fallen four times since her ankle surgery.

Mr. Dolan also testified that Petitioner had rudimentary computer skills and knew how to use e-mail, the internet and had some word processing experience. She also had superior organizational skills, good interpersonal skills, and possessed the ability to take, give and implement instructions. Mr. Dolan testified that these skills would assist someone with experience gain employment. Petitioner did not, however, have any spreadsheet software or bookkeeping software experience. Based on his testing, Petitioner would have good skills to take courses at a community college. Mr. Dolan testified that Petitioner's vocational profile was of a 60-year-old woman approaching retirement age with community college education.

Given Petitioner's limitations and complaints, Mr. Dolan testified that an employer would be more likely to hire another candidate with more vocational skills. He acknowledged that he did not check any resources for job availability in Petitioner's area, stating that he was already familiar with said availability there. Mr. Dolan testified that if he called several employers and asked if they would be willing to hire someone who needs to elevate a foot at waist-high level for much of the day, he would already know the answer. Considering all of this, in conjunction with Petitioner's medical restrictions, Mr. Dolan testified that Petitioner was not employable in the open labor market.

On cross examination, Mr. Dolan acknowledged that having an associate degree or any higher-level education makes a person more marketable in the open labor market. He also acknowledged that Petitioner's complaints regarding her symptoms and restrictions were not reflected in Dr. Krause's June 30, 2014 IME report; thus Mr. Dolan's recitation of Petitioner's complaints were based on her subjective reports. Mr. Dolan acknowledged that there were available jobs within Petitioner's restrictions, but he doubted an employer would hire an unskilled or semi-skilled worker with said restrictions.

G. Current Condition

Regarding her current condition of ill-being, Petitioner testified that she has right ankle range of motion issues. She does not feel comfortable driving anymore, and also has pain and neuropathy in her feet, so she has stopped driving. Petitioner experiences pain daily, which worsens if she stands for too long, walks too much or moves her ankle back and forth. She also props her foot up whenever she is seated to relieve swelling. Petitioner uses a cane or walker when walking and loses her balance when lifting things, although she testified that her use of the walker is not related to her right ankle. Petitioner no longer goes grocery shopping and has

limited her housekeeping. After her surgery, Petitioner was given Vicodin and then Ibuprofen until she began having kidney problems, so now she just deals with the pain.

Petitioner testified that that she suffered a temporary setback when she twisted her ankle in June of 2013 getting out of bed too quickly. Another incident saw Petitioner fall while in her kitchen, but there were no significant consequences to this fall. Petitioner testified that at no point after her ankle fusion did she attempt to return to work for Respondent, nor did she apply for any other employment. Petitioner testified that she did not believe she could work any job after her surgery. She explained that she had to prop her leg on a chair to reduce swelling most of the time and did not believe any employer would approve that. Petitioner currently receives social security disability.

II. CONCLUSIONS OF LAW

A. Accident

The Arbitrator found that Petitioner sustained an accident that arose out of and in the course of employment. "To obtain compensation under the Act, a claimant bears the burden of showing, by a preponderance of the evidence, that he has suffered a disabling injury which arose out of and in the course of his employment." *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill. 2d 193, 203 (2003). An injury "arises out of" employment when "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." *Sisbro*, 207 Ill. 2d at 203.

The question of whether a claimant's injury arose out of his or her employment depends upon the type of risk to which he or she was exposed. *Baldwin v. Illinois Workers' Compensation Comm'n*, 409 Ill. App. 3d 472, 478 (2011). "There are three categories of risk to which an employee may be exposed: (1) risks that are distinctly associated with one's employment, (2) risks that are personal to the employee, such as idiopathic falls, and (3) neutral risks that have no particular employment or personal characteristics, such as those to which the general public is commonly exposed." *Dukich v. Illinois Workers' Comp. Comm'n*, 2017 IL App (2d) 160351WC, ¶ 31.

"By itself, the act of walking across a floor at the employer's place of business does not establish a risk greater than that faced by the general public." *First Cash Financial Services v. Industrial Comm'n*, 367 Ill. App. 3d 102, 105 (2006). "Accordingly, for an injury caused by a fall to arise out of the employment, a claimant must present evidence which supports a reasonable inference that the fall stemmed from a risk associated with her employment." *Id.* at 106. Employment-related risks associated with injuries sustained as a consequence of a fall are those to which the general public is not exposed, including the risk of tripping on a defect at the employer's premises, or performing some work-related task which contributes to the risk of falling. *Id.*

In this case, as the Arbitrator found, the hallway where the accident occurred was not open to the general public but was open to students, staff, faculty, parents and other authorized individuals. Based on this record, the Commission agrees with the Arbitrator that Petitioner's

presence in Respondent's hallway was both incidental to her employment and in the course of her employment.

The Arbitrator also concluded it was unnecessary to consider whether the stripping was defective. The Commission agrees, to the extent that the "defect" nomenclature does not entirely address the issue. "The presence of a 'hazardous condition' on the employer's premises renders the risk of injury a risk incidental to employment; accordingly, a claimant who is injured by such a hazardous condition may recover benefits without having to prove that she was exposed to the risk of that hazard to a greater extent than are members of the general public." *Dukich*, 2017 IL App (2d) 160351WC, ¶ 40. Thus, for example, in *University of Illinois v. Industrial Comm'n*, 365 Ill. App. 3d 906, 911 (2006), the Commission found that the claimant tripped over a metal strip connecting the employer's parking structure to a walkway into the employer's outpatient care facility and that the height of the strip constituted a hazardous condition. The Illinois Appellate Court ruled that the Commission's finding was not against the manifest weight of the evidence. *Id.* at 912.

In this case, Petitioner testified that she tripped on the stripping meant to hold the carpet down and tumbled forward while hurrying back to her child's class. She also explained that one could only see the raised area of carpet by bending down, not standing over it. Petitioner also submitted an exhibit of photographs depicting the loose, raised stripping. Ms. Clark also testified that she could tell the carpet was loose where it joined the tile. Ms. McGreer testified that she examined the hallway and noted that the stripping was not loose, while Mr. Green testified that the accident location appeared normal to him days later. The record does not indicate that Ms. McGreer or Mr. Green examined the area by bending down as Petitioner did. As the Arbitrator found, all witnesses agreed the stripping was higher than the carpet and tile.

Given the record as a whole, the Commission finds that Petitioner was engaged in a work-related task at the time of her fall and the hazardous condition of the stripping contributed to or caused Petitioner's fall. Accordingly, the Commission concludes that Petitioner's accident and injury arose out of and in the course of her employment.

B. Causal Connection/Section 19(d) of the Act

The Arbitrator found the opinions of Respondent's Section 12 examiner, Dr. Schmidt, to be more persuasive than those of Petitioner's independent medical examiner, Dr. Krause. In so concluding, the Arbitrator noted that Dr. Krause was unable to state whether Petitioner's accident aggravated or accelerated Petitioner's need for surgery. He further noted that Dr. Krause did not, like Dr. Schmidt, distinguish the localization of Petitioner's medical treatment prior to her accident and after her accident. The Arbitrator, thus, found the opinions of Dr. Schmidt to be more compelling and credible than those of Dr. Krause finding a causal connection. The Commission agrees with the Arbitrator that Petitioner established a causal connection and finds ample evidence in the record, including the opinions of Dr. Schmidt, supporting a causal connection between Petitioner's post-accident condition of ill-being and her accident on March 13, 2012.

However, the Arbitrator also found that causal connection was severed pursuant to

section 19(d) of the Act. In so concluding, the Arbitrator noted that the Act does not require that an injurious practice be the sole cause of a claimant's condition of ill-being for the Commission to reduce or deny compensation. He noted that several physicians indicated that Petitioner's ongoing pain and permanent restrictions were related to the non-union that developed after her ankle fusion surgery. The Arbitrator found that Petitioner's post-surgical non-compliance with Dr. Klein's recommendations rose to the level of an injurious practice and contributed to the non-union. Pursuant to section 19(d) of the Act, all benefits were denied including treatment, TTD and maintenance subsequent to April 16, 2013.

Section 19(d) of the Act reads:

> If any employee shall persist in insanitary or injurious practices which tend to either imperil or retard his recovery or shall refuse to submit to such medical, surgical, or hospital treatment as is reasonably essential to promote his recovery, the Commission may, in its discretion, reduce or suspend the compensation of any such injured employee. 820 ILCS 305/19(d).

The Commission disagrees with the Arbitrator that Petitioner engaged in an injurious practice that should terminate her entitlement to benefits. There is no evidence in this record that Petitioner deliberately attempted to impede her recovery in any of her actions post-operatively. The cases in which section 19(d) of the Act has been invoked distinguish the intent of the conduct to determine if it is obstructing recovery. See e.g., *Global Prods. v. Illinois Workers' Comp. Comm'n*, 392 Ill. App. 3d 408, 412-13 (2009) (finding no evidence that the claimant smoked cigarettes for the purpose of retarding his recovery and, specifically, that he smoked "in spite of its potential impact on his recovery, not because of it."). The acts involved must rise above mere negligence. Larson's Workers' Compensation Treatise provides additional insight stating: "The degree of claimant misconduct required to break the chain of causation should therefore be not mere negligence, but intentional conduct that is clearly unreasonable. *Larson's Workers' Compensation-Desk Edition*, Section 10.10[1] at 10-34 (2018).

The record reflects that Dr. Klein was pre-operatively concerned with Petitioner's ability to comply with weight-bearing restrictions for optimal recovery. Petitioner was admittedly warned about the risks that might cause a non-union. Drs. Klein, Krause and Schmidt all stated that non-weight bearing was critical to recovery, and that the risk of non-union increases with premature weight-bearing. The physicians further agreed that weight-bearing and smoking were the two main factors causing a non-union of an ankle fusion. Petitioner was not a smoker, so the remaining issue rested with whether she bore weight on her foot too early in her recovery process. Petitioner maintained to both Dr. Klein and at the hearing that she would only put her foot down to balance when her cast got too heavy, which Dr. Klein characterized as weight bearing in her records.

It is reasonable that Petitioner, in particular, would have difficulty fully complying with her treating physician's instructions not to bear any weight for a time. She had been counseled by Dr. Klein pre-operatively to practice non-weight bearing to increase the likelihood of a successful surgical outcome. Dr. Schmidt also understood that it would be difficult for a

neuropathic patient to fully comply with complete non-weight bearing restrictions throughout recovery. Indeed, he specified that it was harder for a neuropathic patient to do so because it doesn't hurt as much. Moreover, while the Arbitrator found that it was no coincidence that Petitioner's fusion did not take, with ample evidence in the medical records of non-compliance, no attention was paid to normal post-operative issues including an ill-fitting boot which may have contributed to Petitioner's discomfort, weight bearing, and need for emergency room care. The June 13, 2013 note from Dr. Klein, before Petitioner presented to the emergency room, reflects that Petitioner's "previous cast became somewhat loose because of calf atrophy[, which Dr. Klein believed] may be why the ankle has been so sore."

The evidence simply does not establish that Petitioner intentionally bore weight to impede her recovery, much less to do harm to herself, such that her conduct rises to the level of an injurious practice requiring a termination of benefits. Accordingly, the Commission reverses the Arbitrator's ruling on this issue.

The Commission further finds that Petitioner's conduct does not rise to the level of an intervening cause severing Respondent's liability. The inquiry here is whether the evidence establishes that Petitioner's condition of ill-being was related, in whole or in part, to her accident. See *Dunteman v. Illinois Workers' Comp. Comm'n*, 2016 IL App (4th) 150543WC, ¶ 44 ("As long as there is a 'but-for' relationship between the work-related injury and subsequent condition of ill-being, the employer remains liable." [citation omitted]). Moreover, "an employer takes his employees as he finds them." *Global Prods.*, 392 Ill. App. 3d at 412 (quoting *Bocian v. Industrial Comm'n*, 282 Ill. App. 3d 519, 528 (1996)).

In this case, Petitioner suffered from neuropathy and degenerative conditions in the right ankle that pre-dated her accident but did not prevent her from working. The ankle fusion recommendation came only after her March 13, 2012 accident following unsuccessful treatment modalities. Petitioner eventually underwent an ankle fusion with Dr. Klein, which Respondent's examiner, Dr. Schmidt, repeatedly found necessary and related to her accident. Even if Petitioner developed a non-union, in part, as a result of premature post-operative weight bearing, her need for medical treatment including the ankle fusion would not have occurred "but for" her March 13, 2012 accident at work. See *Dunteman*, 2016 IL App (4th) 150543WC, ¶ 45. More specifically, "but for" the occupational injury there would have been no need for an ankle fusion and post-operative care of Petitioner's further debilitated right ankle. See *Id.* Thus, the Commission finds that Petitioner's employment remains a cause of her current condition of ill-being and that any premature post-operative weight bearing does not sever causal connection.

C. Medical Expenses

The Arbitrator awarded medical expenses, but only through April 16, 2013, based on his Section 19(d) analysis. In keeping with the ruling on causal connection, the Commission also modifies the Arbitrator's medical expenses award, which terminated Respondent's liability on April 16, 2013. Since the Commission has found causal connection and reversed the Arbitrator's section 19(d) ruling, it also awards all claimed reasonable and necessary medical expenses to Petitioner, pursuant to sections 8(a) and 8.2 of the Act.

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D. Temporary Total Disability

The Arbitrator awarded TTD benefits from April 5, 2013 through April 16, 2013. Benefits were denied from January 11, 2013 through April 4, 2013, and from April 17, 2013 through April 4, 2014.

Regarding the period of January 11, 2013 through April 4, 2013, the Arbitrator reasoned that Petitioner voluntarily abandoned a job that was assigned to her within her restrictions. The Arbitrator noted that Petitioner was restricted to sit-down work only through December 1, 2012. Subsequently she was unrestricted until January 18, 2013, when Dr. Freehill recommended she do "absolutely no twisting, squatting, kneeling, standing, long periods of walking." However, beginning one week prior to that, the Arbitrator noted that Petitioner voluntarily removed herself from the workforce, indicating that she was unable to physically care for the new student to whom she had been assigned after Christmas break. Respondent argues that Petitioner's voluntary removal from the workforce, coupled with Mr. Green's testimony that Respondent would have tried to accommodate any restrictions Petitioner brought to them (which he asserted Petitioner did not), thereby precludes Petitioner from receiving TTD benefits.

A claimant's stabilization is the determinative inquiry for deciding entitlement to TTD benefits. *Interstate Scaffolding, Inc. v. Illinois Workers' Comp. Comm'n*, 236 Ill. 2d 132, 149 (2010). However, the supreme court recognizes three exceptions allowing termination or suspension of TTD benefits. *Sharwarko v. Illinois Workers' Compensation Comm'n*, 2015 IL App (1st) 131733WC, ¶ 47 (citing *Interstate Scaffolding, Inc.*, 236 Ill. 2d at 146-47). The relevant exception to the case at bar is the third, which states TTD benefits may be suspended or terminated if the employee refuses work falling within the physical prescriptions prescribed by his doctor. See *Sharwarko*, 2015 IL App (1st) 131733WC, ¶ 47. Respondent argues that when Petitioner left her job in January of 2013 she triggered this third exception.

The Commission finds that the facts in *Sharwarko* are distinguishable from the case at bar. In *Sharwarko*, the employer was capable of accommodating the claimant's restrictions. *Id.* ¶ 48. In the case at bar, Petitioner wanted to work past January 10, 2013, but was physically unable to perform the job offered by Respondent. A review of Dr. Freehill's restrictions clearly suggests Petitioner was unable to work with a 5 or 6-year-old wheelchair bound child who required frequent lifting. The Commission notes the difficulty in attempting to lift a 5-year-old child alone without twisting and squatting. The Commission also notes that on February 8, 2013 Dr. Schmidt placed Petitioner on restrictions of no standing or walking greater than 2 hours without 15 minutes off her feet. While these restrictions may seem less cumbersome than Dr. Freehill's, it does not circumvent the fact that Respondent had no available work for Petitioner. Mr. Green testified that it would be difficult for Respondent to accommodate a person with Petitioner's restrictions due to the steps in the schools. A March 15, 2013 e-mail from Respondent's Assistant Superintendent indicated Petitioner's desire to return to work when capable. This taken in conjunction with Mr. Green's testimony regarding Petitioner's lack of employability corroborates Petitioner's testimony that her retirement arose out of financial necessity rather than a voluntary removal. Accordingly, the Commission finds that Petitioner does not fall into any of the exceptions to *Interstate Scaffolding*, and since her condition had not stabilized during this period she remained entitled to TTD benefits.

The Arbitrator denied TTD benefits from April 17, 2013 through April 4, 2014 based on his section 19(d) analysis. In keeping with its causal connection finding and reversal of the section 19(d) ruling, the Commission modifies the TTD award and awards benefits for this period as well. Petitioner did not reach maximum medical improvement post-operatively and was not offered work within her restrictions by Respondent. Respondent argues that, even if Petitioner was entitled to TTD benefits while off work, she failed to meet her burden to prove the period in which she could not work as she provided no off work slips from providers. However, determining the TTD period is a question of fact for the Commission and its decision should not be disturbed unless it is against the manifest weight of the evidence. *Ming Auto Body/Ming of Decatur, Inc. v. Industrial Comm'n*, 387 Ill. App. 3d 244, 256 (2008).

The Commission finds no evidence in Petitioner's treatment records that Petitioner's condition between April 17, 2013 and April 4, 2014 would have allowed her to work for Respondent. The Commission also notes the June 30, 2014 report or Dr. Krause supporting the proposition that Petitioner could not perform her duties for Respondent. Accordingly, the Commission finds that Petitioner is entitled to additional TTD benefits as claimed for the period of April 17, 2013 through April 4, 2014.

E. Permanent Disability

Despite Petitioner's argument for odd-lot permanent and total disability benefits, the Arbitrator found that Petitioner suffered a 25% loss of use of her right ankle. The Arbitrator agreed with Respondent finding that Petitioner did not meet her burden of proof for odd-lot permanent and total disablement. In so doing, the Arbitrator noted that Petitioner did not perform any job searches, nor did she look for employment after surgery. The Commission views the evidence differently and finds that Petitioner has established her entitlement to permanent and total disability benefits under an odd-lot theory.

An employee is totally and permanently disabled when she is unable to make some contribution to industry sufficient to justify the payment of wages. *A.M.T.C. of Illinois v. Industrial Comm'n*, 77 Ill. 2d 482, 487 (1979). If a claimant's disability is of such a nature that she is not obviously unemployable, or there is no medical evidence to support a claim of total disability, the burden is upon the claimant to prove that she fits into an "odd lot" category; that being an individual who, although not altogether incapacitated, is so handicapped that she is not regularly employable in any well-known branch of the labor market. *Valley Mold & Iron Co. v. Industrial Comm'n.*, 84 Ill. 2d 538, 546-47 (1981).

A claimant seeking "odd lot" status must establish it by a preponderance of the evidence. *City of Chicago v. Illinois Workers' Compensation Comm'n*, 373 Ill. App. 3d 1080, 1091 (2007). A claimant can satisfy the burden of proving she falls into the odd-lot category in one of two ways; (1) by showing diligent but unsuccessful attempts to find work, or (2) by showing that because of her age, skills, training, and work history, she will not be regularly employed in a well-known branch of the labor market. *Alano v. Industrial Comm'n*, 282 Ill. App. 3d 531, 534 (1996); *Westin Hotel v. Industrial Comm'n*, 372 Ill. App. 3d 527, 544 (2007). Once a claimant meets her burden of proving she falls into the "odd-lot" category, the burden then shifts to the

employer to prove the claimant is employable in a stable labor market and that such market exists. *Waldorf Corp. v. Industrial Comm'n*, 303 Ill. App. 3d 477, 484 (1999); *Westin Hotel*, 372 Ill. App. 3d at 544.

Under this analysis, Petitioner is eligible for PTD benefits. Petitioner was 57 years old at the time of her accident and is currently over the age of 65. She had an associate degree obtained in the 1970's and a remote work history performing duties other than those performed for Respondent in recent decades. Respondent submitted into evidence a labor market survey prepared by an individual who had never met Petitioner nor reviewed her medical records outside of the June 30, 2014 report of Dr. Krause. The survey revealed nine (9) jobs within a 50-mile radius fitting within restrictions identified by Dr. Krause. Some required the ability to type 30-40 wpm, word processing experience, excel experience, collection experience, data entry and audit experience. Petitioner did not possess most of these skills.

Contrary to the conclusions in Respondent's labor market survey, Petitioner's vocational rehabilitation counselor, Mr. Dolan, opined that Petitioner was unemployable. He admitted that he did not perform his own labor market survey, but he testified that he did not need to do so because of his familiarity with the jobs in the area and his knowledge of Petitioner's medical condition/vocational profile. He further testified regarding the positions identified in Respondent's labor market survey and explained that Petitioner would require better skills to perform sedentary office work. Petitioner's computer skills were basic, she was not a good typist, and she had never prepared reports, used a spreadsheet, or used bookkeeping software.

Petitioner did have personal care skills that Mr. Dolan indicated were transferable, but he explained that the jobs looking for these skills (home attendant, certified nursing, etc.) were ones that she could not physically perform. Mr. Dolan also noted that Petitioner would be competing with younger applicants with more recent training, without physical restrictions, making her a less desirable candidate. Additionally, Petitioner experienced daily ankle pain and difficulty with range of motion. She had difficulty driving and climbing stairs, and she could not walk for extended periods. Petitioner also experienced swelling on a daily basis that frequently required her to sit with her foot elevated. Indeed, Mr. Dolan noted that Petitioner had to elevate her foot during his meeting with her, which he found to be credible.

Ultimately, Mr. Dolan opined that there was no reasonably stable labor market for Petitioner. He explained that she would be competing with younger applicants with more recent training and who do not have restrictions. Given Petitioner's age, skills, training, and work history, the Commission finds, as Mr. Dolan opined, that Petitioner will not be regularly employable in a well-known branch of the labor market and that no stable labor market exists for Petitioner.

Respondent also asserts that Petitioner never contacted Respondent for placement any time after surgery. Respondent relies on *Sharwarko* for the proposition that employers should not be liable for benefits if accommodations could have been made but for the employee voluntarily removing himself from employment. *Sharwarko v. Illinois Workers' Comp. Comm'n*, 2015 IL App (1st) 131733WC, ¶ 49 (2015). The Commission is not persuaded by Respondent's assertion, or its claim that it would be able to accommodate Petitioner's

restrictions. Respondent's witness, Mr. Green, admitted that it would be difficult to accommodate Petitioner.

Based on the totality of evidence, the Commission finds the opinions of Mr. Dolan to be persuasive. The Commission thus finds that Petitioner is permanently and totally disabled under an odd-lot theory pursuant to section 8(f) of the Act.

All else is affirmed.

IT IS THEREFORE FOUND BY THE COMMISSION that Petitioner proved she sustained an accident arising out of and in the course of his employment with Respondent on March 13, 2012.

IT IS FURTHER FOUND BY THE COMMISSION that Petitioner has met her burden of proof in relation to causal connection to her work accident suffered on March 13, 2012. Moreover, the Commission finds that Petitioner did not engage in any injurious practices pursuant to section 19(d) of the Act which would limit the duration of the causal connection period.

IT IS ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $345.33 per week from January 11, 2013 through April 4, 2013, and from April 17, 2013 through April 4, 2014, in addition to the period already awarded by the Arbitrator from April 5, 2013 through April 16, 2013. These being the periods of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner all reasonable and necessary medical expenses claimed by Petitioner in relation to her right ankle condition pursuant to sections 8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $483.36 (minimum rate) per week for life, beginning April 5, 2014 as provided in section 8(f) of the Act, for the reason that the injuries sustained caused Petitioner to be permanently and totally disabled.

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

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

No county, city, town, township, incorporated village, school district, body politic or municipal corporation is required to file a bond to secure the payment of the award and the costs of the proceedings in the court to authorize the court to issue such summons. 820 ILCS 305/19(f)(2). Based upon the named Respondent herein, no bond is set by the Commission. The

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

DATED: DEC 3 1 2019
d: 11/7/19
BNF/wde
45

Barbara N. Flores

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

McALEXANDER, ELIZABETH
Employee/Petitioner

Case# **14WC021613**

12WC031793

MOUNT VERNON SCHOOL DISTRICT #80
Employer/Respondent

19IWCC0711

On 7/5/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.08% 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:

4599 SCHUCHAT CCOK & WERNER
CLARE BEHRLE
1221 LOCUST ST SUITE 250
ST LOUIS, MO 63103

2674 BRADY CONNOLLY & MASUDA PC
NEEL MOOKERJEE
211 LANDMARK DR SUITE C-2
NORMAL, IL 61761

19MCC0711

19IWCC0711

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

Elizabeth McAlexander
Employee/Petitioner

v.

Mount Vernon School District #80
Employer/Respondent

Case # 14 WC 021613

Consolidated cases: 12 WC 31793

19IWCC0711

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Mount Vernon**, on **April 6, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **November 12, 2012**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

Petitioner's current condition of ill-being ***is*** causally related to the accident but causal connection for petitioner's right ankle contusion ended on November 12, 2012.

In the year preceding the injury, Petitioner earned **$20,719.93**; the average weekly wage was **$517.99**.

On the date of accident, Petitioner was **57** years of age, ***married*** with **0** dependent children.

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

19IWCC0711

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 $161.52 for other benefits, for a total credit of **$161.52**.

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

ORDER

The Arbitrator finds that the petitioner sustained an accident which arose out of and in the course of her employment on November 12, 2012. The petitioner also proved by a preponderance of the evidence that as a result of that injury, she suffered a right ankle contusion that resolved without treatment, and the causal connection for the right ankle contusion ended on November 12, 2012.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $816.00for treatment at Good Samaritan Hospital on November 12, 2013. All other bills are not causally related to the November 12, 2013 accident, and therefore denied.

Arbitrator finds that petitioner did not sustain any permanent disability as a result of the November 12, 2012 injury.

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

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

Signature of Arbitrator

6/30/18
Date

JUL 5 - 2018

STATEMENT OF FACTS

The parties agreed to bring this matter to trial on April 6, 2018, in Mt. Vernon. At trial, a Motion to Consolidate cases 12 WC 31793 and 14 WC 21613 was made on the record without objection by either party. Accordingly, the Motion was granted. The issues in dispute are accident, causal connection, reasonable and necessary medical, temporary total disability, and the nature and extent of the injuries. The parties also stipulated that if any medical bills were awarded, that they would be paid per the applicable fee schedule and that the respondent would get a credit pursuant to Section 8(j) for any payments made pursuant to that Section.

Trial Testimony of Elizabeth McAlexander

The petitioner testified that she currently lives in Mt. Vernon, Illinois, and her date of birth is July 19, 1954, making her 63 years old. (Tr. 10) She has an Associate's Degree in Arts from Rend Lake College and had started in a nursing program at Rend Lake College but did not complete it. (Tr. 11) Her prior work history included working as a waitress, a nurse's aid, work at a daycare center, and then her last job as an individual aid at Mt. Vernon District #80. (Tr. 11-12) The petitioner owns a computer, and she uses it for Facebook and searching things on the internet. (Tr. 12) Petitioner testified that she did not have any training in Microsoft or Excel, and did not consider herself a good typist. (Tr. 12)

She described her job as a teacher's aid as one-on-one interaction with students with special needs. (Tr. 14) As an individual aid, she worked with one child at a time and assisted that student with their work, staying on task, with their assignment, getting to class, etc. (Tr. 14) The physical aspects of the job depended on the student's physical capabilities that she was working with. (Tr. 15) She also described that depending on the child, she sometimes had to change diapers, transfer the student from the floor to their wheelchair, help feed them, and helped them in PE. (Tr. 15-16)

The petitioner testified that on March 13, 2012, she was at Casey Middle School in the science building. (Tr. 17) She described that there was a section of carpet that transitioned into tile with a strip that holds the carpet and the tile down at the transition. (Tr. 18) She was walking down the hall and her foot got "tripped up" on the stripping causing her to tumble forward falling on her hands and knees with her ankles and feet turned underneath her. (Tr. 19) The petitioner testified that at the time of her fall, she was not carrying anything. (Tr. 20) Immediately after the accident, she felt pain in her hands, wrists, both her knees, and her ankles. (Tr. 20)

She reported the injury to the nurse, Lisa Tucker, who had come out of her office to assist her. (Tr. 20) The petitioner testified that she was wearing sandals that laced across the top of her foot, but she did not believe that her shoes had anything to do with her fall. (Tr. 21) The petitioner testified that there was a camera at the end of the hall and a substitute secretary named Sandy Duncan showed it to her. (Tr. 21-22)

Petitioner sought medical treatment at Good Samaritan Hospital on the same day as the alleged accident where she underwent x-rays to her knees and ankles, was given pain medication and taken off work for three days. (Tr. 25-26) Her main complaint was her right ankle, and she continued to have pain and swelling at that location. (Tr. 27)

After three days off, petitioner returned to work. (Tr. 27) Petitioner testified that she had trouble walking, and subsequently saw Dr. Freehill at the Orthopedic Center of Southern Illinois on March 27, 2012 for her right ankle. (Tr. 28) Dr. Freehill ordered the petitioner physical therapy and gave her pain medication. (Tr. 29)

The petitioner started physical therapy at Physical Rehab Center, but the physical therapy did not help her. (Tr. 29) During this time, she continued to work and continued treatment with Dr. Freehill. (Tr. 29)

The petitioner finished out the 2011-2012 school year and then had the summer off but continued having problems with her right ankle. (Tr. 31) After summer break, she continued working with the same student as the prior year until that student moved away during Christmas break. (Tr. 30) After Christmas break, she was assigned to another student but after three days she had to stop because she could not physically do the job. (Tr. 30) The petitioner identified Petitioner's Exhibit 15 as her swollen right ankle stating that the picture was taken on August 2, 2012. (Tr. 32) Petitioner testified that she continued to have pain and swelling in her right ankle, and she would have to keep her right ankle propped up on a chair while at work. (Tr. 34)

Petitioner testified that she had gone back to look at the strip that she tripped over with Terri Clark, and took pictures of it on August 9, 2012. (Tr. 35, 37) She identified Petitioner's Exhibit 16 as the pictures taken by Terri Clark showing the stripping to be loose. (Tr. 35-36)

The petitioner also had an accident on November 12, 2012. (Tr. 38) She described that she was standing with her student outside of a class waiting for the hallway traffic to pass when a student fell into her right ankle, and "kind of kicked it." (Tr. 38) Petitioner was worried that there may have been more damage to her ankle and sought treatment at Good Samaritan ER where she was told that she had a new fracture. (Tr. 38) She was then referred to Dr. Aubuchon by Dr. Freehill. (Tr. 40) She was also seen Dr. Schmidt on two occasions, and was then referred to Dr. Klein at Washington University. (Tr. 40)

The petitioner eventually underwent an ankle fusion on her right ankle on April 5, 2013. (Tr. 41-42) She testified that the surgery to her right ankle helped, and the ankle was less painful but still painful. (Tr. 42)

Petitioner testified that she did not believe she had been non-compliant with the Dr. Klein's instructions after her surgery. (Tr. 43) She acknowledged that she was told not to put any weight on her right ankle, and she took care to make sure that she did not. (Tr. 43-44) Petitioner testified that sometimes as she would hop around with her walker, and when she would get tired, she would touch her right foot to the floor without putting any weight on it. (Tr. 44)

The petitioner acknowledged that she went to the ER in June 2013 after an incident when she was getting out of bed. (Tr. 45) She thought she got out of bed too fast, and had turned her ankle. (Tr. 45) She testified that she had her boot on at that point. (Tr. 45-46) During that time, she continued to follow up with Dr. Klein. (Tr. 47) Eventually, Dr. Klein thought that her ankle was not fusing and told her that she may need a second surgery. (Tr. 47-48) Petitioner did not have the second surgery as she did not want to go through "all that again." (Tr. 48)

The petitioner testified that after the child she had been working with moved away during Christmas break, she was assigned to a child in a wheelchair in the Early Childhood Center. (Tr. 49) She testified that the child was the size of a 5 or 6 year old, and that she would have to lift that student for everything. (Tr. 49-50) After trying to work with that student for three days, she had to stop as she could not do it physically. (Tr. 50) She testified that she had discussions with Michael Green and Aletta Lawrence to determine whether or not there was any other child she could work with, but the school district did not have one available. (Tr. 51-52) During this time, the petitioner did not receive any temporary total disability from the workers' compensation carrier and was not awarded disability through the school district. (Tr. 53) Eventually, petitioner went on FMLA. (Tr. 54) Petitioner testified that she decided to retire after her FMLA ran out because she needed income, but she had not planned on retiring for at least two more years. (Tr. 54) She testified that she called and talked to Mike Green about her retirement, and told him the reasons why she was retiring. (Tr. 55) Petitioner testified that her retirement was before her surgery, and she has not been employed by anyone else since leaving the school district, has not been offered a job by any other businesses or the school district , and has not applied for any jobs as she did not believe that there was any job available that she could do. (Tr. 55-56)

Currently petitioner has difficulty with range of motion, testified that her ankle does not move anymore, and because of that she does not feel comfortable driving. (Tr. 57-58) She also testified that she had neuropathy in her feet, which also made it hard for her to tell where her feet were as far as the pedals go. (Tr. 58) She complained of still having pain every day that increases with activities, and testified that if she is on her feet too long, if she walks too much or tries to move her ankle, does any exercises that involve her ankles moving back and forth, her pain increases. (Tr. 58-59) Petitioner testified that her right ankle swells, and she tries to keep her foot propped up from keeping it from turning red and to lessen the swelling. (Tr. 59) She testified she uses a cane whenever she walks. (Tr. 60) She testified that she has problems with lifting as she loses her balance and she has trouble walking up and down stairs. (Tr. 60-61) She no longer does any of the shopping and does limited housekeeping tasks. (Tr. 61)

She testified that she likes going to her grandkids' activities, but only goes if her husband takes her. (Tr. 62) The petitioner testified that more recently she's had surgery to her hip, and uses a walker for that surgery. (Tr. 63-64)

Petitioner testified that prior to her March 2012 injury, she had gone to Dr. Gunzel for various conditions including her right ankle. (Tr. 65) She testified that her main problem was neuropathy in her feet and arthritis in her ankles. (Tr. 65) She also saw a pain doctor, and it was regarding several sources of pain throughout her body. (Tr. 67) Petitioner, however, stated that her pain was different after her fall in March 2012, and her ankle became more painful and swollen. (Tr. 68)

On cross-examination, the petitioner acknowledged that she specifically wrote on the intake information at Dr. Gunzel's office that her chief complaint included pain in her right ankle. (Tr. 104-105) She further admitted that Dr. Gunzel had injected her foot on at least two occasions. (Tr. 105) The petitioner also acknowledged that there was swelling in both her ankles, but it was more prominent in her right. (Tr. 106) Petitioner acknowledged that Dr. Gunzel put her on restrictions. (Tr. 107) The petitioner admitted that she had swelling, pain, and osteoarthritis, prior to her March 2012 accident, and the swelling was around the outside ball of her right ankle in the same area seen in Petitioner's Exhibit 15. (Tr. 109-110)

Petitioner testified that Dr. Klein had explained to her the importance of non-weightbearing at a pre-operative visit on March 28, 2013 and further explained to her what she meant by non-weightbearing and why it was important. (Tr. 112-113)

When asked specifically about Dr. Klein's statement in her first post-operative note that the petitioner was putting her foot down on the ground several times, the petitioner testified that she may have told the doctor that, but she did not mean she was weightbearing. (Tr. 113) Petitioner further testified that despite what Dr. Klein's records stated, the she complied with Dr. Klein's instructions. (Tr. 114-115)

The petitioner acknowledged that she does not remember getting any permanent restrictions from any doctors after her surgery, except for Dr. Krause. (Tr. 119) She further acknowledged that she did not believe she had any permanent restrictions on her at the time of her evaluation with Mr. Dolan on September 14, 2014. (Tr. 120) The petitioner further acknowledged that she retired from the school district before she underwent her surgery and never went back to the school district to try to work after her surgery. (Tr. 121)

The petitioner testified that her email resignation did not mention the reason for her retirement, but claimed that she had made a telephone call to the school district first and talked to Michael Green about it. (Tr. 122) The petitioner acknowledged that the photo of the stripping and her ankle were both taken several months after her alleged injury in March 2012. (Tr. 124)

The petitioner testified that she had neuropathy in both her feet prior to her accident. (Tr. 126) She also admitted that she had pain and swelling in her right ankle prior to the 2012 accidents, was put on restrictions limiting her standing and walking prior to the 2012 accidents, and the use of her walker on the date of trial was not related to her right ankle. (Tr. 127)

Petitioner was asked about the handwritten description she gave along with the accident reporting form to the school district. She testified that on the date of the accident, she wrote down what had happened because she did not want to forget. (Tr. 128) After she handwrote it down, she testified then she got the injury form later on and filled it out and attached the handwritten notes. (Tr. 128) The petitioner was specifically asked why she did not mention that there was damage to the strip in her handwritten description immediately after her accident, and she testified that she did not realize there was damage until later on in the day when she went back and looked at it but did not writ it down in her handwritten description. (Tr. 129-131)

On redirect examination, petitioner testified that she associated the prior problems in her feet with her neuropathy but also acknowledged she had pain and swelling in both her ankles although it was worse in her right ankle after her March 2012 accident. (Tr. 133-134)

Regarding whether or not the petitioner was compliant with Dr. Klein's instructions after surgery, the following exchange took place between the petitioner's attorney and the petitioner:

> Q: Okay. All right. And if I understand your testimony correctly, there would be times you would put your foot down, but it would be a balancing sort of action where you didn't actually walk on it when you were not supposed to?
> A: Yes.

(Tr. 136)

The petitioner was also called back to the witness stand after Ms. McGreer, Ms. Clark and Mr. Green testified. She testified that her recollection was different from Mr. Green's, and she remembered having two meetings with Mr. Green and Aletta Lawrence after school resumed after Christmas break in which they discussed her restrictions and what kind of work she could do. (Tr. 194) The petitioner acknowledged that while that was the only child available for her to work with at that time, she could potentially have been moved to another child if one became available. (Tr. 194) She further testified that per her recollection, she had called Mr. Green and expressed that she did not want to retire, that was her last resort, and if Mr. Green could not find her another student she would have no choice but to retire because of financial needs. (Tr. 195-196)

On cross-examination, the petitioner acknowledged that she was assigned with a child to work with, and that Mr. Green and Ms. Lawrence had told her that if another opportunity or student came available in the future they would move her to that student. (Tr. 197) The petitioner admitted that after she retired, she did not have any other conversations with Mr. Green or Ms. Lawrence. (Tr. 199)

Trial Testimony of Terri Clark

Ms. Clark testified on behalf of the petitioner. Ms. Clark testified that in 2012 she was the community liaison for the district and she was also the president of the Mt. Vernon Association of Classified Employees in 2012. (Tr. 145-146) As president of the union, she handled any problems that arose between staff and the administration. (Tr. 147)

Ms. Clark testified that she became aware of the petitioner's alleged accident as she heard it "through the grapevine" that she had fallen. (Tr. 148) Ms. Clark testified that in August 2012 after talking to petitioner, she recommended that they go to the location of her accident to take pictures of the stripping. (Tr. 148) Ms. Clark

testified that she examined the stripping, took pictures, took measurements and prepared a statement. (Tr. 149) She testified that she observed the carpet being loose where it joined with the tile, and slid a ruler under the stripping to demonstrating it was loose. (Tr. 150-151)

Upon cross-examination, Ms. Clark admitted that she had not observed the area prior to August 2012. (Tr. 155) Accordingly, she testified that any knowledge of the condition of the stripping was based on what she observed in August 2012 or what the petitioner told her was the condition before hand. (Tr. 156)

Trial Testimony of Mary McGreer

Ms. McGreer testified on behalf of the respondent. She testified that she was the principal at Casey Middle School in March and November 2012. (Tr. 72) As principal, she was in charge of supervising the campus, doing evaluations of staff, and she was in charge of all safety and security issues of the campus. (Tr. 72) Ms. McGreer had known the petitioner since before she was a principle in her position as Special Education Director, and then as principle at Casey Middle School. (Tr. 72-73)

Ms. McGreer testified that petitioner's March 13, 2012 injury, took place in the science building hallway which housed the science and the social studies classrooms, math classroom, language arts classroom, a nurse, and a Spanish classroom. (Tr. 74) She testified that the hallway was regularly used by all the students, and was open to the general school population including the students, faculty, staff and any other person authorized to be on the grounds. (Tr. 75) Ms. McGreer testified that the hallway in question was one that she used as part of her job on a daily basis. (Tr. 75) She testified that on the March 13, 2012, nurse Lisa Tucker let Ms. McGreer know that the petitioner had taken a fall and was going to the hospital. (Tr. 76-77)

She testified that she received an official accident report from the petitioner on or about March 21, 2012 and that the injury report had a separate sheet with handwritten notes written by petitioner. (Tr. 78) Ms. McGreer testified that after receiving the report, she examined the area where the alleged accident took place. (Tr. 78) Ms. McGreer described that there was an incline in that hallway, and the carpet kept going past the incline for quite a bit of while, then transitioned to tile with a strip in that transition. (Tr. 79-80) She testified that when she observed the area, she did not notice any of the carpet coming up, and did not notice any of the trim coming loose. (Tr. 80)

Ms. McGreer testified that although she had not looked at the area on the date of accident, to her knowledge, no one else had indicated any defect in the transition in that hallway and if there was a maintenance order, it would have gone through Ms. McGreer. (Tr. 80-81)

She testified that the petitioner continued to work after the March 13, 2012 injury, to the end of the school year in 2012, and then after the summer break came back to work in the fall. (Tr. 82) Ms. McGreer testified that the petitioner had never requested any accommodations for permanent restrictions after her retirement. (Tr. 82)

Ms. McGreer testified that there was a video system in place when she became principal but that the system was antiquated and the video was very granular. (Tr. 84) She testified that, in her opinion, it was not very good video, and she did not utilize it a lot as principal because she thought it was not very useful. (Tr. 84) She described that at the time, the software they used would save video on it for just a couple days. (Tr. 84-85) Ms. McGreer testified that in the terms of access to the video, she only had access for herself because of student records. (Tr. 85) She testified that the individual the petitioner stated showed her the video was a substitute secretary at the time, and if she did show her the video, it would have been against Ms. McGreer's instructions. (Tr. 86)

Ms. McGreer was asked about the pictures that were taken of the transition in August 2012, and testified that during the summers there was general summer maintenance where everything was pulled out of every classroom, floors were stripped and waxed, and carpets shampooed. (Tr. 86-87) She further testified that during that summer, there was some construction going on in the hallway and in the building in general for preparations for a major construction project to renovate the building. (Tr. 87) Ms. McGreer testified that although she had examined the area on March 21, 2012 and had not noticed any defect, it was possible that the transition could have been damaged during the summer. (Tr. 88-89)

On cross-examination, Ms. McGreer clarified that the hallway was not open to the general public, but it was open to the general school population and authorized visitors including students from other schools who came for extra-curricular activities and special events. (Tr. 91-92) Further, Ms. McGreer testified that she did not dispute that the petitioner had a fall in that hallway on March 13, 2012

Ms. McGreer testified that although she could not remember exactly how she observed the stripping when she observed it, her general practice is to try to kick the area in question around to see if something was loose and if she did not notice anything, she would have gotten down and tugged at it to see if it was. (Tr. 97-98) She testified that she took safety very seriously, and was in fact, a little bit paranoid about it. (Tr. 98)

Mrs. McGreer testified that prior to the alleged accidents, the petitioner did not have any problems completing her job duties. (Tr. 101)

Trial Testimony of Michael Green

Michael Green testified on behalf of the respondent. He testified that in 2012 he was the superintendent for the Mt. Vernon District 80 school district, and retired as of June 30, 2015. (Tr. 159-160) Mr. Green testified that as superintendent, he was overall the CEO of the district. (Tr. 160) He testified that he was familiar with the petitioner as he was the principal at Casey Middle School from 2006 through 2011 and the petitioner was a very good employee and was very dependable and a good individual aid. (Tr. 160-161) She had great relationships with the kids she worked with, was very professional, and followed the IEP. (Tr. 161)

Mr. Green was familiar with the accident from March 13, 2012, and testified that he performed some investigation on it. (Tr. 161) He described that he heard at the district office that the petitioner had fallen in the hallway at Casey Middle School. (Tr. 161) A day or two days after the date of accident, he went over to the school, met with Greg Lievers (the head of maintenance) to look at the area where the petitioner fell. (Tr. 162) Mr. Green testified that the area looked normal to him, and it looked like a normal strip between the tile and the carpet. (Tr. 162) Mr. Green testified that he observed it from approximately two feet away, he squatted down, he took his fingers and rubbed over it, and asked Mr. Lievers if there was any recent work done to the area, to which Mr. Lievers responded "No." (Tr. 162-163)

Mr. Green testified that the hallway was open to the general student, staff, and faculty population, and specifically noted that the school has over 440-450 children, and that's where the 7th grade was housed. (Tr. 163) He testified that there was a lot of activity in that area every day. (Tr. 163)

Mr. Green was asked to look at Petitioner's Exhibit 16, and testified that the pictures did not depict the condition of the stripping as he observed it a day or two after the alleged work accident. (Tr. 164) Mr. Green testified that summer was unique at Casey Middle School. (Tr. 165) Mr. Green testified that the Board of Education had approved the building of a $6.5 million expansion to the campus to add 10 classrooms, there was a lot of construction and renovation taking place outside and inside the school that summer, and there were a lot of construction crews in that hallway. (Tr. 165) He further testified that there was also just normal cleaning activity in preparation for the new school year, where all the desks were taken out of classrooms and taken into

the hallway. (Tr. 165) He further testified that the traffic in that hallway during that specific summer was more than what would usually be expected during summer break. (Tr. 166)

Regarding the November 12, 2012, accident, he testified he did some investigation of that as well, but did not have any further discussions or conversations with the petitioner regarding it. (Tr. 168)

Mr. Green testified that he remembered in March 2013, he had talked to the petitioner when he came back from spring break. (Tr. 168) He testified that the petitioner had left him a message during spring break to call her, that she was going to retire and that she did not given a reason for her retirement in that message. (Tr. 168-169) Mr. Green returned the petitioner's phone call the same morning he received it, and described that the petitioner and him discussed her retirement and the benefits that she was entitled to. (Tr. 169-170) Mr. Green testified that the conversation did not include any reasons as to why the petitioner was retiring. (Tr. 171)

Mr. Green reviewed Respondent's Exhibit No. 7, and acknowledged that was an email correspondence from the petitioner to him informing him and the Board of Education that she was retiring effective April 10, 2013 and that it did not describe any reasons as to why she was retiring. (Tr. 171) Mr. Green testified that after the petitioner retired, he did not have any further conversations with the petitioner regarding coming back to work, nor did the petitioner ever contact him about accommodating certain restrictions that she may have had. (Tr. 173)

Mr. Green confirmed that prior to the surgery and her retirement, there had been conversations about the restrictions that the petitioner was on, and the restrictions were accommodated per his recollection. (Tr. 174) Mr. Green testified that if an employee came to the school district with permanent work restrictions and wanted accommodations, it was his policy to try to accommodate them. (Tr. 174-175)

On cross-examination, Mr. Green testified that he did not know if the petitioner had fallen or not as he had not witnessed the accident. (Tr. 180) He further admitted that he did not prepare any report after looking at the area specifically. (Tr. 180) Mr. Green also acknowledged that the strip between the carpet and the tile was a little bit higher than the carpet and the tile themselves. (Tr. 180)

Mr. Green acknowledged that he could not remember if there were any other children that the petitioner could aid after the three days she tried to aid the young child at the Franklin School and afterwards the petitioner had applied for FMLA during which she was not provided pay. (Tr. 183-184) However, Mr. Green reiterated that he did not have any conversation with the petitioner regarding the reason she had to retire, and specifically whether or not she was retiring because she needed a paycheck. (Tr. 186) He testified that, although it was possible that the petitioner could have told him that and he had forgotten it, he believed that he would have remembered something like that. (Tr. 186)

On redirect examination, Mr. Green reiterated that after the petitioner worked three days at the beginning of 2013, she never came back to him and asked to be moved to a different student. (Tr. 190) If she had, he would have looked into whether or not there were other students she could work with. (Tr. 190)

On re-cross, Mr. Green acknowledged that if an individual had difficulty going up and down stairs, had difficulty walking, had to elevate their leg, that it would be hard to accommodate those particular restrictions. (Tr. 192)

Medical Evidence

Petitioner treated for right ankle pain dating back to February 4, 2011, with Southern Illinois Foot and Ankle – Dr. Gunzel. Intake information filled out by the petitioner stated that her chief complaint at the time

was "neuropathy, swelling, pain in feet, and right ankle." Dr. Gunzel stated in his report that the petitioner had pain in both feet, and the right foot was worse than the left. The petitioner told Dr. Gunzel she had been diagnosed with osteoarthritis approximately 10 years ago, and Dr. Gunzel noted that the petitioner presented for an initial evaluation of ankle pain, located at the lateral malleolus on the right and the back of the ankle with flexion of the foot. The petitioner told Dr. Gunzel that the condition was gradually worsening over time. Physical examination showed swelling at the right lateral malleolus, in the dorsum of the left mid foot, lateral aspect of the right ankle, and the MTP joints. Dr. Gunzel also specifically noted that the dorsum of the right mid foot, anterior aspect of the right ankle, the right ankle medially, and right Achilles tendon showed evidence of mild pain on palpation. The petitioner's diagnosis included pain in the joint involving the ankle and foot, osteoarthritis localized primarily involving the ankle and foot. She was given medication for Mobic and Lyrica at that point, and told to follow up in one month. (PX 12)

The petitioner followed up with Dr. Gunzel on May 20, 2011. The petitioner noted to Dr. Gunzel that the condition of her feet had not improved, and the medication she was taking was not particularly helpful. The petitioner diagnosis at that visit included degenerative joint disease. She was given an injection of corticosteroids in the tarsal sinus bilaterally, and placed on restrictions of no walking greater than one block and no standing more than 20 minutes at a time. The doctor recommended reduced activity at that point and told her to follow up in four weeks. (PX 12)

Petitioner's next follow up with Dr. Gunzel was on December 9, 2011. The petitioner noted to Dr. Gunzel that her condition had been worsening, and asked for another injection at that point as the last one helped her. Dr. Gunzel provided her with a corticosteroid injection, and discussed the type of shoes that the petitioner should be wearing to minimize her discomfort. She was told to follow up again in 4 weeks. However, Dr. Gunzel's notes indicate that the petitioner cancelled her visit on January 6, 2012, and Dr. Gunzel's medical records were subsequently sent to Dr. Juergens. (PX 12)

The petitioner was evaluated by Dr. Juergens on February 29, 2012. Dr. Juergens stated that the petitioner had complaints of pain in the neck, left shoulder, right shoulder, left foot, right foot, left hand, right hand, and left lower back. Dr. Juergens diagnosed the petitioner with unspecified hereditary or idiopathic peripheral neuropathy, recommended follow up with a neurologist, and ordered some medication. (PX 13)

The petitioner then had her alleged accident on March 13, 2012. She was seen at the Good Samaritan Hospital Emergency Room on that date, and her chief complaints noted injury to the right and left knee, right ankle, and foot. Abrasions were noted on the left knee and left ankle, and she had tenderness and swelling to her right foot/ankle. X-rays of the bilateral knees, the right ankle, and the right foot were taken at that time. The right ankle x-ray showed soft tissue swelling, osteochondral defect and impacted fracture of the talus of indeterminate age and etiology, a healed displaced fracture of the anterior aspect of the tibia of indeterminate age, degenerative changes of the tarsal bones, enthesophyte at the insertion of the plantar aponeurosis in the calcaneus. She was provided with some medications, and recommended to undergo an MRI of her left knee. She was also given a work excuse for three days. (PX 1)

Petitioner then followed up with Dr. Freehill at the Orthopedic Center of Southern Illinois. On the intake form, the petitioner stated that she had tripped over stripping on the floor that was loose and fell on both her knees, both her hands, and her feet were bent underneath her. She complained of right ankle pain and swelling since the date of accident. It was noted that the petitioner had significant swelling over her lateral ankle ligaments, but she was non-tender at the forefoot, midfoot and hindfoot. She was tender at the distal fibula, but non-tender at the medial malleolus and deltoid ligaments. X-rays from the Emergency Room were reviewed, and the doctor noted an old anterior tibial fracture that had healed in a slightly displaced manner, and anterior lateral talar changes consistent with osteochondral injury or possibly even osteonecrosis, but no evidence of any acute fracture. She was diagnosed with a right acute ankle sprain. The doctor recommended

conservative care, and recommended a CAM walker boot but after the petitioner expressed not wanting that, Dr. Freehill recommended an ASO brace and an athletic shoe. She was placed on light duty, and told to avoid prolonged standing and walking. She was also referred to physical therapy. (PX 2)

The petitioner followed up with Dr. Freehill on May 1, 2012. The doctor diagnosed the petitioner with right ankle sprain with persistent pain and swelling, and noted she was concerned about the swelling and possible osteonecrosis of the talus. There was consideration for an MRI, but petitioner was concerned about her cervical fusion with hardware would interfere with it. Therefore, the MRI was put off, she was sent for physical therapy, and told to continue her light duty at that point. (PX 2)

The petitioner had her initial visit with Physical Rehabilitation Center on May 21, 2012. The patient was to undergo physical therapy two times per week for three weeks. (PX 3) After 5 visits, petitioner had a reevaluation on June 11, 2012. Throughout physical therapy, petitioner continued to complain of pain in the right ankle without improvement. As of the reevaluation, the physical therapist recommended that further therapy be placed on hold pending follow up with the doctor. (PX 3)

The petitioner followed up with Dr. Freehill on June 12, 2012. Dr. Freehill noted the petitioner had completed physical therapy, but had increased pain the previous day. Dr. Freehill continued to observe large amount of swelling over the lateral ankle ligaments, tenderness over the lateral ankle, tenderness over the anterolateral ankle ligament, and tightness of the Achilles tendon. The petitioner was recommended to see an ankle specialist, discontinue physical therapy, and be seen back in the office on an as-needed basis. The petitioner continued to not want an MRI at that point. (PX 2)

The petitioner had another follow up with Dr. Freehill on August 28, 2012. The doctor recommended an MRI of the right ankle again. The petitioner was to follow up after her MRI. (PX 2)

The petitioner underwent the MRI of the right ankle on September 17, 2012. The MRI revealed the following:

1. Chronic mild collapse of the central to lateral talar articular cortex with prominent diffuse subcortical degenerative changes.
2. Small to moderate ununited fracture of the anterior to anterolateral tibial plafond.
3. Ununited comminuted fracture distal and anterior aspect of the fibula with disruption of the anterior talofibular ligament.
4. Moderate degenerative changes in the anterior and posterior tibial plafond.
5. Moderate diffuse anterolateral capsular inflammation.
6. Small talotibial effusion with multiple very small ossific loose bodies within the anterior aspect.
7. Mild to moderate diffuse midfoot degenerative change.

(PX 3)

The petitioner followed up with Dr. Freehill on September 28, 2012. Dr. Freehill noted the MRI showed that the petitioner had evidence of central collapse of the central and lateral talar articular cortex, had degenerative changes of the anterior and posterior tibia, and had tibiotalar joint effusion with loose bodies. Dr. Freehill again referred her to a foot and ankle specialist. The petitioner was to follow up on an as-needed basis at that point. (PX 3)

The petitioner was seen for an independent medical evaluation by Dr. Schmidt on October 22, 2012, at the request of the respondent. Petitioner gave Dr. Schmidt a consistent history of her March 13, 2012 accident. At the time of the evaluation, the petitioner reported a painful and swollen right ankle, and reported having trouble with prolonged standing, walking, and driving. She had crepitus in her ankle, and rated her pain at 5/10.

Physical examination showed the circumference of her right ankle at the malleolar to be 31 cm while on the left it was 29 cm. She was tender throughout her anterolateral ankle and had pain with deep palpation. The doctor noted that the point of maximum tenderness was the anterolateral ankle over the talar dome. Per his review of the x-rays, he found that petitioner had an osteochondral lesion over the talar dome encompassing almost the entire lateral talus and osteophytes with an old healed anterior tibial fracture at the tibial plafond along with severe osteoarthritis of the ankle and bone spurring anteriorly, and an old healed fracture of the anterior tibia. He diagnosed the petitioner with osteochondral lesion, osteonecrosis of the talus, and osteoarthritis of the ankle. (PX 9)

Dr. Schmidt believed that the current condition was related to her March 13, 2012, injury, and petitioner had not reached maximum medical improvement. He recommended a CT scan of the ankle, and noted that she would probably need an ankle replacement. (PX 9)

The petitioner then alleges a second injury on November 12, 2012. She was again seen at Good Samaritan Hospital Emergency Room on that same date. An x-ray of the right ankle was taken at that time, and was read to show a new acute avulsion fracture of the distal fibula. (PX 1)

The petitioner was then referred to Dr. Aubuchon, and saw him on November 21, 2012. The petitioner complained that her ankle was very painful and swollen. Upon physical examination, Dr. Aubuchon noted significant swelling at her right ankle, along with significant grinding with flexion and extension of the ankle. Dr. Aubuchon reviewed the MRI and the x-rays, and diagnosed the petitioner with end stage arthritis of the ankle. He advised that her options included a salvage procedure if she did not want a brace, or the other option would be a fusion of the ankle or an ankle replacement. Dr. Aubuchon recommended an ankle fusion and gave petitioner restrictions of sit down work only through December 1, 2012. (PX 4)

The petitioner followed up with Dr. Freehill on January 18, 2013. Dr. Freehill noted that the petitioner's pain was ongoing and she could not walk or stand for long periods of time. She diagnosed petitioner with right ankle arthritis and talar collapse, recommended an ankle fusion, and placed petitioner on restrictions of light duty with no twisting, squatting, kneeling, standing, or long periods of walking. She referred petitioner to Dr. Klein. (PX 5)

The petitioner then underwent a second independent medical evaluation by Dr. Schmidt at the request of the employer on February 8, 2013. Dr. Schmidt noted the second injury on November 12, 2012. Dr. Schmidt reviewed the x-ray from November 12, 2012 and did not see any evidence of an avulsion fracture. Dr. Schmidt noted his opinions remained unchanged, and he believed that the November 12, 2012, injury only caused a contusion and petitioner was at MMI for that injury. He continued to believe that the petitioner's ankle needed to be replaced, and that was related to the March 13, 2012, accident. (PX 9)

The petitioner saw Dr. Klein at Washington University Orthopedics on February 12, 2013. Dr. Klein noted petitioner's pain and swelling in her right ankle. Physical exam showed that the petitioner's gait was severely antalgic and she had a difficult time weight bearing on the right foot. Dr. Klein noted mild hindfoot valgus on the right compared to the left, and severe swelling of the right ankle. Dr. Klein also noted that the petitioner had severe pain with range of motion, and was tender to palpation around the ankle joint. Dr. Klein reviewed x-rays and diagnosed the petitioner with severe right ankle arthritis, right ankle valgus deformity, and idiopathic peripheral neuropathy. She recommended the petitioner undergo a CT scan. Dr. Klein explained to petitioner that if she had surgery, she would be required to use a boot post-operatively, and would also be in a cast. She further urged the petitioner to consider that because Dr. Klein specifically stated that she did not recommend surgery if the petitioner did not think she could comply with post-operative treatment. (PX 5)

The petitioner underwent the CT scan of the right ankle on February 28, 2013, at Barnes Jewish. The CT of the right ankle showed a large osteochondral lesion of the lateral right talar dome with articular collapse involving two-thirds of the talar articular surface, severe secondary right tibiotalar and tibiofibular joint osteoarthritis, and mild right posterior subtalar joint osteoarthritis. (PX 6)

The petitioner followed up with Dr. Klein on that same date. Dr. Klein noted that the petitioner's condition was unchanged at that point, and the petitioner had returned following her CT scan. Dr. Klein's diagnosis was the same, and treatment options were discussed. Dr. Klein noted that the petitioner had a difficult time wearing a boot in the past, and she was a little bit worried about surgical recovery. Dr. Klein advised that the petitioner would be non-weight bearing in the cast for six weeks followed by four weeks in a weight bearing cast. After that, the petitioner would be in a boot which would allow the petitioner to weight bear. (PX 5)

The petitioner had a pre-operative follow up with Dr. Klein on March 28, 2013. Dr. Klein discussed the risks and benefits with the petitioner at that time, and Dr. Klein specifically noted that she advised the petitioner to practice non-weight bearing at home prior to the surgery. (PX 5)

The petitioner underwent surgery on April 5, 2013. The pre-operative and post-operative diagnoses were right ankle arthritis, right ankle valgus deformity, and obesity. A right ankle complex arthrodesis with interposition wedge allograft and a right iliac crest bone graft were performed on the petitioner. In the operative report itself, Dr. Klein again stated that she had conversations with the petitioner regarding the importance of remaining non-weight bearing post-operatively.

The petitioner followed up with Dr. Klein for her first post-operative visit on April 16, 2013. Dr. Klein noted that the petitioner stated that she had been "doing her best" to keep her weight off the foot, but, "It sounds like she is putting it down on the ground several times." Dr. Klein noted that the petitioner denied putting her full weight on it, but Dr. Klein again discussed with the petitioner the importance of remaining non-weight bearing. Sutures were removed at that visit, and the petitioner was placed in a short leg non-weight bearing cast made of synthetic materials. Dr. Klein noted the petitioner would remain non-weight bearing and will continue to ice and elevate the right leg for comfort. Dr. Klein stated at the end of the note, "I discussed the importance of compliance with her once again. She should remain non-weight bearing. I think this gives her the best opportunity for success." (PX 5)

The petitioner had a follow up on May 16, 2013. X-rays did not show any evidence of hardware loosening or failure. Dr. Klein again stated, "It sounds like she has been walking on it somewhat." Dr. Klein noted the long discussions she had with the petitioner prior to surgery, even indicating to her that the petitioner should not consider surgery if she was not willing to be non-weight bearing. Dr. Klein explained to the petitioner again that if she wanted surgery to be successful, she needed to comply with the post-operative regimen. Dr. Klein placed the petitioner in a short leg weight bearing cast made of synthetic materials, and noted that she could place weight on the extremity of the cast. Dr. Klein noted that the petitioner would remain in the cast for four more weeks, but she was concerned about the petitioner's compliance. Dr. Klein had a discussion with the petitioner again extensively, and explained to the petitioner that she could weight bear, but she should not continue to walk on it if it was painful. Dr. Klein specifically stated that she would run the risk of non-union, which could lead to chronic pain. (PX 5)

The petitioner's next followed up with Dr. Klein was on June 13, 2013. At that time, the petitioner again underwent a right ankle x-ray, and the x-ray showed stable hardware with what the doctor characterized as progressive fusion of the ankle joint line. Dr. Klein stated that the radiographs looked good, but the petitioner was still having pain clinically. Dr. Klein advised the petitioner to try to ease into her boot. She advised that the petitioner could weight bear as tolerated in the boot, but she should not walk without it on. Dr. Klein also

noted that the petitioner was to use her crutches and walker to keep the weight off the foot as needed for discomfort. (PX 5)

On June 20, 2013, the petitioner presented at the Emergency Room at Good Samaritan Hospital. In the history portion, the petitioner advised the ER that she had right ankle pain, and had her cast removed approximately one week ago. The petitioner stated that she twisted her ankle that morning when she stepped wrong and possibly twisted it. An x-ray taken at that time showed possible oblique fracture with mild displacement of the distal fibula. Petitioner was given some pain medication at that point. (PX 1)

In a telephone note dated June 24, 2013, from Dr. Klein's office, the petitioner called requesting pain medication, noting that she had gone to the ER the previous week and was diagnosed with a fibular fracture. The nurse talked to Dr. Klein who advised that she believed that the fracture seen in the Emergency Room was actually an osteotomy that was done during surgery. Dr. Klein stated that she would not prescribe any pain medication at that point, and that the petitioner needed to keep her already scheduled appointment with the nurse practitioner on June 25, 2013. (PX 5)

Petitioner had the follow up appointment with Dr. Klein's nurse practitioner on June 25, 2013. The petitioner noted increased pain at that time of the right lateral ankle. Physical examination did show mild tenderness to palpation on the right lateral fibula, but no redness, bruising or swelling was noted. X-rays ordered on that same day were reviewed, and did not show any new fracture. The petitioner was put in a short leg non-weight bearing cast. The petitioner was noted to have asked for some pain medication, but the nurse practitioner told her they would be unable to refill the pain medication for her at this point. (PX 5)

The petitioner next had an appointment with Dr. Klein on July 11, 2013. Petitioner was feeling somewhat better, and stated she had good and bad days. She had moderate swelling of her ankle, it was improved, but she remained tender to palpation around her ankle. At that visit, the petitioner was placed in a short leg weight bearing cast. The doctor was not sure as to why the petitioner's pain had increased a couple weeks ago as her x-rays and exam looked pretty good. The doctor was concerned that the petitioner was developing non-union because of her pain, and she recommended a CT scan prior to her next visit.

On August 1, 2013, the petitioner had a follow up with Dr. Klein. The petitioner was placed in a boot, and told that she could weight bear as tolerated. Dr. Klein stated that if the CT scan showed the joint healing, they would progress her out of the boot. (PX 5)

The petitioner underwent the CT scan on August 1, 2013, which showed non-union of her right ankle arthrodesis, non-union of the distal fibular osteotomy, and mild subtalar osteoarthritis. (PX 7)

In a telephone note from August 13, 2013, Dr. Klein reviewed the CT scan with petitioner telling her that the arthrodesis had not healed. Dr. Klein further stated that pre-operatively she and the petitioner had discussed the need to remain non-weight bearing, and the petitioner suspected that it would be difficult for her to do that but despite that she chose to proceed with surgery. Since surgery, Dr. Klein noted that it had been very difficult for the petitioner to stay off of her right ankle. She stated, "As a result, we discussed the possibility of trying a bone stimulator." A bone stimulator was ordered at that point, and the petitioner was to follow up in six weeks. (PX 5)

On August 23, 2013, the petitioner presented at Good Samaritan Emergency Room again. The petitioner stated she had fallen in her kitchen two weeks ago, and since then, her pain had worsened. X-rays were taken of the ankle, and it was noted there was no change relative to the previous x-rays that had been taken. The petitioner was given Hydrocodone and Naproxen at that time. (PX 1)

The petitioner followed up for an x-ray and a visit with Dr. Klein on September 26, 2013. The x-ray continued to show a non-union of the tibiotalar and distal tibiofibular joints, and a non-union of the distal fibular osteotomy. Dr. Klein stated that the petitioner had early signs of non-union in her ankle joint, and the petitioner was to transition into a solid molded AFO at the ankle to help her get back into a shoe and perhaps out of a boot. The petitioner was to continue her bone stimulator and to follow up in eight weeks. Dr. Klein hoped that there would be some bony healing at that point. (PX 5)

The petitioner followed up with Dr. Klein and for x-rays on January 16, 2014. The x-ray was unchanged at that point. Dr. Klein noted that the x-ray showed a broken screw as well as a loose screw and plate fixation of the talus. Dr. Klein stated that she had evidence of non-union. Dr. Klein stated that the petitioner needed to decide if she wanted to continue to monitor or proceed with some sort of revision. (PX 7)

The petitioner followed up for a CT scan on April 2, 2014. The CT scan confirmed non-union. Following the CT scan, Dr. Klein's office had a telephone conversation with the petitioner on April 4, 2014 and advised that the fusion had not healed and the next step would be a revision surgery. The petitioner wanted to think about that option, and the doctor's office cancelled the petitioner's follow up appointment in May. The petitioner was to call back if she wanted to discuss surgery at that point. (PX 7)

Subsequently, the petitioner was sent for an independent medical evaluation by her attorney with Dr. Krause. The petitioner gave a consistent history of her March 12, 2012 and November 12, 2012 injuries. At the time of the visit with Dr. Krause, the petitioner reported her pain was not severe enough to undergo another surgery. Dr. Krause stated that without evidence to the contrary, he did not dispute the causation opinions by Dr. Schmidt and Dr. Freehill as it pertained to the March 13, 2012 injury. Regarding the November 12, 2012, accident, Dr. Krause stated that the petitioner had a minor ankle contusion that had resolved. Based on that, he believed that the petitioner's need for surgery was related to the March 12, 2012, accident. Dr. Krause stated that petitioner had a non-union of the ankle, but he would not recommend another surgical procedure at that point. The petitioner was at maximum medical improvement regarding the injury on March 12, 2012. Dr. Krause stated that the petitioner could work at sedentary capacity with intermittent standing, and that the petitioner had excellent hindfoot motion and plantigrade foot. He further advised that the petitioner sustained permanency from the March 12, 2012, injury, and had not sustained any permanency from the November 12, 2012, injury. (PX 10)

Approximately three months after her visit with Dr. Krause, the petitioner was sent to see Stephen Dolan for a vocational evaluation. Mr. Dolan noted that the petitioner came to the evaluation using a cane, and the petitioner stated to Mr. Dolan that she used a cane when she was outside of her house. Mr. Dolan further observed that during the assessment, and after an hour and fifteen minutes, she had to elevate her right leg to the waist level on another chair, and then she kept it elevated for the rest of the evaluation. (PX 11)

The petitioner was receiving $671.00 per month from the Illinois Municipal Retirement Fund, and $900.00 per month from Social Security Disability. The petitioner's work history included work as a waitress, work as a nurse's aid, and then work as a teacher's aid since 1990. Mr. Dolan noted that Dr. Krause was the only doctor who placed restrictions on the petitioner, and stated that she would need work in a sitting capacity with intermittent standing. (PX 11)

Subjectively, the petitioner told Mr. Dolan that after sitting for an hour, if she did not elevate her right ankle, it would turn red. She further stated she could only stand for five minutes before increased pain. She complained that she could only walk five to ten minutes, but every step hurt her right ankle. She complained that stooping increased right ankle, knee and back pain, and that she could not crouch or kneel. She avoided stairs and was otherwise dependent on handrails. She stated that she could lift a gallon of milk, but lifting a bag

of groceries was too much weight on her right ankle. She further complained that carrying a gallon of milk was difficult for her. (PX 11)

Testing results showed that the petitioner had good word recognition and sentence comprehension, and spelled above the high school level. Her math was at a ninth grade level, and her reading and spelling were noted to be in line with her education. She scored a 28 on the depression screening, which Mr. Dolan stated was indicative of moderate level depression. (PX 11)

Mr. Dolan stated that based on the non-fusion of the right ankle, he found statements that she needed to elevate her foot as much as possible to be credible. The petitioner had no specific vocational skills for a sedentary job or a sedentary job that she was able to stand intermittently in. Mr. Dolan ultimately concluded that petitioner did not have any access to a reasonably stable labor market. (PX 11)

On October 10, 2016, Dr. Krause provided an addendum report at the request of petitioner's attorney. He was provided additional medical records dating back to 2010. Dr. Krause stated that the additional records did not provide him with anything significant regarding the injury in question, and that the additional records did not change his opinions from his prior IME on June 30, 2014. (PX 10)

An addendum report was also issued by Dr. Schmidt dated July 24, 2017. Dr. Schmidt also reviewed additional medical records and stated it was obvious that the petitioner had right ankle difficulty prior to her March 13, 2012, accident. However, the petitioner was found by Dr. Juergens to be able to walk on her toes which she was unable to do during Dr. Schmidt's evaluation. Therefore, he stated that, "One would feel that she did deteriorate, and, therefore, even though she did have what seems like preexisting ankle arthritis, her fall with catching her foot on the carpet seemed to accentuate the arthritic condition and necessitate further treatment as was outlined in my reports." Dr. Schmidt stated that it appeared that petitioner's ankle had not fused, and that she might have collapsed further as her alignment, in his reports, was listed as neutral. Dr. Schmidt ultimately stated that even with the records available to him, he believed that the fall on March 13, 2012, severely exacerbated the petitioner's preexisting arthritic condition. (PX 9)

Dr. Schmidt, however, noted that in the initial two post-operative notes from Dr. Klein, the petitioner was weight bearing when Dr. Klein had clearly required the petitioner to be non-weight bearing. He opined her non-compliance "would directly relate to her developing a non-union, especially what appears as an atrophic non-union as described in the further notes." He went on to state, "Therefore, I think her early weight bearing and non-compliance with her surgery has a direct effect on developing a non-union in her ankle. It is imperative that the ankle be non-stressed during the healing process so that proper healing can take place. Stressing the construct will contribute to developing a non-union." (PX 9)

Deposition of Dr. Schmidt

Dr. Schmidt's deposition was taken on December 20, 2017. Dr. Schmidt testified that he is an orthopedic surgeon specializing in foot and ankle, and he has been board certified since 1999. Dr. Schmidt testified that he actively treated patients on a daily basis and has performed surgeries for the last 22 years. (PX 14, 4-5)

Dr. Schmidt testified that he first saw the petitioner on October 22, 2012, and his first report was dated October 30, 2012. He was requested to evaluate the petitioner at the request of the Workers' Compensation carrier for an independent medical evaluation. (PX 14, 6) Dr. Schmidt testified consistently as to the history of the petitioner's accident on March 13, 2013 and the medical treatment she underwent after. (PX 14, 7)

The petitioner described to Dr. Schmidt that she had immediate symptoms of pain and swelling in the right ankle, and her current symptoms included continued pain and swelling in the right ankle, trouble with prolonged standing, walking, driving, and crepitus in the right ankle. She stated that her pain gets worse as the day goes on, and she felt she was losing her ability to drive, stand, walk, lift, carry, bend, push, pull, climb, squat, and kneel. (PX 14, 8)

Dr. Schmidt testified that the petitioner did not describe any past medical history that was significant to his evaluation. The petitioner reported to Dr. Schmidt that 85% of her day was spent sitting or lying down, and she did not do any sporting activities or hobbies. (PX 14, 9)

Dr. Schmidt testified as to what his physical examination showed consistently as reported in his report. Dr. Schmidt also reviewed an x-ray done on October 15, 2012 which showed that she had an osteochondral lesion over the talar dome and what appeared to be an old anterior tibial fracture. (PX 14, 9-10) The x-rays that he performed at his office were similar. He diagnosed the petitioner with an osteochondral lesion, osteoarthritis of her ankle, and osteonecrosis of her talus. (PX 14, 10-12)

Dr. Schmidt testified that the osteochondral lesion and the osteoarthritis had been around for a long time, and the fall may have accentuated that. He testified that the objective findings supported the subjective complaints of pain and limitations, and he felt that the petitioner had not reached maximum medical improvement. (PX 14, 12-13)

He recommended the petitioner undergo additional testing, and anticipated that the petitioner was a candidate for a total ankle arthroplasty. Dr. Schmidt testified that within a reasonable degree of medical certainty, need for future treatment was necessitated by the work injury, and his reasoning was because the petitioner did not describe any previous trauma or previous records indicating such. (PX 14, 13) He recommended that the petitioner could work in a light duty capacity. (PX 14, 14)

Dr. Schmidt saw the petitioner again on February 4, 2013, at the request of the Workers' Compensation carrier again. At that point, her chief complaint continued to be right ankle pain, and she described another injury on November 12, 2012. Dr. Schmidt reviewed the medical records from the Emergency Room of November 12, 2012, and performed a physical examination. The physical examination was pretty consistent with his previous one. The x-ray from November 12, 2012, was compared to the x-ray from October 22, 2012, and Dr. Schmidt did not see a big difference. He also did not see a fracture in the x-ray taken at the Emergency Room on November 12, 2012. (PX 14, 15-17)

Dr. Schmidt testified that his second evaluation did not change his opinion regarding the effects of the March 2012 accident, and he continued to believe that the March injury accentuated a preexisting condition necessitating further treatment. He further testified that the November 12, 2012, injury was a contusion to her ankle and had gone on to heal and placed her at maximum medical improvement for the November injury, but not for the March injury. (PX 14, 17-18)

Dr. Schmidt testified that he received additional medical records from respondent's attorney on or about June 20, 2017. Dr. Schmidt testified that the records indicated that the petitioner had been seen previous to her injury, and noted a couple years worth of pain in her feet and ankles. He specifically noted that Dr. Gunzel did not order an x-ray of the ankle, and she was treated with injections to the sinus tarsi, which was not the same as an injection in the ankle. After review of the additional medical records, Dr. Schmidt stated that he did not believe his diagnosis needed to be changed. (PX 14, 19-22)

Dr. Schmidt also testified that he thought it was significant that at the time of Dr. Juergens' evaluation in February 2012, the petitioner was able to get on to her toes. At Dr. Schmidt's initial evaluation, the petitioner

could not do the same thing and that showed some deterioration. Dr. Schmidt testified that his opinion did not change as to the petitioner's need for an ankle replacement. (PX 14, 23-24)

Dr. Schmidt testified that early weight bearing after a fusion was detrimental to the fusion taking. Dr. Schmidt further explained that it was possible to have a non-union even if a person was completely non-weight bearing. (PX 14, 28-30) The petitioner's attorney and Dr. Schmidt had the following exchange:

> Q: She advised that there were times when she had to check her balance, and she put weight on her toes to support her foot because the boot was heavy and it would be hard to stabilize herself. She said there were also times she had to hop, and there were times when she had to touch her right foot to the ground. Otherwise, she only walked on her foot when she was advised by Dr. Klein that she could. If those activities as described are true, were those alone sufficient to create a non-union with a fusion?
> A: Indeed it may be. (PX 14, 32)

Dr. Schmidt also testified the atrophy that was noted in the petitioner's right calf was not an indication of her non-use of the leg and right foot. The petitioner's attorney and Dr. Schmidt had the following exchange:

> Q: Would it be true that you couldn't say within a reasonable degree of medical certainty that any weight bearing by Mrs. McAlexander was the cause of her non-union?
> A: I wouldn't say you could say it's the cause of the non-union; but if you certainly have somebody with a large osteochondral lesion that you have to do a big bone graft on that may have some neuropathy, they ain't helping their cause any by weight bearing on it, that's for sure. And you really want them to really stay off of it because they already have a few strikes against them. (PX 14, 33)

On cross-examination, Dr. Schmidt acknowledged that given the timeframe, the loose bodies that were found and removed in surgery had probably been there prior to the March 2012 accident. Dr. Schmidt also acknowledged that the osteoarthritis, osteochondral lesion, osteonecrosis were all preexisting to the work accident. (PX 14, 35-36)

Dr. Schmidt acknowledged that the petitioner had not told him about the prior treatment she received in her right foot. Dr. Schmidt acknowledged that Dr. Gunzel had noted swelling in the petitioner's right ankle, along with pain. He also agreed that in hindsight, he might be able to say that given the fact that in March she had an x-ray showing arthritis, that the treatment Dr. Gunzel provided was at least in part for the arthritic condition. (PX 14, 39-40)

Dr. Schmidt further acknowledged that the petitioner showed weakness throughout her foot and ankle, global in nature, and evidence of swelling in the lateral malleolus, which was the outside of the ankle. He further testified that based on the picture that the petitioner's attorney had shown him, the swelling seen was on the outside of the ankle as well. Dr. Schmidt also acknowledged that Dr. Gunzel's notes included descriptions of pain in the ankle with limited range of motion. (PX 14, 45-46)

Dr. Schmidt agreed that Dr. Klein counseled the petitioner on the importance of non-weight bearing at points before and after the operation, and it appeared that the petitioner had been weight bearing in several notes after the operation as well. He further testified that he thought it was very important for someone to be non-weight bearing after an ankle fusion. Dr. Schmidt testified that while weight bearing may not be a 100% cause of the non-union, it certainly made it more likely. He testified that the weight bearing contributed to the non-fusion, and was indirectly related to the ongoing complaints of pain. (PX 14, 51-53)

On redirect examination, He confirmed that he had not changed any of his opinions regarding the March 12, 2012, injury being the aggravating or accelerating factor to the need for surgery. (PX 14, 56-58)

Deposition of Dr. Krause

Dr. Krause's deposition was taken on June 2, 2017. Dr. Krause testified that he was an orthopedic surgeon and board certified in orthopedic surgery. His primary practice was to the lower extremities, including the knees, feet, and ankles. (PX 10, 5-6) Dr. Krause first saw the petitioner on June 30, 2014, on referral by the petitioner's attorney. (PX 10, 6)

Dr. Krause testified as to the history given to him by petitioner and described the medical records he reviewed, including Dr. Freehill's. He testified that her diagnosis was an osteochondral injury and osteonecrosis of the lateral talus. The petitioner was eventually seen by Dr. Gary Schmidt on October 30, 2012. At that time, Dr. Schmidt noted a limited ankle range of motion, and diagnosed the petitioner with osteonecrosis of the talus with osteoarthritis. Dr. Schmidt related that to the March 13, 2012, accident, and recommended a CT scan. (PX 10, 9)

Dr. Krause noted the petitioner's second injury on November 12, 2012, and she was treated at St. Mary's Good Samaritan Regional Health Center on that day for what was thought to be a fibular avulsion fracture. Subsequently, the petitioner was seen by Dr. Aubuchon on November 21, 2012 and Dr. Klein in February 2013, and both doctors recommended a right ankle fusion. (PX 10, 10-11)

Dr. Krause testified that based on his review of medical records, Dr. Klein performed a right ankle arthrodesis on April 5, 2013, and the petitioner had routine post-operative care in a cast, then a boot, and non-weight bearing initially. He noted that the petitioner had several falls post-operatively, and she presented for several visits to the Emergency Room. He testified that it looked like she had some difficulty healing, and was eventually given a bone stimulator. Subsequently, Dr. Klein diagnosed the petitioner with a non-healed fusion. (PX 10, 12)

Dr. Krause testified as to the physical exam findings at this visit consistently with what was reported in his report. Dr. Krause testified that upon his review of the CT scan from April 2014, it confirmed the diagnosis of non-union of the ankle arthrodesis with the hardware. (PX 10, 13) Based on that, he diagnosed the petitioner with a history of lateral talar osteochondral lesion versus osteonecrosis with a history of a right ankle arthrodesis non-union. Regarding the November 12, 2012, accident, he diagnosed the petitioner with a right ankle contusion which had resolved. (PX 10, 14)

Dr. Krause further testified that the injury on March 13, 2012, resulting in a contusion or strain of the ankle, worsened her preexisting osteochondral injury to her talus. It was his opinion the petitioner's subsequent surgery was related to the March 13, 2012, accident, and that the petitioner suffered a minor contusion on November 12, 2012, that she did not need treatment for. He further testified that the petitioner had reached maximum medical improvement for the November 12, 2012, accident. (PX 10, 15-16) Dr. Krause testified he did not think the petitioner needed surgery at this point, and that she was at maximum medical improvement for her March 2012 injury. He anticipated that the petitioner could work in a sitting capacity with intermittent standing, but probably could not tolerate standing for 8-10 hours per day. Dr. Krause did not believe the petitioner suffered any permanency from the November injury, but did sustain permanency as a result of the March 12, 2012, injury. (PX 10, 17-18)

Dr. Krause testified that the loose body that Dr. Klein referred to in the operative report was not necessarily objective evidence of injury, and it could come from a non-traumatic cause. (PX 10, 18-19) Dr. Krause reviewed photographs admitted into evidence petitioner's exhibit 15, agreed that there was significant

swelling on the outside portion of the petitioner's right ankle, and that the swelling was in the same location that the loose bodies were retrieved during surgery. Dr. Krause further agreed that swelling could be objective evidence of injury, along with lack of range of motion. (PX 10, 19-20)

Dr. Krause testified that after his initial examination, he was also provided additional medical records to review, and after that review, he issued a report dated October 10, 2016 in which he stated that the additional records did not change his opinion from his original report. (PX 10, 21-25)

On cross-examination, Dr. Krause noted that the petitioner did not tell him about any significant problems with her ankle prior to the date of accident in March 2012, nor mentioned any preexisting conditions on the intake form prior to his independent medical evaluation. Accordingly, he agreed that the history that was given to him on June 30, 2014, was not consistent with the medical records he subsequently saw, and he also acknowledged the medical history taken from the petitioner would have played a large role in his opinions and his reporting. (PX 10, 28-29)

Dr. Krause testified that he had seen the x-ray film from March 13, 2012, and the osteochondral fracture of the talus was clearly old. Dr. Krause testified that the x-ray taken on March 13, 2012, indicated that the osteochondral fracture predated the March 13, 2012, alleged accident and that he thought that the petitioner's collapse and chronic changes came over the course of several months, if not years. (PX 10, 29-31) Dr. Krause testified that the findings from the MRI did not show any acute occurrence and were consistent with the x-ray findings from March 13, 2012 and the CT scan from February 2013. He testified that they all showed a long-standing degenerative osteonecrosis, and did not have any indications of an acute injury. (PX 10, 32-36)

Dr. Krause testified petitioner was eventually diagnosed with a non-union in her right ankle, and that the most common causes for non-union after an ankle fusion is if the patient smokes or the patient puts weight on the ankle too early. (PX 10, 40) Dr. Krause acknowledged that the records from Dr. Klein indicate that the petitioner was weight bearing in the follow ups after her surgery within 6-8 weeks after surgery. He further testified that weight being at that point can lead to a non-union. Dr. Krause also acknowledged that on June 13, 2013, the petitioner was given a boot to wear, but also instructed not to walk at all on the ankle without the boot on. He acknowledged that subsequently on June 20, 2013, the petitioner went to the ER, stating she had sprained her ankle. Dr. Krause stated if the petitioner had been wearing the boot, she would not have been able to twist her ankle, and therefore, he agreed that the petitioner was not being compliant with the doctor's instructions at that point either. (PX 10, 40-43)

Dr. Krause testified that considering the petitioner's weight bearing after her surgery, it was safe to say that the weight bearing contributed to the non-union to some degree. (PX 10, 44)

Dr. Krause acknowledged that an individual can have an injury that can exacerbate a condition without significantly altering a natural course of preexisting condition. He further acknowledged that inflammation in the ankle could be a sign of an ankle sprain as opposed to anything significant to the actual bone. (PX 10, 45-46) Dr. Krause did testify the MRI was done 6 months after the accident and any findings at that time would have been chronic, but also admitted that the MRI taken in September 2012 was consistent with the March 2012 x-ray showing chronic conditions. (PX 10, 46-48)

Dr. Krause admitted that the petitioner's diagnosis started before the March 2012 accident. However, he also stated, "The question is did the injury worsen that or change that? Again, we don't have any evidence that it did or didn't, but Dr. Schmidt and Dr. Freehill had their opinions that it did. I don't have evidence one way or the other, so I'm not going against them. I'm just saying I don't have evidence that it did or it didn't." (PX 10, 48) When asked specifically for his opinion, Dr. Krause testified that everything he saw showed that the

petitioner's condition in her right ankle was chronic, and there was no evidence to show that it was acute. (PX 10, 49)

Upon further questioning regarding Dr. Gunzel's records, Dr. Krause testified that the petitioner had injections done in May 2011 and December 2011. He further testified that the regular course of treatment for arthritis in any joint is to start with conservative care, including less weight bearing, physical therapy, and bracing. The next step is injections. The third step, if injections were not helpful, would then be consideration for an ankle fusion. (PX 10, 49-51)

The following exchange took place between the respondent's attorney and Dr. Krause:

> Q: In seeing that she progressed from conservative treatment with physical therapy and some bracing, then to injections, and then had this alleged injury in March, then eventually had a fusion, wouldn't you agree that even without the alleged injury, that would pretty much be a natural course of the type of condition that she had?
> A: Absolutely.
> Q: Doctor, taking all that into consideration, what exactly did the injury - - or how exactly did the injury accelerate this natural, progressive, degenerative condition that eventually lead to a fusion?
> A: It's hard to know if there's no objective evidence that it did.
> Q: So can you say, within a reasonable degree of medical certainty, whether or not the March 13, 2012, (sic) injury in any way accelerated or aggravated the chronic conditions in the right ankle that eventually lead to the ankle fusion?
> A: I couldn't. (PX 10, 54-56)

Upon redirect testimony, Dr. Krause testified that the March 2013 injury could have made the preexisting conditions worse, and could have accelerated the need for surgery. Furthermore, Dr. Krause testified that the petitioner's alleged injury could have further accelerated the collapse of the ankle and the need for surgery. Dr. Krause also acknowledged that the petitioner could have been at risk for a non-union regardless of the occasions of non-weight bearing, but also stated that the biggest risk, other than smoking, would be premature weight bearing for a non-fusion. (PX 10, 60-62)

On re-cross examination, the following exchange took place between the respondent's attorney and Dr. Krause:

> Q: Is it still your position, as you testified on cross-examination, that based on the medical evidence that you've seen, physical examination, history and everything, that you cannot say one way or the other, within a reasonable degree of medical certainty, whether or not the accident on March 13, 2012, aggravated, accelerated, or altered the natural course of the preexisting osteonecrosis and osteoarthritis?
> A: There's no evidence to suggest that it accelerated or exacerbated or worsened it.
> Q: Just so we're clear, so what you are saying is you cannot state, within a reasonable degree of medical certainty, whether the accident in March 2012 accelerated, altered, or changed the natural progression of that degenerative condition?
> A: I cannot say that with any certainty.
> Q: Since you cannot say that with any degree of medical certainty, is it
> true that you also cannot state within a reasonable degree of medical certainty, whether or not the eventual and subsequent ankle fusion she underwent is causally related to the March 13, 2012, accident?
> A: I cannot say that with any certainty.

Deposition of Mr. Stephen Dolan

19IWCC0711

Stephen Dolan testified on behalf of the petitioner on June 20, 2017. He testified that he was a vocational rehabilitation counsel, and has been working in the field since 1972. He left private practice in 1994. Currently, 20% of his practice is as a vocational expert with the Social Security Administration, and his other vocational expert work is split 50/50 between the petitioner's side and the respondent's side. (PX 11, 5-7)

Mr. Dolan further testified that 80% of his practice right now is vocational assessments in litigation, while 20% is as a vocational expert to the Social Security Administration office. He testified that over the last 10 years, he has probably had up to 60 cases with petitioner's attorney's firm, and that law firm was a firm that he was familiar with. Mr. Dolan further testified that at this point, he does about one to two job placements per year, and the rest of his practice is either vocational reports for litigation or work for the Social Security Administration office. (PX 11, 53-55)

The petitioner was evaluated by Mr. Dolan on September 24, 2014. Mr. Dolan testified consistently with the history of the accident, medical treatment, the petitioner's educational background, and work history. Mr. Dolan noted that the petitioner sat elevating her leg during about half the assessment. (PX 11, 8-10)

Mr. Dolan testified that the petitioner told him if she sat too long, her right ankle swelled and hurt, and she would have to elevate her right ankle to the waist height. She further told him that she could only stand for five minutes before pain increased in the right ankle and the back. She stated that she could only walk for five or ten minutes, and every step hurt her ankle and increased pain. She stated that pain in the right ankle got worse if she stood longer. She testified that stooping increased her right ankle, knee, and back pain. She could not crouch and she could not kneel. The petitioner further stated that she could not crawl and avoided stairs. If she has to maneuver stairs, she stated that she holds the handrail with both hands and takes one step at a time. She stated that she could lift a gallon of milk, but she could not lift a bag of groceries as that was too much weight on her right ankle. She told Mr. Dolan that she had fallen four times since her ankle surgery. (PX 11, 14-16)

Mr. Dolan testified that the petitioner had rudimentary computer skills, knows how to do email and internet, and has some word processing experiencing. She does not have any spreadsheet software or bookkeeping software experience. Based on her testing, he found that the petitioner spelled above a high school level, and did math at the 9th grade level, almost 10th grade. He testified that the reading and spelling scores were in line with her education, but the math score was below the level of education. He noted with the scoring and testing, the petitioner would have good skills to take courses at a community college. (PX 11, 18-19)

Mr. Dolan testified that the petitioner's current vocational profile was that of a 60-year old woman approaching retirement age with community college education. She read and spelled above the high school level, but did math at the 9th grade level. She had worked as an individual aid from 1990-2013, and based on Dr. Krause's restrictions, she needed a sit-down job where she could stand intermittently. However, according to her own description of her problems, she needed to keep her right foot elevated above the waist level much of the time while sitting to keep down pain and edema. Taking all that into consideration, Mr. Dolan testified that it was his conclusion that the petitioner was not employable in the open labor market. He further testified that he did not believe that the petitioner had access to a reasonably stable labor market. (PX 11, 21-23)

On cross-examination, Mr. Dolan acknowledged that having an Associates Degree or any higher level education makes an individual more marketable in the open labor market than someone who does not have one. (PX 11, 27-28)

Mr. Dolan was questioned regarding his statements in his report that the petitioner has not been able to do her job since her last ankle injury primarily because the fusion did not fuse. Mr. Dolan acknowledged that that was what he stated in his report, and he also admitted that the petitioner's fusion actually took place after the petitioner retired from her job in 2013. Mr. Dolan also admitted that the petitioner retired before she knew there was going to be a non-union of the fusion and before she was given any permanent restrictions by Dr. Krause. Mr. Dolan also admitted that the petitioner had never gone back to her job with the school district with her permanent restrictions to see if they would accommodate them. He admitted that he did not know whether or not the petitioner would have gone back to the school district even if her right ankle had fused. (PX 11, 30-32) In terms of number 1 of his conclusions, Mr. Dolan admitted that it was solely his assumption that the petitioner did not go back to work based on the fusion and non-fusion. (PX 11, 33-34)

Mr. Dolan was also asked specifically regarding the IME report performed by Dr. Krause on June 30, 2014. Mr. Dolan acknowledged that the petitioner had not made any comments to Dr. Krause about elevating her right ankle, having problems with standing more than five minutes, with walking more than 5-10 minutes, or any problems with lifting a bag of groceries. Mr. Dolan also admitted that although Dr. Krause provided restrictions of sedentary intermittent standing, there were no lifting restrictions or restrictions regarding pushing or pulling on the petitioner. Mr. Dolan admitted that the complaints that the petitioner told him about as described on page 5 through page 6 of his report were all subjective and based on the petitioner's own reporting. (PX 11, 37-39)

Regarding number 2 of his conclusions section, Mr. Dolan acknowledged and admitted that he was not a medical doctor, did not treat ankle and foot problems, was not an orthopedic surgeon, did not do surgeries, and did not have any expertise from a medical standpoint in terms of whether or not she would need to lift her ankle at all. He further acknowledged that his statement in number 2 of his conclusion section was based on his assumption of her credibility. Mr. Dolan further admitted that none of the medical doctors had opined or determined that the petitioner needed a permanent restriction for the need to elevate her foot as needed. He testified:

> Q: Okay. And based on your direct testimony, you specifically stated that her need to elevate her foot which based on what you're testifying now is subjective, ... is a primary reason as to why she would not be able to return to a stable labor market, correct?
> A: That is correct.
> Q: Okay. So your opinion in terms of her ability to return to a stable labor market is based primarily on her own subjective complaints?
> A: Which I found credible, yes.
> Q: Okay. But it's not based on any of the medical records?
> A: That's correct. (PX 11, 41-43)

Mr. Dolan also admitted on cross-examination that based on the petitioner's job evaluations as shown him, the petitioner did appear to have superior organizational skills, the ability to take and give instructions, implement instructions, and good interpersonal skills which would then help someone in terms of experience to gain other employment. (PX 11, 49-52)

Mr. Dolan testified that he did not provide Ms. McAlexander with any recommendation as to computer courses or training that she could take to improve her computer skills, he did not recommend any types of courses or training that Ms. McAlexander could do to become more employable, and he did not offer the petitioner any resources she could consult with in terms of finding work. Mr. Dolan further admitted that the petitioner did not present to him any job searches she had conducted, and also acknowledged that he did not look at area classified ads, Indeed.com, Monster.com, or any other job placement or job posting websites or

newspapers. Mr. Dolan did not consult any outside resources that would indicate if the type of transferrable skills the petitioner had and the type of experience would translate into any other sort of jobs. (PX 11, 55-58)

On redirect examination, Mr. Dolan testified that he had no basis to question the petitioner's credibility, and that she did appear entirely credible to him. Mr. Dolan testified that with the petitioner's limitations and complaints, assuming they are true, an employer would be more likely to hire someone without those limitations, and would be more likely to hire someone who is younger with more vocational skills. He testified that employers generally prefer someone without restrictions or physical problems versus someone who has them. (PX 11, 59-61)

Mr. Dolan further testified that it was his feeling that it would have been a waste of time for him to check outside sources as to job availability, and he was familiar with the types of jobs available in her area. (PX 11, 61)

On re-cross examination, Mr. Dolan acknowledged that as part of the ADA, employers are not supposed to inquire as to physical limitations or disabilities that are not essential to job functions. (PX 11, 62-63)

Mr. Dolan admitted that the job of a receptionist was primarily a sedentary job, and if the petitioner took computer classes, word processing classes, and typing classes, that would improve the petitioner's efficiency in word processing and would be the type of job the petitioner would be able to do within Dr. Krause's recommended restrictions. (PX 11, 66-67) Mr. Dolan testified that he knew that there were jobs available that met Dr. Krause's restrictions. He was asked the following:

> Q: Without doing any sort of labor market survey, how do you even know that there aren't any other types of sedentary-type work that are within Dr. Krause's recommended restrictions that would even be available?
> A: Well, I know that there are jobs available that meet Dr. Krause's restrictions. (PX 11, 71)

Respondent's Exhibits

Respondent admitted exhibits 1-7 into evidence without objection from the petitioner's attorney. Exhibit 1 was a copy of the petitioner's wage statement. Per the Request for Hearing Sheet for both cases, the parties agreed to an average weekly wage of $517.99.

Respondent's exhibit 2 consisted of a medical pay log from the Sandner Group Claims Management showing that $161.52 was paid by the insurance company towards the petitioner's medical costs.

Respondent's exhibit 3 consisted of the deposition transcript of Nancy Herzing. Nancy Herzing's deposition was taken on September 26, 2017, on behalf of the respondent. Ms. Herzing testified that she was employed by the Mt. Vernon School District at the time of the petitioner's alleged accidents, and had been through May 2017 as the School District's Director of Business. She testified that she retired as of May 19, 2017. (RX 3, 4)

As the Director of Business, Ms. Herzing's job duties included supervising the accounting positions at the School District, doing all of the state and federal reporting, and she was also assigned responsibilities of workers' compensation reporting and filling out paperwork regarding workers' compensation claims. She testified that her process for handling workers' compensation injuries started with receiving a personnel injury report. At that point, she would fill out the Form 45, and submit it to Bushue HR. Bushue HR would then review it, and send the information on to the workers' compensation carrier. (PX 3, 5) Ms. Herzing testified

that although she did not do the investigation of any accidents, she was the one who was in charge of doing the initial paperwork, obtain the signed releases, and collecting all reporting documents. (RX 3, 5-6)

Ms. Herzing testified that she had filled out two workers' compensation claims on behalf of the petitioner, and she never had any direct face-to-face communications with the petitioner. (RX 3, 6) Ms. Herzing primarily testified to the workers' compensation files that she kept and maintained on behalf of the School District regarding the petitioner's two alleged accidents. She also recalled receiving some information and paperwork from IMRF regarding the petitioner's retirement at some point in April 2013. Based on her own personal knowledge, it was her understanding that the retirement was voluntary in nature. (RX 3, 13-15)

Respondent's exhibits 4 and 5 were the workers' compensation files from the School District for the March 13, 2012, date of injury and the November 12, 2012, date of injury, respectively.

Respondent's exhibit 6 was a labor market survey done in the fall of 2017 by Natasha Charleston. Ms. Charleston reviewed Mr. Dolan's counseling report dated January 15, 2015, and Dr. Krause's report dated June 30, 2014, stating that the petitioner was at maximum medical improvement and could work at a sedentary-type job with intermittent standing. Based on the labor market survey, Ms. Charleston found a total of nine jobs that would fall within the petitioner's return to work restrictions or with employers willing to make reasonable accommodations. She noted that the positions were all within a 50 mile radius of the petitioner's home in Mt. Vernon, Illinois. She also recommended that the petitioner obtain computer and typing skills training as-needed. (RX 6)

Respondent's exhibit 7 were email communications between Michael Green and the petitioner regarding her retirement.

CONCLUSIONS OF LAW

With respect to issue (C), did an accident occur that arose out of and in the course of the petitioner's employment by the respondent, the arbitrator finds as follows:

Respondent did not present any evidence refuting petitioner's alleged injury on November 12, 2012. Accordingly, Arbitrator finds that petitioner suffered a compensable injury under the Act on that day.

With respect to issue (F), is the petitioner's present condition of ill-being causally related to the injury, the arbitrator finds as follows:

The Arbitrator notes that both Dr. Krause and Dr. Schmidt stated that they did not see a fracture in the x-rays from the ER visit on November 12, 2012. Accordingly, both doctors opined that at most the petitioner suffered a minor contusion, and Dr. Krause further testified that petitioner did not suffer any permanency from it. Accordingly, the Arbitrator finds that the petitioner suffered a minor contusion to her right ankle in this injury that resolved without any treatment. Accordingly, the Arbitrator finds that petitioner present condition of ill0being is not causally related to the November 12, 2012 work accident.

With respect to issue (J), were the medical services 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 testimonies of Dr. Schmidt and Dr. Krause, petitioner suffered a minor contusion that resolved without much treatment. Dr. Krause further testified that the contusion resolved without the need of treatment. Accordingly, the Arbitrator finds that only petitioner's initial treatment at Good Samaritan Hospital

ER on November 12, 2012 was reasonable and necessary to cure and relieve the effects of this injury. The Arbitrator finds that all other treatment petitioner received to her right ankle is not causally related to the accident on November 12, 2012.

With respect to issue (K), what amount of compensation is due for temporary total disability, temporary partial disability and/or maintenance, the arbitrator finds as follows:

The Arbitrator does not find that the petitioner is entitled to any temporary total disability, temporary partial disability, and/or maintenance.

With respect to issue (L), what is the nature and extent of the injury, the arbitrator finds as follows:

Based on the testimony of the doctors, petitioner suffered a minor contusion in this accident. Dr. Krause testified that petitioner did not suffer any permanency from this accident, while Dr. Schmidt was silent on the matter.

Pursuant to Section 8.1(b) of the Act, in determining permanent partial disability for all injuries on or after September 1, 2011, an arbitrator must weigh five factors, including an AMA impairment rating prepared by a physician licensed to practice medicine pursuant to the American Medical Association's guides to evaluation of permanent impairment most current edition; the occupation of the injured employee; the age of the employee at the time of the injury; the employee's future earning capacity; and evidence of disability corroborated by the treating medical records.

The parties did not submit an impairment rating for either one of the injuries and this factor was given no weight.

The petitioner was employed as an individual aid for the school district, and testified that her job duties required a lot of walking, and occasionally lifting of students, depending on how disabled they were. The Arbitrator put little weight on this factor considering the amount of walking petitioner had to do.

At the time of her accidents, the petitioner was 57 years old. The Arbitrator put little weight on this factor.

The medical records from the ER on November 12, 2013 initially indicated petitioner had a new fracture in her right ankle. However, Dr. Krause and Dr. Schmidt both reviewed the x-ray taken on November 12, 2013 and stated that they did not see a fracture. Instead, both doctors testified that petitioner at most suffered a contusion that resolved with minimal treatment if any at all. Dr. Krause testified that petitioner did not suffer any disability from this accident. The Arbitrator put great weight on this factor.

After considering the factors under Section 8.1b, the Arbitrator finds that the petitioner did not suffer any permanent partial disability as a result of this injury.

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

McALEXANDER, ELIZABETH
Employee/Petitioner

Case# **12WC031793**
14WC021613

MOUNT VERNON SCHOOL DISTRICT #80
Employer/Respondent

19IWCC0711

On 7/5/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.08% 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:

4599 SCHUCHAT COOK & WERNER
CLARE BEHRLE
1221 LOCUST ST SUITE 250
ST LOUIS, MO 63103

2674 BRADY CONNOLLY & MASUDA PC
NEEL MOOKERJEE
211 LANDMARK DR SUITE C-2
NORMAL, IL 61761

19IMCCOV11

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

Elizabeth McAlexander
Employee/Petitioner

v.

Mount Vernon School District #80
Employer/Respondent

Case # 12 WC 031793

Consolidated cases: 14 WC 021613

19IWCC0711

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Mount Vernon**, on **April 6, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ 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 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 but causal connection for petitioner's right ankle ended on April 16, 2013.

In the year preceding the injury, Petitioner earned **$20,719.93**; the average weekly wage was **$517.99**.

On the date of accident, Petitioner was **57** years of age, ***married*** with **0** dependent children.

19IWCC0711

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 $161.52 for other benefits, for a total credit of **$161.52**.

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

ORDER

The Arbitrator finds that the petitioner sustained an accident which arose out of and in the course of her employment on March 13, 2012. The petitioner also proved by a preponderance of the evidence that as a result of that injury, she suffered a right ankle sprain that aggravated pre-existing arthritis in her right ankle accelerating the need for a right ankle fusion. However, pursuant to Section 19(d) of the Act, the Arbitrator finds that that causal connection ended on April 16, 2013.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $2,446.11 for treatment at Good Samaritan Hospital on March 13, 2012, $3,290.00 for treatment at Orthopedic Center of Southern Illinois/Physical Rehabilitation Center for treatment from March 27, 2012 through January 18, 2013, $277.00 for treatment with Dr. Craig Aubuchon on November 21, 2012, $12,977.00 for treatment with Dr. Klein/Washington University Physicians up to April 16, 2013, $41,895.00 for treatment at Barnes Jewish Hospital up to April 16, 2013 and $167.28 for bills from Mid-America Radiology for testing on March 13, 2012, as provided in Sections 8(a) and 8.2 of the Act. All other bills are not causally related to the March 13, 2012 accident, and therefore denied.

Respondent shall pay Petitioner temporary total disability benefits at a rate of $345.33 per week for 1 and 5/7ths weeks that have accrued from April 5, 2013 through April 16, 2013 for a total of $591.99.

Respondent shall pay petitioner permanent partial disability benefits of $310.79 per week for 41.75 weeks, because the injury sustained as a result of this accident caused 25% loss of the right ankle at the 167 week level, as provided in Section 8(e) of the Act. Respondent shall pay petitioner compensation that has accrued from June 12, 2012 through April 6, 2018, 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

6/30/18
Date

ICArbDec p. 2

JUL 5 - 2018

STATEMENT OF FACTS

The parties agreed to bring this matter to trial on April 6, 2018, in Mt. Vernon. At trial, a Motion to Consolidate cases 12 WC 31793 and 14 WC 21613 was made on the record without objection by either party. Accordingly, the Motion was granted. The issues in dispute are accident, causal connection, reasonable and necessary medical, temporary total disability, and the nature and extent of the injuries. The parties also stipulated that if any medical bills were awarded, that they would be paid per the applicable fee schedule and that the respondent would get a credit pursuant to Section 8(j) for any payments made pursuant to that Section.

Trial Testimony of Elizabeth McAlexander

The petitioner testified that she currently lives in Mt. Vernon, Illinois, and her date of birth is July 19, 1954, making her 63 years old. (Tr. 10) She has an Associate's Degree in Arts from Rend Lake College and had started in a nursing program at Rend Lake College but did not complete it. (Tr. 11) Her prior work history included working as a waitress, a nurse's aid, work at a daycare center, and then her last job as an individual aid at Mt. Vernon District #80. (Tr. 11-12) The petitioner owns a computer, and she uses it for Facebook and searching things on the internet. (Tr. 12) Petitioner testified that she did not have any training in Microsoft or Excel, and did not consider herself a good typist. (Tr. 12)

She described her job as a teacher's aid as one-on-one interaction with students with special needs. (Tr. 14) As an individual aid, she worked with one child at a time and assisted that student with their work, staying on task, with their assignment, getting to class, etc. (Tr. 14) The physical aspects of the job depended on the student's physical capabilities that she was working with. (Tr. 15) She also described that depending on the child, she sometimes had to change diapers, transfer the student from the floor to their wheelchair, help feed them, and helped them in PE. (Tr. 15-16)

The petitioner testified that on March 13, 2012, she was at Casey Middle School in the science building. (Tr. 17) She described that there was a section of carpet that transitioned into tile with a strip that holds the carpet and the tile down at the transition. (Tr. 18) She was walking down the hall and her foot got "tripped up" on the stripping causing her to tumble forward falling on her hands and knees with her ankles and feet turned underneath her. (Tr. 19) The petitioner testified that at the time of her fall, she was not carrying anything. (Tr. 20) Immediately after the accident, she felt pain in her hands, wrists, both her knees, and her ankles. (Tr. 20)

She reported the injury to the nurse, Lisa Tucker, who had come out of her office to assist her. (Tr. 20) The petitioner testified that she was wearing sandals that laced across the top of her foot, but she did not believe that her shoes had anything to do with her fall. (Tr. 21) The petitioner testified that there was a camera at the end of the hall and a substitute secretary named Sandy Duncan showed it to her. (Tr. 21-22)

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Petitioner sought medical treatment at Good Samaritan Hospital on the same day as the alleged accident where she underwent x-rays to her knees and ankles, was given pain medication and taken off work for three days. (Tr. 25-26) Her main complaint was her right ankle, and she continued to have pain and swelling at that location. (Tr. 27)

After three days off, petitioner returned to work. (Tr. 27) Petitioner testified that she had trouble walking, and subsequently saw Dr. Freehill at the Orthopedic Center of Southern Illinois on March 27, 2012 for her right ankle. (Tr. 28) Dr. Freehill ordered the petitioner physical therapy and gave her pain medication. (Tr. 29)

The petitioner started physical therapy at Physical Rehab Center, but the physical therapy did not help her. (Tr. 29) During this time, she continued to work and continued treatment with Dr. Freehill. (Tr. 29)

The petitioner finished out the 2011-2012 school year and then had the summer off but continued having problems with her right ankle. (Tr. 31) After summer break, she continued working with the same student as the prior year until that student moved away during Christmas break. (Tr. 30) After Christmas break, she was assigned to another student but after three days she had to stop because she could not physically do the job. (Tr. 30) The petitioner identified Petitioner's Exhibit 15 as her swollen right ankle stating that the picture was taken on August 2, 2012. (Tr. 32) Petitioner testified that she continued to have pain and swelling in her right ankle, and she would have to keep her right ankle propped up on a chair while at work. (Tr. 34)

Petitioner testified that she had gone back to look at the strip that she tripped over with Terri Clark, and took pictures of it on August 9, 2012. (Tr. 35, 37) She identified Petitioner's Exhibit 16 as the pictures taken by Terri Clark showing the stripping to be loose. (Tr. 35-36)

The petitioner also had an accident on November 12, 2012. (Tr. 38) She described that she was standing with her student outside of a class waiting for the hallway traffic to pass when a student fell into her right ankle, and "kind of kicked it." (Tr. 38) Petitioner was worried that there may have been more damage to her ankle and sought treatment at Good Samaritan ER where she was told that she had a new fracture. (Tr. 38) She was then referred to Dr. Aubuchon by Dr. Freehill. (Tr. 40) She was also seen Dr. Schmidt on two occasions, and was then referred to Dr. Klein at Washington University. (Tr. 40)

The petitioner eventually underwent an ankle fusion on her right ankle on April 5, 2013. (Tr. 41-42) She testified that the surgery to her right ankle helped, and the ankle was less painful but still painful. (Tr. 42)

Petitioner testified that she did not believe she had been non-compliant with the Dr. Klein's instructions after her surgery. (Tr. 43) She acknowledged that she was told not to put any weight on her right ankle, and she took care to make sure that she did not. (Tr. 43-44) Petitioner testified that sometimes as she would hop around with her walker, and when she would get tired, she would touch her right foot to the floor without putting any weight on it. (Tr. 44)

The petitioner acknowledged that she went to the ER in June 2013 after an incident when she was getting out of bed. (Tr. 45) She thought she got out of bed too fast, and had turned her ankle. (Tr. 45) She testified that she had her boot on at that point. (Tr. 45-46) During that time, she continued to follow up with Dr. Klein. (Tr. 47) Eventually, Dr. Klein thought that her ankle was not fusing and told her that she may need a second surgery. (Tr. 47-48) Petitioner did not have the second surgery as she did not want to go through "all that again." (Tr. 48)

The petitioner testified that after the child she had been working with moved away during Christmas break, she was assigned to a child in a wheelchair in the Early Childhood Center. (Tr. 49) She testified that the

child was the size of a 5 or 6 year old, and that she would have to lift that student for everything. (Tr. 49-50) After trying to work with that student for three days, she had to stop as she could not do it physically. (Tr. 50) She testified that she had discussions with Michael Green and Aletta Lawrence to determine whether or not there was any other child she could work with, but the school district did not have one available. (Tr. 51-52) During this time, the petitioner did not receive any temporary total disability from the workers' compensation carrier and was not awarded disability through the school district. (Tr. 53) Eventually, petitioner went on FMLA. (Tr. 54) Petitioner testified that she decided to retire after her FMLA ran out because she needed income, but she had not planned on retiring for at least two more years. (Tr. 54) She testified that she called and talked to Mike Green about her retirement, and told him the reasons why she was retiring. (Tr. 55) Petitioner testified that her retirement was before her surgery, and she has not been employed by anyone else since leaving the school district, has not been offered a job by any other businesses or the school district , and has not applied for any jobs as she did not believe that there was any job available that she could do. (Tr. 55-56)

Currently petitioner has difficulty with range of motion, testified that her ankle does not move anymore, and because of that she does not feel comfortable driving. (Tr. 57-58) She also testified that she had neuropathy in her feet, which also made it hard for her to tell where her feet were as far as the pedals go. (Tr. 58) She complained of still having pain every day that increases with activities, and testified that if she is on her feet too long, if she walks too much or tries to move her ankle, does any exercises that involve her ankles moving back and forth, her pain increases. (Tr. 58-59) Petitioner testified that her right ankle swells, and she tries to keep her foot propped up from keeping it from turning red and to lessen the swelling. (Tr. 59) She testified she uses a cane whenever she walks. (Tr. 60) She testified that she has problems with lifting as she loses her balance and she has trouble walking up and down stairs. (Tr. 60-61) She no longer does any of the shopping and does limited housekeeping tasks. (Tr. 61)

She testified that she likes going to her grandkids' activities, but only goes if her husband takes her. (Tr. 62) The petitioner testified that more recently she's had surgery to her hip, and uses a walker for that surgery. (Tr. 63-64)

Petitioner testified that prior to her March 2012 injury, she had gone to Dr. Gunzel for various conditions including her right ankle. (Tr. 65) She testified that her main problem was neuropathy in her feet and arthritis in her ankles. (Tr. 65) She also saw a pain doctor, and it was regarding several sources of pain throughout her body. (Tr. 67) Petitioner, however, stated that her pain was different after her fall in March 2012, and her ankle became more painful and swollen. (Tr. 68)

On cross-examination, the petitioner acknowledged that she specifically wrote on the intake information at Dr. Gunzel's office that her chief complaint included pain in her right ankle. (Tr. 104-105) She further admitted that Dr. Gunzel had injected her foot on at least two occasions. (Tr. 105) The petitioner also acknowledged that there was swelling in both her ankles, but it was more prominent in her right. (Tr. 106) Petitioner acknowledged that Dr. Gunzel put her on restrictions. (Tr. 107) The petitioner admitted that she had swelling, pain, and osteoarthritis, prior to her March 2012 accident, and the swelling was around the outside ball of her right ankle in the same area seen in Petitioner's Exhibit 15. (Tr. 109-110)

Petitioner testified that Dr. Klein had explained to her the importance of non-weightbearing at a pre-operative visit on March 28, 2013 and further explained to her what she meant by non-weightbearing and why it was important. (Tr. 112-113)

When asked specifically about Dr. Klein's statement in her first post-operative note that the petitioner was putting her foot down on the ground several times, the petitioner testified that she may have told the doctor that, but she did not mean she was weightbearing. (Tr. 113) Petitioner further testified that despite what Dr. Klein's records stated, the she complied with Dr. Klein's instructions. (Tr. 114-115)

The petitioner acknowledged that she does not remember getting any permanent restrictions from any doctors after her surgery, except for Dr. Krause. (Tr. 119) She further acknowledged that she did not believe she had any permanent restrictions on her at the time of her evaluation with Mr. Dolan on September 14, 2014. (Tr. 120) The petitioner further acknowledged that she retired from the school district before she underwent her surgery and never went back to the school district to try to work after her surgery. (Tr. 121)

The petitioner testified that her email resignation did not mention the reason for her retirement, but claimed that she had made a telephone call to the school district first and talked to Michael Green about it. (Tr. 122) The petitioner acknowledged that the photo of the stripping and her ankle were both taken several months after her alleged injury in March 2012. (Tr. 124)

The petitioner testified that she had neuropathy in both her feet prior to her accident. (Tr. 126) She also admitted that she had pain and swelling in her right ankle prior to the 2012 accidents, was put on restrictions limiting her standing and walking prior to the 2012 accidents, and the use of her walker on the date of trial was not related to her right ankle. (Tr. 127)

Petitioner was asked about the handwritten description she gave along with the accident reporting form to the school district. She testified that on the date of the accident, she wrote down what had happened because she did not want to forget. (Tr. 128) After she handwrote it down, she testified then she got the injury form later on and filled it out and attached the handwritten notes. (Tr. 128) The petitioner was specifically asked why she did not mention that there was damage to the strip in her handwritten description immediately after her accident, and she testified that she did not realize there was damage until later on in the day when she went back and looked at it but did not writ it down in her handwritten description. (Tr. 129-131)

On redirect examination, petitioner testified that she associated the prior problems in her feet with her neuropathy but also acknowledged she had pain and swelling in both her ankles although it was worse in her right ankle after her March 2012 accident. (Tr. 133-134)

Regarding whether or not the petitioner was compliant with Dr. Klein's instructions after surgery, the following exchange took place between the petitioner's attorney and the petitioner:

> Q: Okay. All right. And if I understand your testimony correctly, there would be times you would put your foot down, but it would be a balancing sort of action where you didn't actually walk on it when you were not supposed to?
> A: Yes.

(Tr. 136)

The petitioner was also called back to the witness stand after Ms. McGreer, Ms. Clark and Mr. Green testified. She testified that her recollection was different from Mr. Green's, and she remembered having two meetings with Mr. Green and Aletta Lawrence after school resumed after Christmas break in which they discussed her restrictions and what kind of work she could do. (Tr. 194) The petitioner acknowledged that while that was the only child available for her to work with at that time, she could potentially have been moved to another child if one became available. (Tr. 194) She further testified that per her recollection, she had called Mr. Green and expressed that she did not want to retire, that was her last resort, and if Mr. Green could not find her another student she would have no choice but to retire because of financial needs. (Tr. 195-196)

On cross-examination, the petitioner acknowledged that she was assigned with a child to work with, and that Mr. Green and Ms. Lawrence had told her that if another opportunity or student came available in the future

they would move her to that student. (Tr. 197) The petitioner admitted that after she retired, she did not have any other conversations with Mr. Green or Ms. Lawrence. (Tr. 199)

Trial Testimony of Terri Clark

Ms. Clark testified on behalf of the petitioner. Ms. Clark testified that in 2012 she was the community liaison for the district and she was also the president of the Mt. Vernon Association of Classified Employees in 2012. (Tr. 145-146) As president of the union, she handled any problems that arose between staff and the administration. (Tr. 147)

Ms. Clark testified that she became aware of the petitioner's alleged accident as she heard it "through the grapevine" that she had fallen. (Tr. 148) Ms. Clark testified that in August 2012 after talking to petitioner, she recommended that they go to the location of her accident to take pictures of the stripping. (Tr. 148) Ms. Clark testified that she examined the stripping, took pictures, took measurements and prepared a statement. (Tr. 149) She testified that she observed the carpet being loose where it joined with the tile, and slid a ruler under the stripping to demonstrating it was loose. (Tr. 150-151)

Upon cross-examination, Ms. Clark admitted that she had not observed the area prior to August 2012. (Tr. 155) Accordingly, she testified that any knowledge of the condition of the stripping was based on what she observed in August 2012 or what the petitioner told her was the condition before hand. (Tr. 156)

Trial Testimony of Mary McGreer

Ms. McGreer testified on behalf of the respondent. She testified that she was the principal at Casey Middle School in March and November 2012. (Tr. 72) As principal, she was in charge of supervising the campus, doing evaluations of staff, and she was in charge of all safety and security issues of the campus. (Tr. 72) Ms. McGreer had known the petitioner since before she was a principle in her position as Special Education Director, and then as principle at Casey Middle School. (Tr. 72-73)

Ms. McGreer testified that petitioner's March 13, 2012 injury, took place in the science building hallway which housed the science and the social studies classrooms, math classroom, language arts classroom, a nurse, and a Spanish classroom. (Tr. 74) She testified that the hallway was regularly used by all the students, and was open to the general school population including the students, faculty, staff and any other person authorized to be on the grounds. (Tr. 75) Ms. McGreer testified that the hallway in question was one that she used as part of her job on a daily basis. (Tr. 75) She testified that on the March 13, 2012, nurse Lisa Tucker let Ms. McGreer know that the petitioner had taken a fall and was going to the hospital. (Tr. 76-77)

She testified that she received an official accident report from the petitioner on or about March 21, 2012 and that the injury report had a separate sheet with handwritten notes written by petitioner. (Tr. 78) Ms. McGreer testified that after receiving the report, she examined the area where the alleged accident took place. (Tr. 78) Ms. McGreer described that there was an incline in that hallway, and the carpet kept going past the incline for quite a bit of while, then transitioned to tile with a strip in that transition. (Tr. 79-80) She testified that when she observed the area, she did not notice any of the carpet coming up, and did not notice any of the trim coming loose. (Tr. 80)

Ms. McGreer testified that although she had not looked at the area on the date of accident, to her knowledge, no one else had indicated any defect in the transition in that hallway and if there was a maintenance order, it would have gone through Ms. McGreer. (Tr. 80-81)

She testified that the petitioner continued to work after the March 13, 2012 injury, to the end of the school year in 2012, and then after the summer break came back to work in the fall. (Tr. 82) Ms. McGreer testified that the petitioner had never requested any accommodations for permanent restrictions after her retirement. (Tr. 82)

Ms. McGreer testified that there was a video system in place when she became principal but that the system was antiquated and the video was very granular. (Tr. 84) She testified that, in her opinion, it was not very good video, and she did not utilize it a lot as principal because she thought it was not very useful. (Tr. 84) She described that at the time, the software they used would save video on it for just a couple days. (Tr. 84-85) Ms. McGreer testified that in the terms of access to the video, she only had access for herself because of student records. (Tr. 85) She testified that the individual the petitioner stated showed her the video was a substitute secretary at the time, and if she did show her the video, it would have been against Ms. McGreer's instructions. (Tr. 86)

Ms. McGreer was asked about the pictures that were taken of the transition in August 2012, and testified that during the summers there was general summer maintenance where everything was pulled out of every classroom, floors were stripped and waxed, and carpets shampooed. (Tr. 86-87) She further testified that during that summer, there was some construction going on in the hallway and in the building in general for preparations for a major construction project to renovate the building. (Tr. 87) Ms. McGreer testified that although she had examined the area on March 21, 2012 and had not noticed any defect, it was possible that the transition could have been damaged during the summer. (Tr. 88-89)

On cross-examination, Ms. McGreer clarified that the hallway was not open to the general public, but it was open to the general school population and authorized visitors including students from other schools who came for extra-curricular activities and special events. (Tr. 91-92) Further, Ms. McGreer testified that she did not dispute that the petitioner had a fall in that hallway on March 13, 2012

Ms. McGreer testified that although she could not remember exactly how she observed the stripping when she observed it, her general practice is to try to kick the area in question around to see if something was loose and if she did not notice anything, she would have gotten down and tugged at it to see if it was. (Tr. 97-98) She testified that she took safety very seriously, and was in fact, a little bit paranoid about it. (Tr. 98)

Mrs. McGreer testified that prior to the alleged accidents, the petitioner did not have any problems completing her job duties. (Tr. 101)

Trial Testimony of Michael Green

Michael Green testified on behalf of the respondent. He testified that in 2012 he was the superintendent for the Mt. Vernon District 80 school district, and retired as of June 30, 2015. (Tr. 159-160) Mr. Green testified that as superintendent, he was overall the CEO of the district. (Tr. 160) He testified that he was familiar with the petitioner as he was the principal at Casey Middle School from 2006 through 2011 and the petitioner was a very good employee and was very dependable and a good individual aid. (Tr. 160-161) She had great relationships with the kids she worked with, was very professional, and followed the IEP. (Tr. 161)

Mr. Green was familiar with the accident from March 13, 2012, and testified that he performed some investigation on it. (Tr. 161) He described that he heard at the district office that the petitioner had fallen in the hallway at Casey Middle School. (Tr. 161) A day or two days after the date of accident, he went over to the school, met with Greg Lievers (the head of maintenance) to look at the area where the petitioner fell. (Tr. 162) Mr. Green testified that the area looked normal to him, and it looked like a normal strip between the tile and the carpet. (Tr. 162) Mr. Green testified that he observed it from approximately two feet away, he squatted down,

he took his fingers and rubbed over it, and asked Mr. Lievers if there was any recent work done to the area, to which Mr. Lievers responded "No." (Tr. 162-163)

Mr. Green testified that the hallway was open to the general student, staff, and faculty population, and specifically noted that the school has over 440-450 children, and that's where the 7th grade was housed. (Tr. 163) He testified that there was a lot of activity in that area every day. (Tr. 163)

Mr. Green was asked to look at Petitioner's Exhibit 16, and testified that the pictures did not depict the condition of the stripping as he observed it a day or two after the alleged work accident. (Tr. 164) Mr. Green testified that summer was unique at Casey Middle School. (Tr. 165) Mr. Green testified that the Board of Education had approved the building of a $6.5 million expansion to the campus to add 10 classrooms, there was a lot of construction and renovation taking place outside and inside the school that summer, and there were a lot of construction crews in that hallway. (Tr. 165) He further testified that there was also just normal cleaning activity in preparation for the new school year, where all the desks were taken out of classrooms and taken into the hallway. (Tr. 165) He further testified that the traffic in that hallway during that specific summer was more than what would usually be expected during summer break. (Tr. 166)

Regarding the November 12, 2012, accident, he testified he did some investigation of that as well, but did not have any further discussions or conversations with the petitioner regarding it. (Tr. 168)

Mr. Green testified that he remembered in March 2013, he had talked to the petitioner when he came back from spring break. (Tr. 168) He testified that the petitioner had left him a message during spring break to call her, that she was going to retire and that she did not given a reason for her retirement in that message. (Tr. 168-169) Mr. Green returned the petitioner's phone call the same morning he received it, and described that the petitioner and him discussed her retirement and the benefits that she was entitled to. (Tr. 169-170) Mr. Green testified that the conversation did not include any reasons as to why the petitioner was retiring. (Tr. 171)

Mr. Green reviewed Respondent's Exhibit No. 7, and acknowledged that was an email correspondence from the petitioner to him informing him and the Board of Education that she was retiring effective April 10, 2013 and that it did not describe any reasons as to why she was retiring. (Tr. 171) Mr. Green testified that after the petitioner retired, he did not have any further conversations with the petitioner regarding coming back to work, nor did the petitioner ever contact him about accommodating certain restrictions that she may have had. (Tr. 173)

Mr. Green confirmed that prior to the surgery and her retirement, there had been conversations about the restrictions that the petitioner was on, and the restrictions were accommodated per his recollection. (Tr. 174) Mr. Green testified that if an employee came to the school district with permanent work restrictions and wanted accommodations, it was his policy to try to accommodate them. (Tr. 174-175)

On cross-examination, Mr. Green testified that he did not know if the petitioner had fallen or not as he had not witnessed the accident. (Tr. 180) He further admitted that he did not prepare any report after looking at the area specifically. (Tr. 180) Mr. Green also acknowledged that the strip between the carpet and the tile was a little bit higher than the carpet and the tile themselves. (Tr. 180)

Mr. Green acknowledged that he could not remember if there were any other children that the petitioner could aid after the three days she tried to aid the young child at the Franklin School and afterwards the petitioner had applied for FMLA during which she was not provided pay. (Tr. 183-184) However, Mr. Green reiterated that he did not have any conversation with the petitioner regarding the reason she had to retire, and specifically whether or not she was retiring because she needed a paycheck. (Tr. 186) He testified that, although it was

possible that the petitioner could have told him that and he had forgotten it, he believed that he would have remembered something like that. (Tr. 186)

On redirect examination, Mr. Green reiterated that after the petitioner worked three days at the beginning of 2013, she never came back to him and asked to be moved to a different student. (Tr. 190) If she had, he would have looked into whether or not there were other students she could work with. (Tr. 190)

On re-cross, Mr. Green acknowledged that if an individual had difficulty going up and down stairs, had difficulty walking, had to elevate their leg, that it would be hard to accommodate those particular restrictions. (Tr. 192)

Medical Evidence

Petitioner treated for right ankle pain dating back to February 4, 2011, with Southern Illinois Foot and Ankle – Dr. Gunzel. Intake information filled out by the petitioner stated that her chief complaint at the time was "neuropathy, swelling, pain in feet, and right ankle." Dr. Gunzel stated in his report that the petitioner had pain in both feet, and the right foot was worse than the left. The petitioner told Dr. Gunzel she had been diagnosed with osteoarthritis approximately 10 years ago, and Dr. Gunzel noted that the petitioner presented for an initial evaluation of ankle pain, located at the lateral malleolus on the right and the back of the ankle with flexion of the foot. The petitioner told Dr. Gunzel that the condition was gradually worsening over time. Physical examination showed swelling at the right lateral malleolus, in the dorsum of the left mid foot, lateral aspect of the right ankle, and the MTP joints. Dr. Gunzel also specifically noted that the dorsum of the right mid foot, anterior aspect of the right ankle, the right ankle medially, and right Achilles tendon showed evidence of mild pain on palpation. The petitioner's diagnosis included pain in the joint involving the ankle and foot, osteoarthritis localized primarily involving the ankle and foot. She was given medication for Mobic and Lyrica at that point, and told to follow up in one month. (PX 12)

The petitioner followed up with Dr. Gunzel on May 20, 2011. The petitioner noted to Dr. Gunzel that the condition of her feet had not improved, and the medication she was taking was not particularly helpful. The petitioner diagnosis at that visit included degenerative joint disease. She was given an injection of corticosteroids in the tarsal sinus bilaterally, and placed on restrictions of no walking greater than one block and no standing more than 20 minutes at a time. The doctor recommended reduced activity at that point and told her to follow up in four weeks. (PX 12)

Petitioner's next follow up with Dr. Gunzel was on December 9, 2011. The petitioner noted to Dr. Gunzel that her condition had been worsening, and asked for another injection at that point as the last one helped her. Dr. Gunzel provided her with a corticosteroid injection, and discussed the type of shoes that the petitioner should be wearing to minimize her discomfort. She was told to follow up again in 4 weeks. However, Dr. Gunzel's notes indicate that the petitioner cancelled her visit on January 6, 2012, and Dr. Gunzel's medical records were subsequently sent to Dr. Juergens. (PX 12)

The petitioner was evaluated by Dr. Juergens on February 29, 2012. Dr. Juergens stated that the petitioner had complaints of pain in the neck, left shoulder, right shoulder, left foot, right foot, left hand, right hand, and left lower back. Dr. Juergens diagnosed the petitioner with unspecified hereditary or idiopathic peripheral neuropathy, recommended follow up with a neurologist, and ordered some medication. (PX 13)

The petitioner then had her alleged accident on March 13, 2012. She was seen at the Good Samaritan Hospital Emergency Room on that date, and her chief complaints noted injury to the right and left knee, right ankle, and foot. Abrasions were noted on the left knee and left ankle, and she had tenderness and swelling to her right foot/ankle. X-rays of the bilateral knees, the right ankle, and the right foot were taken at that time.

The right ankle x-ray showed soft tissue swelling, osteochondral defect and impacted fracture of the talus of indeterminate age and etiology, a healed displaced fracture of the anterior aspect of the tibia of indeterminate age, degenerative changes of the tarsal bones, enthesophyte at the insertion of the plantar aponeurosis in the calcaneus. She was provided with some medications, and recommended to undergo an MRI of her left knee. She was also given a work excuse for three days. (PX 1)

Petitioner then followed up with Dr. Freehill at the Orthopedic Center of Southern Illinois. On the intake form, the petitioner stated that she had tripped over stripping on the floor that was loose and fell on both her knees, both her hands, and her feet were bent underneath her. She complained of right ankle pain and swelling since the date of accident. It was noted that the petitioner had significant swelling over her lateral ankle ligaments, but she was non-tender at the forefoot, midfoot and hindfoot. She was tender at the distal fibula, but non-tender at the medial malleolus and deltoid ligaments. X-rays from the Emergency Room were reviewed, and the doctor noted an old anterior tibial fracture that had healed in a slightly displaced manner, and anterior lateral talar changes consistent with osteochondral injury or possibly even osteonecrosis, but no evidence of any acute fracture. She was diagnosed with a right acute ankle sprain. The doctor recommended conservative care, and recommended a CAM walker boot but after the petitioner expressed not wanting that, Dr. Freehill recommended an ASO brace and an athletic shoe. She was placed on light duty, and told to avoid prolonged standing and walking. She was also referred to physical therapy. (PX 2)

The petitioner followed up with Dr. Freehill on May 1, 2012. The doctor diagnosed the petitioner with right ankle sprain with persistent pain and swelling, and noted she was concerned about the swelling and possible osteonecrosis of the talus. There was consideration for an MRI, but petitioner was concerned about her cervical fusion with hardware would interfere with it. Therefore, the MRI was put off, she was sent for physical therapy, and told to continue her light duty at that point. (PX 2)

The petitioner had her initial visit with Physical Rehabilitation Center on May 21, 2012. The patient was to undergo physical therapy two times per week for three weeks. (PX 3) After 5 visits, petitioner had a reevaluation on June 11, 2012. Throughout physical therapy, petitioner continued to complain of pain in the right ankle without improvement. As of the reevaluation, the physical therapist recommended that further therapy be placed on hold pending follow up with the doctor. (PX 3)

The petitioner followed up with Dr. Freehill on June 12, 2012. Dr. Freehill noted the petitioner had completed physical therapy, but had increased pain the previous day. Dr. Freehill continued to observe large amount of swelling over the lateral ankle ligaments, tenderness over the lateral ankle, tenderness over the anterolateral ankle ligament, and tightness of the Achilles tendon. The petitioner was recommended to see an ankle specialist, discontinue physical therapy, and be seen back in the office on an as-needed basis. The petitioner continued to not want an MRI at that point. (PX 2)

The petitioner had another follow up with Dr. Freehill on August 28, 2012. The doctor recommended an MRI of the right ankle again. The petitioner was to follow up after her MRI. (PX 2)

The petitioner underwent the MRI of the right ankle on September 17, 2012. The MRI revealed the following:

1. Chronic mild collapse of the central to lateral talar articular cortex with prominent diffuse subcortical degenerative changes.
2. Small to moderate ununited fracture of the anterior to anterolateral tibial plafond.
3. Ununited comminuted fracture distal and anterior aspect of the fibula with disruption of the anterior talofibular ligament.
4. Moderate degenerative changes in the anterior and posterior tibial plafond.

5. Moderate diffuse anterolateral capsular inflammation.
6. Small talotibial effusion with multiple very small ossific loose bodies within the anterior aspect.
7. Mild to moderate diffuse midfoot degenerative change.

(PX 3)

The petitioner followed up with Dr. Freehill on September 28, 2012. Dr. Freehill noted the MRI showed that the petitioner had evidence of central collapse of the central and lateral talar articular cortex, had degenerative changes of the anterior and posterior tibia, and had tibiotalar joint effusion with loose bodies. Dr. Freehill again referred her to a foot and ankle specialist. The petitioner was to follow up on an as-needed basis at that point. (PX 3)

The petitioner was seen for an independent medical evaluation by Dr. Schmidt on October 22, 2012, at the request of the respondent. Petitioner gave Dr. Schmidt a consistent history of her March 13, 2012 accident. At the time of the evaluation, the petitioner reported a painful and swollen right ankle, and reported having trouble with prolonged standing, walking, and driving. She had crepitus in her ankle, and rated her pain at 5/10. Physical examination showed the circumference of her right ankle at the malleolar to be 31 cm while on the left it was 29 cm. She was tender throughout her anterolateral ankle and had pain with deep palpation. The doctor noted that the point of maximum tenderness was the anterolateral ankle over the talar dome. Per his review of the x-rays, he found that petitioner had an osteochondral lesion over the talar dome encompassing almost the entire lateral talus and osteophytes with an old healed anterior tibial fracture at the tibial plafond along with severe osteoarthritis of the ankle and bone spurring anteriorly, and an old healed fracture of the anterior tibia. He diagnosed the petitioner with osteochondral lesion, osteonecrosis of the talus, and osteoarthritis of the ankle. (PX 9)

Dr. Schmidt believed that the current condition was related to her March 13, 2012, injury, and petitioner had not reached maximum medical improvement. He recommended a CT scan of the ankle, and noted that she would probably need an ankle replacement. (PX 9)

The petitioner then alleges a second injury on November 12, 2012. She was again seen at Good Samaritan Hospital Emergency Room on that same date. An x-ray of the right ankle was taken at that time, and was read to show a new acute avulsion fracture of the distal fibula. (PX 1)

The petitioner was then referred to Dr. Aubuchon, and saw him on November 21, 2012. The petitioner complained that her ankle was very painful and swollen. Upon physical examination, Dr. Aubuchon noted significant swelling at her right ankle, along with significant grinding with flexion and extension of the ankle. Dr. Aubuchon reviewed the MRI and the x-rays, and diagnosed the petitioner with end stage arthritis of the ankle. He advised that her options included a salvage procedure if she did not want a brace, or the other option would be a fusion of the ankle or an ankle replacement. Dr. Aubuchon recommended an ankle fusion and gave petitioner restrictions of sit down work only through December 1, 2012. (PX 4)

The petitioner followed up with Dr. Freehill on January 18, 2013. Dr. Freehill noted that the petitioner's pain was ongoing and she could not walk or stand for long periods of time. She diagnosed petitioner with right ankle arthritis and talar collapse, recommended an ankle fusion, and placed petitioner on restrictions of light duty with no twisting, squatting, kneeling, standing, or long periods of walking. She referred petitioner to Dr. Klein. (PX 5)

The petitioner then underwent a second independent medical evaluation by Dr. Schmidt at the request of the employer on February 8, 2013. Dr. Schmidt noted the second injury on November 12, 2012. Dr. Schmidt reviewed the x-ray from November 12, 2012 and did not see any evidence of an avulsion fracture. Dr. Schmidt noted his opinions remained unchanged, and he believed that the November 12, 2012, injury only caused a

contusion and petitioner was at MMI for that injury. He continued to believe that the petitioner's ankle needed to be replaced, and that was related to the March 13, 2012, accident. (PX 9)

The petitioner saw Dr. Klein at Washington University Orthopedics on February 12, 2013. Dr. Klein noted petitioner's pain and swelling in her right ankle. Physical exam showed that the petitioner's gait was severely antalgic and she had a difficult time weight bearing on the right foot. Dr. Klein noted mild hindfoot valgus on the right compared to the left, and severe swelling of the right ankle. Dr. Klein also noted that the petitioner had severe pain with range of motion, and was tender to palpation around the ankle joint. Dr. Klein reviewed x-rays and diagnosed the petitioner with severe right ankle arthritis, right ankle valgus deformity, and idiopathic peripheral neuropathy. She recommended the petitioner undergo a CT scan. Dr. Klein explained to petitioner that if she had surgery, she would be required to use a boot post-operatively, and would also be in a cast. She further urged the petitioner to consider that because Dr. Klein specifically stated that she did not recommend surgery if the petitioner did not think she could comply with post-operative treatment. (PX 5)

The petitioner underwent the CT scan of the right ankle on February 28, 2013, at Barnes Jewish. The CT of the right ankle showed a large osteochondral lesion of the lateral right talar dome with articular collapse involving two-thirds of the talar articular surface, severe secondary right tibiotalar and tibiofibular joint osteoarthritis, and mild right posterior subtalar joint osteoarthritis. (PX 6)

The petitioner followed up with Dr. Klein on that same date. Dr. Klein noted that the petitioner's condition was unchanged at that point, and the petitioner had returned following her CT scan. Dr. Klein's diagnosis was the same, and treatment options were discussed. Dr. Klein noted that the petitioner had a difficult time wearing a boot in the past, and she was a little bit worried about surgical recovery. Dr. Klein advised that the petitioner would be non-weight bearing in the cast for six weeks followed by four weeks in a weight bearing cast. After that, the petitioner would be in a boot which would allow the petitioner to weight bear. (PX 5)

The petitioner had a pre-operative follow up with Dr. Klein on March 28, 2013. Dr. Klein discussed the risks and benefits with the petitioner at that time, and Dr. Klein specifically noted that she advised the petitioner to practice non-weight bearing at home prior to the surgery. (PX 5)

The petitioner underwent surgery on April 5, 2013. The pre-operative and post-operative diagnoses were right ankle arthritis, right ankle valgus deformity, and obesity. A right ankle complex arthrodesis with interposition wedge allograft and a right iliac crest bone graft were performed on the petitioner. In the operative report itself, Dr. Klein again stated that she had conversations with the petitioner regarding the importance of remaining non-weight bearing post-operatively.

The petitioner followed up with Dr. Klein for her first post-operative visit on April 16, 2013. Dr. Klein noted that the petitioner stated that she had been "doing her best" to keep her weight off the foot, but, "It sounds like she is putting it down on the ground several times." Dr. Klein noted that the petitioner denied putting her full weight on it, but Dr. Klein again discussed with the petitioner the importance of remaining non-weight bearing. Sutures were removed at that visit, and the petitioner was placed in a short leg non-weight bearing cast made of synthetic materials. Dr. Klein noted the petitioner would remain non-weight bearing and will continue to ice and elevate the right leg for comfort. Dr. Klein stated at the end of the note, "I discussed the importance of compliance with her once again. She should remain non-weight bearing. I think this gives her the best opportunity for success." (PX 5)

The petitioner had a follow up on May 16, 2013. X-rays did not show any evidence of hardware loosening or failure. Dr. Klein again stated, "It sounds like she has been walking on it somewhat." Dr. Klein noted the long discussions she had with the petitioner prior to surgery, even indicating to her that the petitioner should not consider surgery if she was not willing to be non-weight bearing. Dr. Klein explained to the

petitioner again that if she wanted surgery to be successful, she needed to comply with the post-operative regimen. Dr. Klein placed the petitioner in a short leg weight bearing cast made of synthetic materials, and noted that she could place weight on the extremity of the cast. Dr. Klein noted that the petitioner would remain in the cast for four more weeks, but she was concerned about the petitioner's compliance. Dr. Klein had a discussion with the petitioner again extensively, and explained to the petitioner that she could weight bear, but she should not continue to walk on it if it was painful. Dr. Klein specifically stated that she would run the risk of non-union, which could lead to chronic pain. (PX 5)

The petitioner's next followed up with Dr. Klein was on June 13, 2013. At that time, the petitioner again underwent a right ankle x-ray, and the x-ray showed stable hardware with what the doctor characterized as progressive fusion of the ankle joint line. Dr. Klein stated that the radiographs looked good, but the petitioner was still having pain clinically. Dr. Klein advised the petitioner to try to ease into her boot. She advised that the petitioner could weight bear as tolerated in the boot, but she should not walk without it on. Dr. Klein also noted that the petitioner was to use her crutches and walker to keep the weight off the foot as needed for discomfort. (PX 5)

On June 20, 2013, the petitioner presented at the Emergency Room at Good Samaritan Hospital. In the history portion, the petitioner advised the ER that she had right ankle pain, and had her cast removed approximately one week ago. The petitioner stated that she twisted her ankle that morning when she stepped wrong and possibly twisted it. An x-ray taken at that time showed possible oblique fracture with mild displacement of the distal fibula. Petitioner was given some pain medication at that point. (PX 1)

In a telephone note dated June 24, 2013, from Dr. Klein's office, the petitioner called requesting pain medication, noting that she had gone to the ER the previous week and was diagnosed with a fibular fracture. The nurse talked to Dr. Klein who advised that she believed that the fracture seen in the Emergency Room was actually an osteotomy that was done during surgery. Dr. Klein stated that she would not prescribe any pain medication at that point, and that the petitioner needed to keep her already scheduled appointment with the nurse practitioner on June 25, 2013. (PX 5)

Petitioner had the follow up appointment with Dr. Klein's nurse practitioner on June 25, 2013. The petitioner noted increased pain at that time of the right lateral ankle. Physical examination did show mild tenderness to palpation on the right lateral fibula, but no redness, bruising or swelling was noted. X-rays ordered on that same day were reviewed, and did not show any new fracture. The petitioner was put in a short leg non-weight bearing cast. The petitioner was noted to have asked for some pain medication, but the nurse practitioner told her they would be unable to refill the pain medication for her at this point. (PX 5)

The petitioner next had an appointment with Dr. Klein on July 11, 2013. Petitioner was feeling somewhat better, and stated she had good and bad days. She had moderate swelling of her ankle, it was improved, but she remained tender to palpation around her ankle. At that visit, the petitioner was placed in a short leg weight bearing cast. The doctor was not sure as to why the petitioner's pain had increased a couple weeks ago as her x-rays and exam looked pretty good. The doctor was concerned that the petitioner was developing non-union because of her pain, and she recommended a CT scan prior to her next visit.

On August 1, 2013, the petitioner had a follow up with Dr. Klein. The petitioner was placed in a boot, and told that she could weight bear as tolerated. Dr. Klein stated that if the CT scan showed the joint healing, they would progress her out of the boot. (PX 5)

The petitioner underwent the CT scan on August 1, 2013, which showed non-union of her right ankle arthrodesis, non-union of the distal fibular osteotomy, and mild subtalar osteoarthritis. (PX 7)

In a telephone note from August 13, 2013, Dr. Klein reviewed the CT scan with petitioner telling her that the arthrodesis had not healed. Dr. Klein further stated that pre-operatively she and the petitioner had discussed the need to remain non-weight bearing, and the petitioner suspected that it would be difficult for her to do that but despite that she chose to proceed with surgery. Since surgery, Dr. Klein noted that it had been very difficult for the petitioner to stay off of her right ankle. She stated, "As a result, we discussed the possibility of trying a bone stimulator." A bone stimulator was ordered at that point, and the petitioner was to follow up in six weeks. (PX 5)

On August 23, 2013, the petitioner presented at Good Samaritan Emergency Room again. The petitioner stated she had fallen in her kitchen two weeks ago, and since then, her pain had worsened. X-rays were taken of the ankle, and it was noted there was no change relative to the previous x-rays that had been taken. The petitioner was given Hydrocodone and Naproxen at that time. (PX 1)

The petitioner followed up for an x-ray and a visit with Dr. Klein on September 26, 2013. The x-ray continued to show a non-union of the tibiotalar and distal tibiofibular joints, and a non-union of the distal fibular osteotomy. Dr. Klein stated that the petitioner had early signs of non-union in her ankle joint, and the petitioner was to transition into a solid molded AFO at the ankle to help her get back into a shoe and perhaps out of a boot. The petitioner was to continue her bone stimulator and to follow up in eight weeks. Dr. Klein hoped that there would be some bony healing at that point. (PX 5)

The petitioner followed up with Dr. Klein and for x-rays on January 16, 2014. The x-ray was unchanged at that point. Dr. Klein noted that the x-ray showed a broken screw as well as a loose screw and plate fixation of the talus. Dr. Klein stated that she had evidence of non-union. Dr. Klein stated that the petitioner needed to decide if she wanted to continue to monitor or proceed with some sort of revision. (PX 7)

The petitioner followed up for a CT scan on April 2, 2014. The CT scan confirmed non-union. Following the CT scan, Dr. Klein's office had a telephone conversation with the petitioner on April 4, 2014 and advised that the fusion had not healed and the next step would be a revision surgery. The petitioner wanted to think about that option, and the doctor's office cancelled the petitioner's follow up appointment in May. The petitioner was to call back if she wanted to discuss surgery at that point. (PX 7)

Subsequently, the petitioner was sent for an independent medical evaluation by her attorney with Dr. Krause. The petitioner gave a consistent history of her March 12, 2012 and November 12, 2012 injuries. At the time of the visit with Dr. Krause, the petitioner reported her pain was not severe enough to undergo another surgery. Dr. Krause stated that without evidence to the contrary, he did not dispute the causation opinions by Dr. Schmidt and Dr. Freehill as it pertained to the March 13, 2012 injury. Regarding the November 12, 2012, accident, Dr. Krause stated that the petitioner had a minor ankle contusion that had resolved. Based on that, he believed that the petitioner's need for surgery was related to the March 12, 2012, accident. Dr. Krause stated that petitioner had a non-union of the ankle, but he would not recommend another surgical procedure at that point. The petitioner was at maximum medical improvement regarding the injury on March 12, 2012. Dr. Krause stated that the petitioner could work at sedentary capacity with intermittent standing, and that the petitioner had excellent hindfoot motion and plantigrade foot. He further advised that the petitioner sustained permanency from the March 12, 2012, injury, and had not sustained any permanency from the November 12, 2012, injury. (PX 10)

Approximately three months after her visit with Dr. Krause, the petitioner was sent to see Stephen Dolan for a vocational evaluation. Mr. Dolan noted that the petitioner came to the evaluation using a cane, and the petitioner stated to Mr. Dolan that she used a cane when she was outside of her house. Mr. Dolan further observed that during the assessment, and after an hour and fifteen minutes, she had to elevate her right leg to the waist level on another chair, and then she kept it elevated for the rest of the evaluation. (PX 11)

The petitioner was receiving $671.00 per month from the Illinois Municipal Retirement Fund, and $900.00 per month from Social Security Disability. The petitioner's work history included work as a waitress, work as a nurse's aid, and then work as a teacher's aid since 1990. Mr. Dolan noted that Dr. Krause was the only doctor who placed restrictions on the petitioner, and stated that she would need work in a sitting capacity with intermittent standing. (PX 11)

Subjectively, the petitioner told Mr. Dolan that after sitting for an hour, if she did not elevate her right ankle, it would turn red. She further stated she could only stand for five minutes before increased pain. She complained that she could only walk five to ten minutes, but every step hurt her right ankle. She complained that stooping increased right ankle, knee and back pain, and that she could not crouch or kneel. She avoided stairs and was otherwise dependent on handrails. She stated that she could lift a gallon of milk, but lifting a bag of groceries was too much weight on her right ankle. She further complained that carrying a gallon of milk was difficult for her. (PX 11)

Testing results showed that the petitioner had good word recognition and sentence comprehension, and spelled above the high school level. Her math was at a ninth grade level, and her reading and spelling were noted to be in line with her education. She scored a 28 on the depression screening, which Mr. Dolan stated was indicative of moderate level depression. (PX 11)

Mr. Dolan stated that based on the non-fusion of the right ankle, he found statements that she needed to elevate her foot as much as possible to be credible. The petitioner had no specific vocational skills for a sedentary job or a sedentary job that she was able to stand intermittently in. Mr. Dolan ultimately concluded that petitioner did not have any access to a reasonably stable labor market. (PX 11)

On October 10, 2016, Dr. Krause provided an addendum report at the request of petitioner's attorney. He was provided additional medical records dating back to 2010. Dr. Krause stated that the additional records did not provide him with anything significant regarding the injury in question, and that the additional records did not change his opinions from his prior IME on June 30, 2014. (PX 10)

An addendum report was also issued by Dr. Schmidt dated July 24, 2017. Dr. Schmidt also reviewed additional medical records and stated it was obvious that the petitioner had right ankle difficulty prior to her March 13, 2012, accident. However, the petitioner was found by Dr. Juergens to be able to walk on her toes which she was unable to do during Dr. Schmidt's evaluation. Therefore, he stated that, "One would feel that she did deteriorate, and, therefore, even though she did have what seems like preexisting ankle arthritis, her fall with catching her foot on the carpet seemed to accentuate the arthritic condition and necessitate further treatment as was outlined in my reports." Dr. Schmidt stated that it appeared that petitioner's ankle had not fused, and that she might have collapsed further as her alignment, in his reports, was listed as neutral. Dr. Schmidt ultimately stated that even with the records available to him, he believed that the fall on March 13, 2012, severely exacerbated the petitioner's preexisting arthritic condition. (PX 9)

Dr. Schmidt, however, noted that in the initial two post-operative notes from Dr. Klein, the petitioner was weight bearing when Dr. Klein had clearly required the petitioner to be non-weight bearing. He opined her non-compliance "would directly relate to her developing a non-union, especially what appears as an atrophic non-union as described in the further notes." He went on to state, "Therefore, I think her early weight bearing and non-compliance with her surgery has a direct effect on developing a non-union in her ankle. It is imperative that the ankle be non-stressed during the healing process so that proper healing can take place. Stressing the construct will contribute to developing a non-union." (PX 9)

Deposition of Dr. Schmidt

Dr. Schmidt's deposition was taken on December 20, 2017. Dr. Schmidt testified that he is an orthopedic surgeon specializing in foot and ankle, and he has been board certified since 1999. Dr. Schmidt testified that he actively treated patients on a daily basis and has performed surgeries for the last 22 years. (PX 14, 4-5)

Dr. Schmidt testified that he first saw the petitioner on October 22, 2012, and his first report was dated October 30, 2012. He was requested to evaluate the petitioner at the request of the Workers' Compensation carrier for an independent medical evaluation. (PX 14, 6) Dr. Schmidt testified consistently as to the history of the petitioner's accident on March 13, 2013 and the medical treatment she underwent after. (PX 14, 7)

The petitioner described to Dr. Schmidt that she had immediate symptoms of pain and swelling in the right ankle, and her current symptoms included continued pain and swelling in the right ankle, trouble with prolonged standing, walking, driving, and crepitus in the right ankle. She stated that her pain gets worse as the day goes on, and she felt she was losing her ability to drive, stand, walk, lift, carry, bend, push, pull, climb, squat, and kneel. (PX 14, 8)

Dr. Schmidt testified that the petitioner did not describe any past medical history that was significant to his evaluation. The petitioner reported to Dr. Schmidt that 85% of her day was spent sitting or lying down, and she did not do any sporting activities or hobbies. (PX 14, 9)

Dr. Schmidt testified as to what his physical examination showed consistently as reported in his report. Dr. Schmidt also reviewed an x-ray done on October 15, 2012 which showed that she had an osteochondral lesion over the talar dome and what appeared to be an old anterior tibial fracture. (PX 14, 9-10) The x-rays that he performed at his office were similar. He diagnosed the petitioner with an osteochondral lesion, osteoarthritis of her ankle, and osteonecrosis of her talus. (PX 14, 10-12)

Dr. Schmidt testified that the osteochondral lesion and the osteoarthritis had been around for a long time, and the fall may have accentuated that. He testified that the objective findings supported the subjective complaints of pain and limitations, and he felt that the petitioner had not reached maximum medical improvement. (PX 14, 12-13)

He recommended the petitioner undergo additional testing, and anticipated that the petitioner was a candidate for a total ankle arthroplasty. Dr. Schmidt testified that within a reasonable degree of medical certainty, need for future treatment was necessitated by the work injury, and his reasoning was because the petitioner did not describe any previous trauma or previous records indicating such. (PX 14, 13) He recommended that the petitioner could work in a light duty capacity. (PX 14, 14)

Dr. Schmidt saw the petitioner again on February 4, 2013, at the request of the Workers' Compensation carrier again. At that point, her chief complaint continued to be right ankle pain, and she described another injury on November 12, 2012. Dr. Schmidt reviewed the medical records from the Emergency Room of November 12, 2012, and performed a physical examination. The physical examination was pretty consistent with his previous one. The x-ray from November 12, 2012, was compared to the x-ray from October 22, 2012, and Dr. Schmidt did not see a big difference. He also did not see a fracture in the x-ray taken at the Emergency Room on November 12, 2012. (PX 14, 15-17)

Dr. Schmidt testified that his second evaluation did not change his opinion regarding the effects of the March 2012 accident, and he continued to believe that the March injury accentuated a preexisting condition necessitating further treatment. He further testified that the November 12, 2012, injury was a contusion to her

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ankle and had gone on to heal and placed her at maximum medical improvement for the November injury, but not for the March injury. (PX 14, 17-18)

Dr. Schmidt testified that he received additional medical records from respondent's attorney on or about June 20, 2017. Dr. Schmidt testified that the records indicated that the petitioner had been seen previous to her injury, and noted a couple years worth of pain in her feet and ankles. He specifically noted that Dr. Gunzel did not order an x-ray of the ankle, and she was treated with injections to the sinus tarsi, which was not the same as an injection in the ankle. After review of the additional medical records, Dr. Schmidt stated that he did not believe his diagnosis needed to be changed. (PX 14, 19-22)

Dr. Schmidt also testified that he thought it was significant that at the time of Dr. Juergens' evaluation in February 2012, the petitioner was able to get on to her toes. At Dr. Schmidt's initial evaluation, the petitioner could not do the same thing and that showed some deterioration. Dr. Schmidt testified that his opinion did not change as to the petitioner's need for an ankle replacement. (PX 14, 23-24)

Dr. Schmidt testified that early weight bearing after a fusion was detrimental to the fusion taking. Dr. Schmidt further explained that it was possible to have a non-union even if a person was completely non-weight bearing. (PX 14, 28-30) The petitioner's attorney and Dr. Schmidt had the following exchange:

> Q: She advised that there were times when she had to check her balance, and she put weight on her toes to support her foot because the boot was heavy and it would be hard to stabilize herself. She said there were also times she had to hop, and there were times when she had to touch her right foot to the ground. Otherwise, she only walked on her foot when she was advised by Dr. Klein that she could. If those activities as described are true, were those alone sufficient to create a non-union with a fusion?
> A: Indeed it may be. (PX 14, 32)

Dr. Schmidt also testified the atrophy that was noted in the petitioner's right calf was not an indication of her non-use of the leg and right foot. The petitioner's attorney and Dr. Schmidt had the following exchange:

> Q: Would it be true that you couldn't say within a reasonable degree of medical certainty that any weight bearing by Mrs. McAlexander was the cause of her non-union?
> A: I wouldn't say you could say it's the cause of the non-union; but if you certainly have somebody with a large osteochondral lesion that you have to do a big bone graft on that may have some neuropathy, they ain't helping their cause any by weight bearing on it, that's for sure. And you really want them to really stay off of it because they already have a few strikes against them. (PX 14, 33)

On cross-examination, Dr. Schmidt acknowledged that given the timeframe, the loose bodies that were found and removed in surgery had probably been there prior to the March 2012 accident. Dr. Schmidt also acknowledged that the osteoarthritis, osteochondral lesion, osteonecrosis were all preexisting to the work accident. (PX 14, 35-36)

Dr. Schmidt acknowledged that the petitioner had not told him about the prior treatment she received in her right foot. Dr. Schmidt acknowledged that Dr. Gunzel had noted swelling in the petitioner's right ankle, along with pain. He also agreed that in hindsight, he might be able to say that given the fact that in March she had an x-ray showing arthritis, that the treatment Dr. Gunzel provided was at least in part for the arthritic condition. (PX 14, 39-40)

Dr. Schmidt further acknowledged that the petitioner showed weakness throughout her foot and ankle, global in nature, and evidence of swelling in the lateral malleolus, which was the outside of the ankle. He further testified that based on the picture that the petitioner's attorney had shown him, the swelling seen was on the outside of the ankle as well. Dr. Schmidt also acknowledged that Dr. Gunzel's notes included descriptions of pain in the ankle with limited range of motion. (PX 14, 45-46)

Dr. Schmidt agreed that Dr. Klein counseled the petitioner on the importance of non-weight bearing at points before and after the operation, and it appeared that the petitioner had been weight bearing in several notes after the operation as well. He further testified that he thought it was very important for someone to be non-weight bearing after an ankle fusion. Dr. Schmidt testified that while weight bearing may not be a 100% cause of the non-union, it certainly made it more likely. He testified that the weight bearing contributed to the non-fusion, and was indirectly related to the ongoing complaints of pain. (PX 14, 51-53)

On redirect examination, He confirmed that he had not changed any of his opinions regarding the March 12, 2012, injury being the aggravating or accelerating factor to the need for surgery. (PX 14, 56-58)

Deposition of Dr. Krause

Dr. Krause's deposition was taken on June 2, 2017. Dr. Krause testified that he was an orthopedic surgeon and board certified in orthopedic surgery. His primary practice was to the lower extremities, including the knees, feet, and ankles. (PX 10, 5-6) Dr. Krause first saw the petitioner on June 30, 2014, on referral by the petitioner's attorney. (PX 10, 6)

Dr. Krause testified as to the history given to him by petitioner and described the medical records he reviewed, including Dr. Freehill's. He testified that her diagnosis was an osteochondral injury and osteonecrosis of the lateral talus. The petitioner was eventually seen by Dr. Gary Schmidt on October 30, 2012. At that time, Dr. Schmidt noted a limited ankle range of motion, and diagnosed the petitioner with osteonecrosis of the talus with osteoarthritis. Dr. Schmidt related that to the March 13, 2012, accident, and recommended a CT scan. (PX 10, 9)

Dr. Krause noted the petitioner's second injury on November 12, 2012, and she was treated at St. Mary's Good Samaritan Regional Health Center on that day for what was thought to be a fibular avulsion fracture. Subsequently, the petitioner was seen by Dr. Aubuchon on November 21, 2012 and Dr. Klein in February 2013, and both doctors recommended a right ankle fusion. (PX 10, 10-11)

Dr. Krause testified that based on his review of medical records, Dr. Klein performed a right ankle arthrodesis on April 5, 2013, and the petitioner had routine post-operative care in a cast, then a boot, and non-weight bearing initially. He noted that the petitioner had several falls post-operatively, and she presented for several visits to the Emergency Room. He testified that it looked like she had some difficulty healing, and was eventually given a bone stimulator. Subsequently, Dr. Klein diagnosed the petitioner with a non-healed fusion. (PX 10, 12)

Dr. Krause testified as to the physical exam findings at this visit consistently with what was reported in his report. Dr. Krause testified that upon his review of the CT scan from April 2014, it confirmed the diagnosis of non-union of the ankle arthrodesis with the hardware. (PX 10, 13) Based on that, he diagnosed the petitioner with a history of lateral talar osteochondral lesion versus osteonecrosis with a history of a right ankle arthrodesis non-union. Regarding the November 12, 2012, accident, he diagnosed the petitioner with a right ankle contusion which had resolved. (PX 10, 14)

Dr. Krause further testified that the injury on March 13, 2012, resulting in a contusion or strain of the ankle, worsened her preexisting osteochondral injury to her talus. It was his opinion the petitioner's subsequent surgery was related to the March 13, 2012, accident, and that the petitioner suffered a minor contusion on November 12, 2012, that she did not need treatment for. He further testified that the petitioner had reached maximum medical improvement for the November 12, 2012, accident. (PX 10, 15-16) Dr. Krause testified he did not think the petitioner needed surgery at this point, and that she was at maximum medical improvement for her March 2012 injury. He anticipated that the petitioner could work in a sitting capacity with intermittent standing, but probably could not tolerate standing for 8-10 hours per day. Dr. Krause did not believe the petitioner suffered any permanency from the November injury, but did sustain permanency as a result of the March 12, 2012, injury. (PX 10, 17-18)

Dr. Krause testified that the loose body that Dr. Klein referred to in the operative report was not necessarily objective evidence of injury, and it could come from a non-traumatic cause. (PX 10, 18-19) Dr. Krause reviewed photographs admitted into evidence petitioner's exhibit 15, agreed that there was significant swelling on the outside portion of the petitioner's right ankle, and that the swelling was in the same location that the loose bodies were retrieved during surgery. Dr. Krause further agreed that swelling could be objective evidence of injury, along with lack of range of motion. (PX 10, 19-20)

Dr. Krause testified that after his initial examination, he was also provided additional medical records to review, and after that review, he issued a report dated October 10, 2016 in which he stated that the additional records did not change his opinion from his original report. (PX 10, 21-25)

On cross-examination, Dr. Krause noted that the petitioner did not tell him about any significant problems with her ankle prior to the date of accident in March 2012, nor mentioned any preexisting conditions on the intake form prior to his independent medical evaluation. Accordingly, he agreed that the history that was given to him on June 30, 2014, was not consistent with the medical records he subsequently saw, and he also acknowledged the medical history taken from the petitioner would have played a large role in his opinions and his reporting. (PX 10, 28-29)

Dr. Krause testified that he had seen the x-ray film from March 13, 2012, and the osteochondral fracture of the talus was clearly old. Dr. Krause testified that the x-ray taken on March 13, 2012, indicated that the osteochondral fracture predated the March 13, 2012, alleged accident and that he thought that the petitioner's collapse and chronic changes came over the course of several months, if not years. (PX 10, 29-31) Dr. Krause testified that the findings from the MRI did not show any acute occurrence and were consistent with the x-ray findings from March 13, 2012 and the CT scan from February 2013. He testified that they all showed a long-standing degenerative osteonecrosis, and did not have any indications of an acute injury. (PX 10, 32-36)

Dr. Krause testified petitioner was eventually diagnosed with a non-union in her right ankle, and that the most common causes for non-union after an ankle fusion is if the patient smokes or the patient puts weight on the ankle too early. (PX 10, 40) Dr. Krause acknowledged that the records from Dr. Klein indicate that the petitioner was weight bearing in the follow ups after her surgery within 6-8 weeks after surgery. He further testified that weight being at that point can lead to a non-union. Dr. Krause also acknowledged that on June 13, 2013, the petitioner was given a boot to wear, but also instructed not to walk at all on the ankle without the boot on. He acknowledged that subsequently on June 20, 2013, the petitioner went to the ER, stating she had sprained her ankle. Dr. Krause stated if the petitioner had been wearing the boot, she would not have been able to twist her ankle, and therefore, he agreed that the petitioner was not being compliant with the doctor's instructions at that point either. (PX 10, 40-43)

Dr. Krause testified that considering the petitioner's weight bearing after her surgery, it was safe to say that the weight bearing contributed to the non-union to some degree. (PX 10, 44)

Dr. Krause acknowledged that an individual can have an injury that can exacerbate a condition without significantly altering a natural course of preexisting condition. He further acknowledged that inflammation in the ankle could be a sign of an ankle sprain as opposed to anything significant to the actual bone. (PX 10, 45-46) Dr. Krause did testify the MRI was done 6 months after the accident and any findings at that time would have been chronic, but also admitted that the MRI taken in September 2012 was consistent with the March 2012 x-ray showing chronic conditions. (PX 10, 46-48)

Dr. Krause admitted that the petitioner's diagnosis started before the March 2012 accident. However, he also stated, "The question is did the injury worsen that or change that? Again, we don't have any evidence that it did or didn't, but Dr. Schmidt and Dr. Freehill had their opinions that it did. I don't have evidence one way or the other, so I'm not going against them. I'm just saying I don't have evidence that it did or it didn't." (PX 10, 48) When asked specifically for his opinion, Dr. Krause testified that everything he saw showed that the petitioner's condition in her right ankle was chronic, and there was no evidence to show that it was acute. (PX 10, 49)

Upon further questioning regarding Dr. Gunzel's records, Dr. Krause testified that the petitioner had injections done in May 2011 and December 2011. He further testified that the regular course of treatment for arthritis in any joint is to start with conservative care, including less weight bearing, physical therapy, and bracing. The next step is injections. The third step, if injections were not helpful, would then be consideration for an ankle fusion. (PX 10, 49-51)

The following exchange took place between the respondent's attorney and Dr. Krause:

> Q: In seeing that she progressed from conservative treatment with physical therapy and some bracing, then to injections, and then had this alleged injury in March, then eventually had a fusion, wouldn't you agree that even without the alleged injury, that would pretty much be a natural course of the type of condition that she had?
> A: Absolutely.
> Q: Doctor, taking all that into consideration, what exactly did the injury - - or how exactly did the injury accelerate this natural, progressive, degenerative condition that eventually lead to a fusion?
> A: It's hard to know if there's no objective evidence that it did.
> Q: So can you say, within a reasonable degree of medical certainty, whether or not the March 13, 2012, (sic) injury in any way accelerated or aggravated the chronic conditions in the right ankle that eventually lead to the ankle fusion?
> A: I couldn't. (PX 10, 54-56)

Upon redirect testimony, Dr. Krause testified that the March 2013 injury could have made the preexisting conditions worse, and could have accelerated the need for surgery. Furthermore, Dr. Krause testified that the petitioner's alleged injury could have further accelerated the collapse of the ankle and the need for surgery. Dr. Krause also acknowledged that the petitioner could have been at risk for a non-union regardless of the occasions of non-weight bearing, but also stated that the biggest risk, other than smoking, would be premature weight bearing for a non-fusion. (PX 10, 60-62)

On re-cross examination, the following exchange took place between the respondent's attorney and Dr. Krause:

> Q: Is it still your position, as you testified on cross-examination, that based on the medical evidence that you've seen, physical examination, history and everything, that you cannot say one

way or the other, within a reasonable degree of medical certainty, whether or not the accident on March 13, 2012, aggravated, accelerated, or altered the natural course of the preexisting osteonecrosis and osteoarthritis?
A: There's no evidence to suggest that it accelerated or exacerbated or worsened it.
Q: Just so we're clear, so what you are saying is you cannot state, within a reasonable degree of medical certainty, whether the accident in March 2012 accelerated, altered, or changed the natural progression of that degenerative condition?
A: I cannot say that with any certainty.
Q: Since you cannot say that with any degree of medical certainty, is it
true that you also cannot state within a reasonable degree of medical certainty, whether or not the eventual and subsequent ankle fusion she underwent is causally related to the March 13, 2012, accident?
A: I cannot say that with any certainty.

Deposition of Mr. Stephen Dolan

Stephen Dolan testified on behalf of the petitioner on June 20, 2017. He testified that he was a vocational rehabilitation counsel, and has been working in the field since 1972. He left private practice in 1994. Currently, 20% of his practice is as a vocational expert with the Social Security Administration, and his other vocational expert work is split 50/50 between the petitioner's side and the respondent's side. (PX 11, 5-7)

Mr. Dolan further testified that 80% of his practice right now is vocational assessments in litigation, while 20% is as a vocational expert to the Social Security Administration office. He testified that over the last 10 years, he has probably had up to 60 cases with petitioner's attorney's firm, and that law firm was a firm that he was familiar with. Mr. Dolan further testified that at this point, he does about one to two job placements per year, and the rest of his practice is either vocational reports for litigation or work for the Social Security Administration office. (PX 11, 53-55)

The petitioner was evaluated by Mr. Dolan on September 24, 2014. Mr. Dolan testified consistently with the history of the accident, medical treatment, the petitioner's educational background, and work history. Mr. Dolan noted that the petitioner sat elevating her leg during about half the assessment. (PX 11, 8-10)

Mr. Dolan testified that the petitioner told him if she sat too long, her right ankle swelled and hurt, and she would have to elevate her right ankle to the waist height. She further told him that she could only stand for five minutes before pain increased in the right ankle and the back. She stated that she could only walk for five or ten minutes, and every step hurt her ankle and increased pain. She stated that pain in the right ankle got worse if she stood longer. She testified that stooping increased her right ankle, knee, and back pain. She could not crouch and she could not kneel. The petitioner further stated that she could not crawl and avoided stairs. If she has to maneuver stairs, she stated that she holds the handrail with both hands and takes one step at a time. She stated that she could lift a gallon of milk, but she could not lift a bag of groceries as that was too much weight on her right ankle. She told Mr. Dolan that she had fallen four times since her ankle surgery. (PX 11, 14-16)

Mr. Dolan testified that the petitioner had rudimentary computer skills, knows how to do email and internet, and has some word processing experiencing. She does not have any spreadsheet software or bookkeeping software experience. Based on her testing, he found that the petitioner spelled above a high school level, and did math at the 9th grade level, almost 10th grade. He testified that the reading and spelling scores were in line with her education, but the math score was below the level of education. He noted with the scoring and testing, the petitioner would have good skills to take courses at a community college. (PX 11, 18-19)

Mr. Dolan testified that the petitioner's current vocational profile was that of a 60-year old woman approaching retirement age with community college education. She read and spelled above the high school level, but did math at the 9th grade level. She had worked as an individual aid from 1990-2013, and based on Dr. Krause's restrictions, she needed a sit-down job where she could stand intermittently. However, according to her own description of her problems, she needed to keep her right foot elevated above the waist level much of the time while sitting to keep down pain and edema. Taking all that into consideration, Mr. Dolan testified that it was his conclusion that the petitioner was not employable in the open labor market. He further testified that he did not believe that the petitioner had access to a reasonably stable labor market. (PX 11, 21-23)

On cross-examination, Mr. Dolan acknowledged that having an Associates Degree or any higher level education makes an individual more marketable in the open labor market than someone who does not have one. (PX 11, 27-28)

Mr. Dolan was questioned regarding his statements in his report that the petitioner has not been able to do her job since her last ankle injury primarily because the fusion did not fuse. Mr. Dolan acknowledged that that was what he stated in his report, and he also admitted that the petitioner's fusion actually took place after the petitioner retired from her job in 2013. Mr. Dolan also admitted that the petitioner retired before she knew there was going to be a non-union of the fusion and before she was given any permanent restrictions by Dr. Krause. Mr. Dolan also admitted that the petitioner had never gone back to her job with the school district with her permanent restrictions to see if they would accommodate them. He admitted that he did not know whether or not the petitioner would have gone back to the school district even if her right ankle had fused. (PX 11, 30-32) In terms of number 1 of his conclusions, Mr. Dolan admitted that it was solely his assumption that the petitioner did not go back to work based on the fusion and non-fusion. (PX 11, 33-34)

Mr. Dolan was also asked specifically regarding the IME report performed by Dr. Krause on June 30, 2014. Mr. Dolan acknowledged that the petitioner had not made any comments to Dr. Krause about elevating her right ankle, having problems with standing more than five minutes, with walking more than 5-10 minutes, or any problems with lifting a bag of groceries. Mr. Dolan also admitted that although Dr. Krause provided restrictions of sedentary intermittent standing, there were no lifting restrictions or restrictions regarding pushing or pulling on the petitioner. Mr. Dolan admitted that the complaints that the petitioner told him about as described on page 5 through page 6 of his report were all subjective and based on the petitioner's own reporting. (PX 11, 37-39)

Regarding number 2 of his conclusions section, Mr. Dolan acknowledged and admitted that he was not a medical doctor, did not treat ankle and foot problems, was not an orthopedic surgeon, did not do surgeries, and did not have any expertise from a medical standpoint in terms of whether or not she would need to lift her ankle at all. He further acknowledged that his statement in number 2 of his conclusion section was based on his assumption of her credibility. Mr. Dolan further admitted that none of the medical doctors had opined or determined that the petitioner needed a permanent restriction for the need to elevate her foot as needed. He testified:

> Q: Okay. And based on your direct testimony, you specifically stated that her need to elevate her foot which based on what you're testifying now is subjective, ... is a primary reason as to why she would not be able to return to a stable labor market, correct?
> A: That is correct.
> Q: Okay. So your opinion in terms of her ability to return to a stable labor market is based primarily on her own subjective complaints?
> A: Which I found credible, yes.
> Q: Okay. But it's not based on any of the medical records?
> A: That's correct. (PX 11, 41-43)

Mr. Dolan also admitted on cross-examination that based on the petitioner's job evaluations as shown him, the petitioner did appear to have superior organizational skills, the ability to take and give instructions, implement instructions, and good interpersonal skills which would then help someone in terms of experience to gain other employment. (PX 11, 49-52)

Mr. Dolan testified that he did not provide Ms. McAlexander with any recommendation as to computer courses or training that she could take to improve her computer skills, he did not recommend any types of courses or training that Ms. McAlexander could do to become more employable, and he did not offer the petitioner any resources she could consult with in terms of finding work. Mr. Dolan further admitted that the petitioner did not present to him any job searches she had conducted, and also acknowledged that he did not look at area classified ads, Indeed.com, Monster.com, or any other job placement or job posting websites or newspapers. Mr. Dolan did not consult any outside resources that would indicate if the type of transferrable skills the petitioner had and the type of experience would translate into any other sort of jobs. (PX 11, 55-58)

On redirect examination, Mr. Dolan testified that he had no basis to question the petitioner's credibility, and that she did appear entirely credible to him. Mr. Dolan testified that with the petitioner's limitations and complaints, assuming they are true, an employer would be more likely to hire someone without those limitations, and would be more likely to hire someone who is younger with more vocational skills. He testified that employers generally prefer someone without restrictions or physical problems versus someone who has them. (PX 11, 59-61)

Mr. Dolan further testified that it was his feeling that it would have been a waste of time for him to check outside sources as to job availability, and he was familiar with the types of jobs available in her area. (PX 11, 61)

On re-cross examination, Mr. Dolan acknowledged that as part of the ADA, employers are not supposed to inquire as to physical limitations or disabilities that are not essential to job functions. (PX 11, 62-63)

Mr. Dolan admitted that the job of a receptionist was primarily a sedentary job, and if the petitioner took computer classes, word processing classes, and typing classes, that would improve the petitioner's efficiency in word processing and would be the type of job the petitioner would be able to do within Dr. Krause's recommended restrictions. (PX 11, 66-67) Mr. Dolan testified that he knew that there were jobs available that met Dr. Krause's restrictions. He was asked the following:

> Q: Without doing any sort of labor market survey, how do you even know that there aren't any other types of sedentary-type work that are within Dr. Krause's recommended restrictions that would even be available?
> A: Well, I know that there are jobs available that meet Dr. Krause's restrictions. (PX 11, 71)

Respondent's Exhibits

Respondent admitted exhibits 1-7 into evidence without objection from the petitioner's attorney. Exhibit 1 was a copy of the petitioner's wage statement. Per the Request for Hearing Sheet for both cases, the parties agreed to an average weekly wage of $517.99.

Respondent's exhibit 2 consisted of a medical pay log from the Sandner Group Claims Management showing that $161.52 was paid by the insurance company towards the petitioner's medical costs.

Respondent's exhibit 3 consisted of the deposition transcript of Nancy Herzing. Nancy Herzing's deposition was taken on September 26, 2017, on behalf of the respondent. Ms. Herzing testified that she was employed by the Mt. Vernon School District at the time of the petitioner's alleged accidents, and had been through May 2017 as the School District's Director of Business. She testified that she retired as of May 19, 2017. (RX 3, 4)

As the Director of Business, Ms. Herzing's job duties included supervising the accounting positions at the School District, doing all of the state and federal reporting, and she was also assigned responsibilities of workers' compensation reporting and filling out paperwork regarding workers' compensation claims. She testified that her process for handling workers' compensation injuries started with receiving a personnel injury report. At that point, she would fill out the Form 45, and submit it to Bushue HR. Bushue HR would then review it, and send the information on to the workers' compensation carrier. (PX 3, 5) Ms. Herzing testified that although she did not do the investigation of any accidents, she was the one who was in charge of doing the initial paperwork, obtain the signed releases, and collecting all reporting documents. (RX 3, 5-6)

Ms. Herzing testified that she had filled out two workers' compensation claims on behalf of the petitioner, and she never had any direct face-to-face communications with the petitioner. (RX 3, 6) Ms. Herzing primarily testified to the workers' compensation files that she kept and maintained on behalf of the School District regarding the petitioner's two alleged accidents. She also recalled receiving some information and paperwork from IMRF regarding the petitioner's retirement at some point in April 2013. Based on her own personal knowledge, it was her understanding that the retirement was voluntary in nature. (RX 3, 13-15)

Respondent's exhibits 4 and 5 were the workers' compensation files from the School District for the March 13, 2012, date of injury and the November 12, 2012, date of injury, respectively.

Respondent's exhibit 6 was a labor market survey done in the fall of 2017 by Natasha Charleston. Ms. Charleston reviewed Mr. Dolan's counseling report dated January 15, 2015, and Dr. Krause's report dated June 30, 2014, stating that the petitioner was at maximum medical improvement and could work at a sedentary-type job with intermittent standing. Based on the labor market survey, Ms. Charleston found a total of nine jobs that would fall within the petitioner's return to work restrictions or with employers willing to make reasonable accommodations. She noted that the positions were all within a 50 mile radius of the petitioner's home in Mt. Vernon, Illinois. She also recommended that the petitioner obtain computer and typing skills training as-needed. (RX 6)

Respondent's exhibit 7 were email communications between Michael Green and the petitioner regarding her retirement.

CONCLUSIONS OF LAW

With respect to issue (C), did an accident occur that arose out of and in the course of the petitioner's employment by the respondent, the arbitrator finds as follows:

The petitioner bears the burden of proving by a preponderance of the evidence that her injury arose out of and in the course of the employment. 820 ILCS 305/2 (West 2002). The petitioner must show both elements in order to justify a compensable case. Illinois Bell Telephone Co. v. Industrial Comm'n, 131 Ill. 2d 478, 483, 546 N.E. 2d 603, 137 Ill.Dec. 658 (1989).

An injury arises out of employment when "the injury has 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." William G. Ceas & Co. v. Industrial Comm'n, 261 Ill.App. 3d 630, 636, 633 N.E. 2d 994, 199 Ill.Dec.

198 (1994). The general rule is that an injury arises out of an individual's employment if one was performing acts she was instructed to perform by her employer, acts which she had a common law or statutory duty to perform, or acts which the employee would be reasonably expected to perform that are incidental to her assigned duties. Caterpillar Tractor Co. v. Industrial Comm'n, 129 Ill. 2d 52, 58, 541 N.E. 2d 665, 667, 133 Ill.Dec. 545 (989). Furthermore, a risk is noted to be incidental to an individual's employment when it is connected with what the employee has to do to fulfill their duties. *Id.* Employment related risks associated with injuries sustained as a consequence of a fall due to a defect at the employer's premises is a risk to which the general public is not exposed to. Nabisco Brands, Inc. v. Industrial Comm'n, 266 Ill.App. 3d 1103, 1107, 641 N.E.2d 578, 204 Ill.Dec. 354 (1994)

In this case, we do not need to consider whether the stripping in the hallway in question was defective causing the petitioner's fall. The hallway in question is inherently not open to the general public as Ms. McGreer testified that the school premises was not open to the general public and was only open to individuals authorized to be on the premises. As such, the petitioner presence in that hallway was incidental to her employment.

Furthermore, the petitioner testified that her student had class in that hallway and that was why she was walking in that hallway. Respondent did not offer any evidence refuting that. Furthermore, the witnesses all agreed that the stripping, whether defective or not, was higher up than the carpet and tile.

As the petitioner had to traverse that hallway to fulfill her duties as an individual aid, and as the stripping itself was raised higher than the carpeting and tile, the petitioner was inherently exposed to a risk that was incidental to her employment and connected with what the petitioner had to do to fulfill her job duties. Accordingly, the Arbitrator finds that the petitioner suffered a compensable injury on March 13, 2012.

With respect to issue (F), is the petitioner's present condition of ill-being causally related to the injury, the arbitrator finds as follows:

With regard to causal relationship, the arbitrator finds Dr. Schmidt's testimony more compelling than Dr. Krause's. Therefore, the Arbitrator finds that the petitioner's need for an ankle fusion was causally related to her work accident on March 13, 2012.

Dr. Krause initially stated that he believed the petitioner's March 13, 2012, accident was causally related to her need for an ankle fusion. However, during his testimony, Dr. Krause conceded that with the additional medical records predating this accident, he could not say within a reasonable degree of medical certainty that the petitioner's work accident on March 13, 2012, changed the natural course, aggravated, or accelerated the preexisting degenerative process in the petitioner's right ankle that subsequently necessitated the ankle fusion. The basis of his change in opinion was the fact that the petitioner had a symptomatic right ankle, the fact that the x-ray taken on March 13, 2012, was consistent with the MRI taken in September 2012 and the CT scan taken in February 2013. Dr. Krause stated that all three diagnostic exams showed a long-standing degenerative process that was well advanced by March 13, 2012. While Dr. Krause testified that the accident might or could have aggravated the preexisting condition, he stated multiple times that he could not say within a reasonable degree of medical certainty if the accident actually had.

Dr. Schmidt provided a different opinion in his report and in his testimony. Dr. Schmidt's independent medical evaluations were closer in time to the March 13, 2012, accident and was before the ankle fusion surgery. Dr. Schmidt was in a much better positon to appreciate and determine if the physical examination showed a condition that had worsened after the date of accident.

Dr. Schmidt testified that in Dr. Juergens' report from February 2012, the petitioner was able to walk on her toes, while the petitioner was unable to do so in Dr. Schmidt's examination. Furthermore, he stated that Dr. Klein's reports indicated that the petitioner lined up in valgus, which indicated further collapse of her talus from what was seen during Dr. Schmidt's evaluation. He testified that with that, the fusion would have been more appropriate than the ankle replacement. Dr. Schmidt also noted that the corticosteroid injections that Dr. Gunzel had provided to the petitioner prior to her March 13, 2012, accident were in her tarsi and not the ankle, and therefore did not show any treatment directly for ankle arthritis. Dr. Krause did not make this distinction.

Finally, while Dr. Krause testified that he could not state within a reasonable degree of medical certainty whether or not the accident aggravated or accelerated the preexisting condition, he was essentially saying that he did not know one way or the other whether or not the accident had any effect on the condition. Dr. Schmidt, however, testified that in his opinion, within a reasonable degree of medical certainty, the accident on March 13, 2012, did aggravate the preexisting arthritis. He did not hedge on that opinion, and he supported it by making distinctions between the treatment records and physical condition as noted in medical records prior to the March 13, 2012, accident versus the physical examination and condition seen in the medical records after. Accordingly, I find Dr. Schmidt's testimony more compelling and credible than Dr. Krause's.

With that being said, the respondent also argues that the petitioner was non-compliant with treatment after her ankle fusion on April 5, 2013, and due to that, she developed a non-union of the right ankle which then lead to chronic pain, permanent restrictions, and a continued diagnosis of non-union of a right ankle fusion.

Section 19(d) of the Illinois Workers' Compensation Act states:

> "If any employee shall persist in insanitary or injurious practices which tend to either imperil or retard his recovery or shall refuse to submit to such medical, surgical, or hospital treatment as is reasonably essential to promote his recovery, the Commission may, in its discretion, reduce or suspend the compensation of any such injured employee."

Under Section 19(d) of the Illinois Workers' Compensation Act, the Commission may, in its discretion, reduce an award in whole or in part if it finds that a claimant did acted in a way to to retard her recovery. There is no requirement that an injurious practice be the sole cause of the claimant's condition of ill-being for the Commission to reduce or deny compensation.

Dr. Klein's medical records prior to the petitioner's surgery on April 5, 2013, clearly showed Dr. Klein counseled the petitioner on the importance of non-weight bearing after her surgery. The petitioner even expressed some concern that she would not be able to non-weight bear after surgery, and Dr. Klein told petitioner to practice non-weight bearing if she wanted to go forward with the surgery. During her testimony, the petitioner acknowledged that Dr. Klein had counseled her on the importance of non-weight bearing after surgery and the potential risk if she was not compliant with that.

In the first post-operative visit, Dr. Klein stated that it sounded like the petitioner was putting it down on the ground several times. The petitioner, however, denied to Dr. Klein that she was putting any weight on it, and also testified to that effect at trial. However, per the petitioner's own testimony, she admitted that she would put her right foot down when her leg would get tired from the weight of the cast, and upon further questioning by her own attorney, stated she would use the right foot occasionally to balance herself. If the petitioner was using the right foot to occasionally balance herself by putting it down, that in and of itself indicates that the petitioner was putting some weight on the ankle as opposed to remaining non-weight bearing. Dr. Klein thought it was significant enough to again discuss the importance of non-weight bearing with the petitioner again.

Despite the warnings, Dr. Klein noted that the petitioner sounded like she had been walking on her right ankle at the next follow up. Dr. Klein was concerned enough that she reiterated that she had counseled petitioner not to consider surgery if she could not be non-weight bearing. Dr. Klein noted that she was specifically concerned with the petitioner's compliance, and also warned the petitioner that she ran the risk of non-union which would lead to chronic pain. She even noted to the petitioner that if she could not comply with the post-operative regimen now then a revision surgery would not be a good option for her.Dr. At that point, the petitioner was placed in a short leg weight bearing cast, and told that she could weight bear, but she could not continue to walk on it if it was painful.

At follow up on June 13, 2013, she was transitioned to a boot, and told that she could weight bear in it but not to walk on it with the boot on. Seven days after that visit, the petitioner presented to Good Samaritan Hospital stating she had twisted her ankle that morning at home. The petitioner testified that she was wearing her boot. As Dr. Krause testified, the petitioner would not have been able to twist her ankle on June 20, 2013.

Dr. Klein, Dr. Krause, and Dr. Schmidt all stated, that non-weight bearing was essential to the recovery from an ankle fusion. All three of the doctors noted that the risk of non-union of the fusion increases significantly if patient weight bears after the surgery. Dr. Schmidt and Dr. Krause both agreed that the two main factors in non-union of an ankle fusion were if the patient smoked or if the patient bore weight on the surgically repaired ankle. The petitioner was not a smoker, but she clearly bore weight on her ankle.

The petitioner may have had other factors that could have caused a non-union and non-union of a fusion is certainly a risk of that surgery, but the Arbitrator finds that it is no coincidence that petitioner's fusion did not take when there is ample evidence in the medical records that she was not compliant with the treating doctor's instructions after surgery.

The Act does not require that the injurious practice be the sole cause of the claimant's condition of ill-being for the Commission to reduce or deny compensation. The evidence shows that Dr. Klein, Dr. Krause and Dr. Schmidt all thought petitioner's weight-bearing particularly within 6-8 weeks after surgery was a contributing factor in the non-union of the ankle fusion. The doctors also testified that petitioner's ongoing pain and permanent restrictions from Dr. Krause are related to that non-union Accordingly, the Arbitrator finds that the petitioner engaged in an injurious practice which imperiled and retarded her recovery from her ankle fusion surgery ultimately contributing to the non-union of the right ankle, and pursuant to Section 19(d) of the Act denies all benefits, including treatment and any temporary total disability or maintenance benefits, subsequent to April 16, 2013.

With respect to issue (K), what amount of compensation is due for temporary total disability, temporary partial disability and/or maintenance, the arbitrator finds as follows:

The petitioner was taken off work for three days following the March 13, 2012, accident. After that point, she finished out the school year, and returned to work the following school year in August. She worked continuously through the end of that semester. At that point, the student she was aiding left the school district, and she was assigned to another student after discussing her limitations and restrictions with Mr. Green and Ms. Lawrence. She aided that student for three days at the start of the spring semester of 2013, after which she took FMLA and then eventually voluntarily retired.

Based on the medical records, on November 21, 2012, Dr. Aubuchon gave the petitioner restrictions of sit down work only through December 1, 2012. The next indication of any restrictions were from January 18, 2013, at which point Dr. Freehill placed the petitioner on restrictions limiting her from standing or walking for long periods, from any squatting or kneeling, and clarifying that the petitioner could not get up from a kneeling position. It is unclear if these restrictions were placed on petitioner after she left her job with the District or

before. Furthermore, on February 8, 2013, the petitioner was placed on work restrictions of no standing or walking greater than two hours without 15 minutes off her feet by Dr. Schmidt. Per the petitioner's own testimony, after having a discussion with Mr. Green and Mrs. Lawrence regarding her restrictions and limitations, the petitioner returned back to work aiding another student. Mr. Green testified that the school district assigned her accommodating her restrictions. However, petitioner stopped aiding that student after 3 days. As petitioner abandoned a job that was assigned accommodating restrictions, I do not find that the petitioner was entitled to any temporary total disability from March 13, 2012, through April 5, 2013.

The petitioner underwent the ankle fusion on April 5, 2013 and was told to be completely non-weightbearing until May 16, 2013. Presumably, the petitioner was expected to be off work during that time as well even though Dr. Klein did not issue any work slips throughout petitioner's treatment with her. Under normal circumstances, the petitioner would be owed temporary total disability for the time she was complete taken off work even if she had voluntarily resigned or abandoned an accommodated position. As she voluntarily retired from her job however, if petitioner was released with restrictions that could have been accommodated by her employer but for her retirement, the respondent would not own temporary total disability during that time frame. However, in this case, all benefits after April 16, 2013, have been denied pursuant to Section 19(d). Accordingly, any temporary total disability benefits the petitioner may have been entitled to after April 16, 2013 have been denied. The petitioner is not claiming any maintenance benefits after her last visit with Dr. Klein on April 4, 2014.

Therefore, the Arbitrator finds that the only period of time that the respondent owes temporary total disability to the petitioner is from April 5, 2013, through April 16, 2013 as it relates to the March 13, 2012 injury.

With respect to issue (L), what is the nature and extent of the injury, the arbitrator finds as follows:

The petitioner claims that there is no stable labor market for her in her current condition, and accordingly she is not employable in the open labor market. The Arbitrator finds that the petitioner has not proved by a preponderance of the evidence that she is permanently and totally disabled and not employable in the open labor market.

Petitioner did not perform any job searches, and admitted that she had not looked for any employment after her surgery. Petitioner presented testimony from Mr. Stephen Dolan, a vocational expert, stating that there was no stable labor market in which the petitioner could work. However, Mr. Dolan admitted that he had not performed a labor market survey, and the primary reason that he opined that there was no stable labor market for the petitioner was because of her need to elevate her right ankle at waist level due to pain. Mr. Dolan further admitted that was a subjective limitation from the petitioner as opposed to a physical restriction placed on her by medical professional. The only permanent restrictions were from Dr. Krause, and Mr. Dolan testified that he knew that there were jobs available for the petitioner within those restrictions.

The Arbitrator also finds it questionable that at the time of her visit with Dr. Krause in June 2014, the petitioner relayed to Dr. Krause that she was having mild symptoms in the right ankle, while only three months later she told Mr. Dolan about rather severe pain complaints and limitations. The petitioner testified that she may not have told Dr. Krause about those symptoms as he never specifically asked her. The Arbitrator does not find that testimony credible as Dr. Krause must have asked the petitioner what her current pain complaints were as Dr. Krause specifically noted and testified that her complaints at the time of the evaluation were mild in nature.

The respondent admitted into evidence a labor market survey, which showed several jobs that fit within Dr. Krause's restrictions that the petitioner could potentially work at. The labor market survey indicated that the

petitioner would most likely need some additional computer training to be more marketable on the open labor market, but it certainly identified some jobs that were readily available to the petitioner within Dr. Krause's restrictions.

Therefore, the evidence shows that the only restrictions that were placed on petitioner by any medical professional were from Dr. Krause. Mr. Dolan testified that he knew there were jobs available within those restrictions in the open labor market, and the labor market survey supported that statement. The petitioner has not done any job searches and testified that she has not sought any jobs on her own. With those facts alone, the petitioner has not met her burden to show by a preponderance of the evidence that she is permanently and totally disabled.

Additionally, petitioner retired from the school district in March 2013, prior to her ankle fusion, prior to the non-union of that fusion, and prior to any potential restrictions that were placed on her permanently. Although she testified that she had told Mike Green specifically that she was retiring because she could not do the job, Mr. Green testified credibly that she never had that discussion with him. Even if she did, it is clear that she was never asked to retire or leave her employment, nor did she ever return to the school district after surgery to see if they would accommodate her restrictions even though the petitioner and Mr. Green both testified that it had in the past. Mr. Green further testified that it was regular course for the school district under his leadership to try to work with employees to accommodate any work restrictions that they had.

In Sharwarko v. Illinois Workers Compensation Comm'n, 2015 IL App (1st) 131733WC, the Court found that if a claimant voluntarily retires before ever reaching maximum medical improvement and there is evidence that the employer would have accommodated restrictions had the petitioner not retired, TTD benefits would be denied. The logic of Sharwarko rests on the concept that employers should not have to pay temporary benefits if restrictions could have been accommodated but for the employee voluntarily removing themselves from the labor market. Similarly, if we follow that ruling to its logical conclusion, if an employee voluntarily retires and is subsequently released with permanent restrictions that could have been accommodated by the employer but for the employee's voluntary retirement, can the employee show that she is not employable in the open labor market? It is a long settled practice that employers have the first chance to accommodate the employee with a good faith job offer for a position of need within permanent restrictions. Employers cannot make up jobs for the employee or offer a "sham" job just to reduce exposure, but they get the first chance to employ that employee. Mr. Green testified that the district would have made every attempt to do so, but the petitioner retired and admittedly never approached the district again looking for employment within her permanent restrictions. Furthermore, petitioner testified that she has not made any attempts at all to re-enter the labor market since her surgery.

Accordingly, based on the totality of the evidence, the Arbitrator finds that petitioner failed to meet her burden of showing that she is permanently and totally disabled from the open labor market.

The Arbitrator has found that petitioner's pre-existing advanced arthritis was aggravated by this injury and accelerated the need for the eventual right ankle fusion causing some permanent disability in petitioner's right ankle.

Pursuant to Section 8.1(b) of the Act, in determining permanent partial disability for all injuries on or after September 1, 2011, an arbitrator must weigh five factors, including an AMA impairment rating prepared by a physician licensed to practice medicine pursuant to the American Medical Association's guides to evaluation of permanent impairment most current edition; the occupation of the injured employee; the age of the employee at the time of the injury; the employee's future earning capacity; and evidence of disability corroborated by the treating medical records.

The parties did not submit an impairment rating for either one of the injuries and this factor was given no weight.

The petitioner was employed as an individual aid for the school district, and testified that her job duties required a lot of walking, and occasionally lifting of students, depending on how disabled they were. The Arbitrator put some weight on this factor considering the amount of walking petitioner had to do.

At the time of her accidents, the petitioner was 57 years old. The Arbitrator put some weight on this factor.

The medical records indicate that the petitioner had a long-standing preexisting condition of the right ankle, and the testimonies of Dr. Krause and Dr. Schmidt support that. However, Dr. Schmidt testified that there was deterioration of petitioner's right ankle condition after the March 13, 2012 accident accelerating the need for the ankle fusion. Medical records from Dr. Klein, the doctor who performed the ankle fusion, notes petitioner was not compliant with treatment instructions after surgery by weight-bearing on her right ankle, and Dr. Klein, Dr. Schmidt and Dr. Krause all agreed that the noncompliance contributed to the petitioner's ultimate diagnosis of a non-union of her fusion and the subsequent symptoms and problems that she has had. The Arbitrator put great weight on this factor.

Therefore, the Arbitrator finds that the petitioner suffered 25% permanent partial disability of her right ankle.

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BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Elizabeth McAlexander,
Petitioner,

vs.

NO: 12 WC 31793
14 WC 21613
19 IWCC 0711

Mt. Vernon School District #80,
Respondent.

DISSENT

I respectfully dissent from the decision of the majority. The majority modified the Decision of the Arbitrator to award all medical bills incurred, to increase TTD from 1&5/7 weeks to 64&2/7 weeks, and to increase the PPD award from 25% loss of use of the right "ankle" [foot] to declare Petitioner permanently and totally disabled as of April 5, 2014. I would have affirmed the Decision of the Arbitrator in which he found that Petitioner's proved compensable accident caused the condition of ill-being of her right ankle, that such causation ceased after April 16, 2016, awarded TTD and medical expenses to that date, and awarded 41.75 weeks of PPD representing loss of the use of 25% of the right foot. The Arbitrator held that causation ceased on April 16, 2016 pursuant to Section 19(d) of the Act because he found Petitioner engaged in injurious practices.

Petitioner sustained a fall at work on March 13, 2012. The Arbitrator found that the accident was compensable, that it aggravated Petitioner's underlying pre-existing arthritis, and caused the need for ankle fusion surgery. The surgery was performed on April 5, 2013. Prior to surgery, her surgeon, Dr. Klein, counseled Petitioner on the need to be completely non-weight bearing after the surgery. She even indicated that she would not proceed with the surgery if Petitioner would not comply with that directive. In the initial post-surgical visit, Dr. Klein noted that it appeared to her that Petitioner was not completely complying with her non-weight bearing direction. Dr. Klein considered that to be of sufficient importance to again admonish Petitioner about the necessity of avoiding all weight bearing. She advised Petitioner that bearing weight could lead to non-fusion and chronic pain. Dr. Klein continued such admonishments in later visits. While Petitioner denied that she bore weight to Dr. Klein at the time of her visit, she acknowledged in her testimony that she was repeatedly admonished to avoid all weight bearing and that she occasionally put weight on her right foot when it became tired from the weight of the cast or to balance herself. Respondent's Section 12 medical examiners, Dr. Krause and Dr. Schmidt, concurred with Dr. Klein that avoiding weight bearing is absolutely essential to recovery from ankle-fusion surgery.

On June 13, 2013, Petitioner was put in a walking boot. She was advised that she could bear some weight on the right foot while wearing the boot. Seven days later, Petitioner presented to the emergency department at Good Samaritan Hospital reporting that she had twisted her right ankle. Dr. Krause specifically testified that it would be impossible for Petitioner to have twisted her ankle if she were wearing the boot. Thereafter, Petitioner's fusion failed resulting to a non-fusion. The non-fusion resulted in a significantly increased period of time she was off work and significantly increased permanent partial disability. As correctly noted by the Arbitrator, Section

19(d) does not mandate that the injurious practice be the sole cause of a claimant's condition of ill-being to deny benefits.

For the reasons stated above, I would have affirmed the Decision of the Arbitrator in which he found Petitioner's failure to comply with treatment directives from her treating surgeon aggravated her work-related condition of ill-being and resulted in cessation of causation. Therefore, I respectfully dissent from the decision of the majority.

DLS/dw
O-11/7/19

DEC 3 1 2019

Deborah L. Simpson

Deborah L. Simpson

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 on Accident	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify Choose direction	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

LEONARD LUDTKE,

Petitioner,

vs. NO: 16 WC 009295

COUNTY OF DeKALB,

Respondent.

19IWCC0712

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, medical expenses, partial permanent disability, and penalties, and being advised of the facts and law, reverses the Decision of the Arbitrator as stated below.

I. FINDINGS OF FACT

A. Background

On December 30, 2015, Petitioner was employed by Respondent as a Maintenance Worker II. Petitioner testified he had been employed by Respondent for approximately 17 years. Petitioner stated his job duties included general maintenance, snow removal, light electrical and plumbing work, and cleaning. Petitioner added that he was available to assist others or fill in for unavailable co-workers. Petitioner was 56 years old at the time of his injury.

On December 30, 2015, Petitioner was generally assigned to the DeKalb County Courthouse. He could not recall how long he had been assigned to the courthouse but estimated it had been a couple of years. Petitioner testified the campus of Respondent in Sycamore, Illinois

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included the courthouse at the corner of State and Main, along with the Public Safety Building (commonly known as the jail), the Legislative Center and the Administration Building. According to Petitioner, the jail was across Main Street, directly east of the courthouse, while the Legislative Center and Administrative Building were north of the courthouse. Petitioner described the campus as an L-shape, with the Administration building at the top or furthest north, with the courthouse to the west. Petitioner acknowledged there is metered parking on the public streets surrounding the courthouse.

Petitioner testified that prior to December 30, 2015, there had been a substantial improvement of the courthouse, including an addition to the north side. He later clarified that the improvements were constructed years earlier and there was no ongoing construction. Petitioner stated that after the addition was completed, additional parking was created on the north side of the building, directly adjacent to the addition. He testified that part of the street was taken as in-line parking for the courthouse. He described the parking as angled spaces just off the street, generally reserved for courthouse employees from 8:00 or 8:30 a.m. through 4:30 p.m. Petitioner stated that his department (facilities management) maintained those parking stalls, including snow removal, ice removal, salting and the like.

Petitioner also testified that the public entered the courthouse only through the main entrance on the south side of the building but there were four other entrances available for employees. According to Petitioner, there was a main employee entrance on the north side of the courthouse, as well as entrances at the east side, northwest corner, and the west side. Petitioner stated the employee entrances required entering a code into a keypad.

B. Accident

Petitioner testified that on December 30, 2015, his shift was from 7:00 a.m. to 3:30 p.m. He stated he arrived on the campus that day at approximately 6:45 to 6:50 a.m. Petitioner acknowledged he was not called into work early and was not paid for the time before his shift.

Petitioner testified he parked in one of the spaces on the north side of the courthouse. According to Petitioner, these spaces were reserved for particular employees, including judges. Petitioner stated that other employees generally parked in the main parking lot east of the Legislative Center, but to his knowledge, they were not required to do so.

Petitioner explained that he parked in a space reserved for another county employee to drop off his lunch and coffee; he wanted to avoid carrying it across the campus because he generally ate lunch at the courthouse. He explained that his coffee would have become cold carrying it from the main lot to the Public Safety Building to sign in for work before going to the courthouse. Petitioner stated he typically would deposit his lunch, drive to and park in the main lot, and enter the Public Safety Building to sign in on his time sheet.

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Petitioner acknowledged he could have parked elsewhere and was not required to eat lunch at the courthouse. He later added that he had occasionally been telephoned to respond to emergencies while off-site during lunch.

Petitioner testified that after parking, he entered the courthouse through the northwest entrance and dropped off his lunch in the shop area. He stated that while entering the building, he noticed there was a thin layer of ice covering the parking lot, but the sidewalk seemed clear. According to Petitioner, it did not appear that anyone had cleared ice or snow, or salted the parking lot, but he observed ice melt on the sidewalk. Petitioner acknowledged it was icy throughout the city and there was snow around. He also acknowledged that he walked through snow to reach the public sidewalk and his shoes may have become wet.

Petitioner testified that after dropping off his lunch, he exited the building. Petitioner stated that as he was returning to his car, he slipped and fell in the parking area, approximately five or six feet away from his car. He added that his feet came out from under him and he landed heavily on his left shoulder and arm. Petitioner agreed there was no crack or defect in the sidewalk, or anything other than ice that caused him to fall.

According to Petitioner, he experienced extreme pain in his left shoulder and further examination revealed very limited mobility of the arm with extreme pain. Petitioner also testified that prior to his fall, he had never injured or received medical treatment involving his left shoulder and arm. Petitioner testified he notified his supervisor of the incident and drove himself to the emergency room at Kishwaukee Hospital.

C. Medical Treatment

On December 30, 2015, Petitioner presented to the emergency department at Kishwaukee Hospital. The medical records indicate Petitioner informed the staff he was outside at work and slipped on the ice, landing on the left shoulder/humerus; he denied any head injury, neck pain, chest pain, abdominal pain, or syncope. According to the records, two X-rays of the left shoulder showed no fracture, dislocation, focal bony abnormality or degenerative changes. Two X-rays of the left humerus showed similar results. A report on a CT scan of the head indicated no evidence of acute intracranial abnormality. Another report on a CT scan of the cervical spine indicated: no fractures; straightening of the normal cervical lordosis, which may be secondary to patient positioning or can be seen with muscle spasm; and multilevel cervical spondylosis.

Petitioner was diagnosed with a left shoulder contusion, with the notation of no obvious fracture or dislocation. The patient summary report also indicates instructions were given for a shoulder sprain. Petitioner was discharged to home care with instructions for rest, heat, ice and a shoulder sling as needed.

On January 4, 2016, Petitioner was seen at the Midwest Orthopedic Institute by Marcus Roman, assistant to Dr. Tony Choi. After providing a history of the incident, Petitioner

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complained of pain with sleeping, especially on the left shoulder. Petitioner also complained of pain with overhead movements. Roman noted Petitioner previously had a right rotator cuff repair performed by Dr. Choi.

Roman's physical examination indicated the range of motion on both shoulders actively was 160/60/T9. Roman noted that on the left, he could forward elevate Petitioner to 160 degrees with a little pain. Strength was 4/5 in forward elevation on the left, 5/5 with external rotation but with pain, and 5/5 with internal rotation. Roman's impression was left shoulder pain, with suspicion of a rotator cuff tear. Roman recommended obtaining an MRI to rule out a rotator cuff tear. Roman also issued a work note stating Petitioner could not return to work.

The MRI of Petitioner's left shoulder was performed on January 7, 2016. The interpreting radiologist's impressions were: (1) complete full-thickness tear supraspinatus tendon and full-thickness tear of the anterior-most infraspinatus tendon with more mild diffuse infraspinatus tendinosis; (2) full-thickness tear of the cephalad 2/3 subscapularis tendon; (3) moderately severe acromioclavicular degenerative change; and (4) moderately large hemarthrosis freely communicating with the subacromial-subdeltoid bursa.

On January 11, 2016, Roman reviewed the MRI results and recommended surgical fixation for Petitioner's acute rotator cuff tears, to which Petitioner agreed. Roman noted that Dr. Choi also reviewed the MRI. On February 5, 2016, Petitioner saw Dr. Choi, whose notes confirm he reviewed the MRI and recommended arthroscopic rotator cuff surgery (as opposed to open surgery).

On February 11, 2016, Dr. Choi performed a left shoulder arthroscopic double row subscapularis repair and supraspinatus repair, subacromial decompression and biceps tenodesis. Dr. Choi's pre- and post-operative diagnoses were the same: left shoulder massive rotator cuff tear supraspinatus, infraspinatus, subscapularis. Petitioner was also referred to Dr. Manav Salwan on this date for post-operative medical management and diabetic management.

On February 12, 2016, Dr. Choi noted Petitioner was doing well and the plan would be to discharge him home. The doctor also noted he was trying to arrange home health therapy, as Petitioner had troubles with transportation due to living alone.

On February 19, 2016, Petitioner followed up with Roman, rating his pain at 1/10 at rest and 6/10 with activity. Petitioner also reported his pain was moderately controlled with Norco. Roman scheduled another visit in a week to remove Petitioner's sutures. Roman noted Petitioner would continue physical therapy and transition from home health to outpatient therapy the next week. Roman also continued Petitioner's use of a sling and abductor wedge. On February 24, 2016, Petitioner began twice-weekly occupational therapy. On February 26, 2016, Roman continued therapy, as well as the sling and abductor wedge, scheduling a visit with Dr. Choi in two weeks.

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On March 11, 2016, Petitioner saw Dr. Choi, reporting his physical therapy was going well. Petitioner reported he was not taking Norco most days but would occasionally for neck pain. Dr. Choi noted Petitioner externally rotated passively relatively easy to 45 degrees with forward elevation of approximately 90 degrees. The doctor noted Petitioner was progressing well and removed the abduction portion of the sling. He also scheduled a follow-up visit with Roman in four weeks.

Petitioner saw Roman again on April 8, 2016. The record indicates Petitioner complained of some left shoulder pain at night. Roman's physical examination showed an active range of motion for the left shoulder of 90/45/L5, while the passive range of motion was 140/50/L5. The range of motion for the right shoulder was 170/60/T10. Roman continued Petitioner's physical therapy and ordered a follow-up visit in four weeks.

On May 6, 2016, Petitioner's only complaint to Roman was of left shoulder pain in the mornings, which improved with exercises and extra-strength Tylenol. Roman's examination showed the range of motion of the left shoulder was 150/60/L1, while the right shoulder was 170/60/T10. Petitioner's strength in forward elevation was 4/5, while his strength in internal and external rotation was 5/5. Roman again continued Petitioner's physical therapy and scheduled a visit in four weeks.

On June 3, 2016, Petitioner reported to Roman that he had no change in his shoulder pain, but felt his left shoulder was getting a little stiff. The range of motion and strength measurements were the same as his prior visit. Roman noted that in that morning's therapy, Petitioner only reached 130 degrees in forward elevation, but was able to get to 150 degrees when tested at the clinic. Roman extended Petitioner's physical therapy and scheduled another monthly visit, noting Petitioner would remain off work because there was no light duty work available.

Petitioner saw Dr. Choi on July 1, 2016. The record indicates Petitioner's range of motion for his left shoulder remained the same, but the strength in forward elevation was 4+/5. Dr. Choi noted Petitioner was still weak in forward elevation, but gradually improving. The doctor ordered continued physical therapy, with a follow-up in four weeks.

On July 9, 2016, Petitioner complained to Dr. Choi that earlier in the week, he was exercising during physical therapy and felt a pop in his neck/trapezius region, resulting in soreness around the neck which made it difficult to progress in the protocol. Dr. Choi found Petitioner's range of motion in the left shoulder was 160/60/T11, while strength in forward elevation remained 4+/5. Dr. Choi noted that Petitioner may have strained something and recommended possible deep tissue massage in addition to physical therapy. The doctor also recommended continuing strengthening exercises for endurance.

On August 26, 2016, Petitioner reported some remaining weakness to Dr. Choi, but stated the physical therapy was going well. Dr. Choi's examination found Petitioner's range of motion

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in the left shoulder was 160/60/T9, while strength in forward elevation was 5-/5. Dr. Choi noted that Petitioner's residual weakness should improve with further endurance strengthening in physical therapy. The doctor also discussed work with Petitioner, who stated his boss would not let him return until he reached 100 percent. Dr. Choi hoped to return Petitioner to work after another four-week evaluation.

On September 30, 2016, Dr. Choi found Petitioner's range of motion in the left shoulder was 160/60/T9, while strength in forward elevation was 5/5. Dr. Choi noted that Petitioner still had a little endurance-limited weakness but was able to hold against forward elevation for quite some time before he fatigued. As Petitioner was not experiencing pain and his strength was near normal, Dr. Choi believed he would advance Petitioner to full-duty work and consider placing him at MMI in four weeks.

Petitioner last visited Dr. Choi on October 28, 2016. Petitioner's range of motion in the left shoulder and strength in forward elevation remained the same. Dr. Choi noted he sent Petitioner back to work after the prior visit and Petitioner reported tolerating it well, with little to no discomfort. Dr. Choi placed Petitioner at MMI and indicated he would see Petitioner on an as-needed basis.

D. Narrative Report by Dr. Choi

On June 29, 2016, Dr. Choi wrote a two-page report on his treatment of Petitioner. In the report, Dr. Choi briefly recounts Petitioner's history, the MRI results, the surgery, and the post-operative follow-up visits. Dr. Choi then opined with a reasonable degree of medical certainty that the fall on December 30, 2015 in the workplace parking lot did cause the acute rotator cuff tear on Petitioner's left shoulder.

E. Section 12 Examination by Dr. Weiss

On February 8, 2017, Petitioner was examined by Dr. Stephen Weiss, an orthopedic surgeon, at Respondent's request. Dr. Weiss prepared a report on February 17, 2017 wherein, following a review of Petitioner's medical records and a physical examination, Dr. Weiss diagnosed Petitioner with a full-thickness rotator cuff tear of the left shoulder, and a right shoulder rotator cuff repair by history (approximately seven years prior). Dr. Weiss also provided ratings according to the AMA Guides of a 7% upper extremity impairment, equivalent to a 4% whole person impairment.

F. Additional Information

Petitioner testified that between December 30, 2015 and October 3, 2016, he did not return to work, excepting a half-day on January 2 or 3, 2016. Petitioner also testified that $92,699.94 was paid by his group health insurer for treatment of his left shoulder injury, and that after his $225.00 out-of-pocket payments, there was an outstanding balance of $12,172.74.

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Petitioner further testified he has returned to his full job as a maintenance worker, earning slightly more than he did prior to his injury. Petitioner stated he is right arm dominant.

Regarding his current condition of ill-being, Petitioner testified that upon returning to work for Respondent, he has had to self-modify his work to compensate for lifting and moving heavy objects such as file boxes, copy paper, and bags of ice melt or water softener salt. Petitioner acknowledged he lifts items weighing over 50 pounds himself but is more careful about how he balances the load and stacks items. Petitioner added that climbing vertical ladders on the roof of the Public Safety Building (where he now works) to check the roof and exhaust fans is difficult; shoveling snow can be painful. Petitioner testified he has continued to exercise at home, though it was not prescribed.

II. CONCLUSIONS OF LAW

A. Petitioner's Work-Related Accident

The Arbitrator found Petitioner failed to prove by a preponderance of evidence that he sustained an accident that arose out of and in the course of his employment which resulted in a disabling injury. The Arbitrator concluded the danger of slipping on the ice was not peculiar to his work and his exposure to the risk was not greater than that of the general public.

The issue of whether an injury arose out of and in the course of employment is generally a question of fact. *Suter v. Illinois Workers' Compensation Comm'n*, 2013 IL App (4th) 130049WC, ¶ 15. "However, when the facts are undisputed and susceptible to but a single inference, the question is one of law subject to *de novo* review." *Id.* In this case, the material facts are not susceptible to a single inference, the chief examples being whether the parking lot at issue is a public lot or provided to Respondent's employees when its use is restricted to particular employees for much of the day. Accordingly, the issue remains a question of fact.

"To obtain compensation under the Act, a claimant bears the burden of showing, by a preponderance of the evidence, that he has suffered a disabling injury which arose out of and in the course of his employment." *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill. 2d 193, 203 (2003). An injury "arises out of" employment when "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." *Sisbro*, 207 Ill. 2d at 203.

The question of whether a claimant's injury arose out of his or her employment depends upon the type of risk to which he or she was exposed. *Baldwin v. Illinois Workers' Compensation Comm'n*, 409 Ill. App. 3d 472, 478 (2011). "There are three categories of risk to which an employee may be exposed: (1) risks that are distinctly associated with one's employment, (2) risks that are personal to the employee, such as idiopathic falls, and (3) neutral risks that have no particular employment or personal characteristics, such as those to which the

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general public is commonly exposed." *Dukich v. Illinois Workers' Comp. Comm'n*, 2017 IL App (2d) 160351WC, ¶ 31.

"[B]oth our supreme court and our appellate court have repeatedly held that accidental injuries sustained on property that is either owned or controlled by an employer within a reasonable time before or after work are generally deemed to arise out of and in the course of employment when the claimant's injury was sustained as a result of the hazardous condition of the employer's premises." *Dukich*, 2017 IL App (2d) 160351WC, ¶ 40 (and cases cited therein); see also *Mores-Harvey v. Industrial Comm'n*, 345 Ill. App. 3d 1034, 1038 (2004) (and cases cited therein). "The presence of a 'hazardous condition' on the employer's premises renders the risk of injury a risk incidental to employment; accordingly, a claimant who is injured by such a hazardous condition may recover benefits without having to prove that she was exposed to the risk of that hazard to a greater extent than are members of the general public." *Dukich*, 2017 IL App (2d) 160351WC, ¶ 40. "In other words, such injuries are not analyzed under 'neutral risk' principles; rather they are deemed to be risks 'distinctly associated' with the employment." *Id.*

The Arbitrator, in focusing on whether Petitioner's exposure to the risk of the ice was greater than that of the general public, appears to have analyzed this case as a "neutral risk" situation and did not consider whether it was a "hazardous condition" situation. The "hazardous condition" cases generally involve injuries caused by the natural accumulation of snow or ice in a parking lot or other outdoor space owned or controlled by the employer. *Dukich*, 2017 IL App (2d) 160351WC, ¶ 41; see also *Mores-Harvey v. Industrial Comm'n*, 345 Ill. App. 3d 1034, 1038 (2004) (and cases cited therein).

In this case, the unrebutted evidence shows that Petitioner was injured after falling due to ice and show in a parking area controlled by Respondent. Indeed, Petitioner's department was responsible for ice and snow removal in this parking area. Therefore, it cannot be said that Petitioner would never be expected to be in this parking area in the course of his work duties. Moreover, Respondent controlled when the parking lot was to be used solely by employees and when it was open to other members of the public.

Respondent argues that Petitioner fell in a public parking lot and not one designated for employees. This is not strictly true. The parking area at issue is restricted to particular courthouse employees from 8:00 or 8:30 a.m. through 4:30 p.m. Respondent also permits members of the public to park in this area during "non-business" hours, including at the time of the injury in this case. However, in *Mores-Harvey*, our appellate court considered that dual usage of a parking lot was not the issue:

> "Whether a parking lot is used primarily by employees or by the general public, the proper inquiry is whether the employer maintains and provides the lot for its employees' use. If this is the case, then the lot constitutes part of the employer's premises. The presence of a hazardous condition on the employer's premises that causes a claimant's injury supports the finding of a compensable claim." *Mores-*

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Harvey, 345 Ill. App. 3d at 1040 (citing *Archer Daniels Midland Co. v. Industrial Comm'n*, 91 Ill. 2d 210, 216 (1982)).

In *Wal-Mart Stores, Inc. v. Industrial Comm'n*, 326 Ill. App. 3d 438 (2001), however, the appellate court reversed an award based in part on the fact that the employer's parking lot was open to both employees and the public. See *id.* at 445 (distinguishing *Hiram Walker & Sons, Inc. v. Industrial Comm'n*, 41 Ill. 2d 429, 430-31 (1968), and *American Electric Cordsets v. Industrial Comm'n*, 198 Ill. App. 3d 87, 91(1990)). Respondent also notes that the *Mores-Harvey* court, relying in part on *Homerding v. Industrial Comm'n*, 327 Ill. App. 3d 1050 (2002), ruled in favor of the claimant in part because "the general public was free to park anywhere in the lot, [but] claimant's choices were restricted. Therefore, claimant's exposure to risk was necessarily greater than that of the general public." *Mores-Harvey*, 345 Ill. App. 3d at 1042.

Respondent overlooks that the *Mores-Harvey* court, *after* concluding that a hazardous condition in the parking lot supported finding a compensable claim, discussed *Wal-Mart Stores* and *Homerding* as cases which considered *only* the second exception to the "general premises" rule. See *Mores-Harvey*, 345 Ill. App. 3d at 1040. This second exception permits recovery for off-premises injuries where "'the employee's presence at the place where the accident occurred was required in the performance of his duties and the employee is exposed to a risk common to the general public to a greater degree than other persons.'" *Id.* at 1038 (quoting *Illinois Bell Telephone Co. v. Industrial Comm'n*, 131 Ill. 2d 478, 484 (1989)). The *Mores-Harvey* court concluded the claimant would also recover under the second exception. *Mores-Harvey*, 345 Ill. App. 3d at 1042. But it was not required to do so, having already concluded the first exception applied because the parking lot, even if dual-use, was maintained and provided for employees' use.[1]

Respondent contends Petitioner was also required to prove he had begun his work day, and that he was required to park in the lot where the injury occurred. The latter asserted requirement is based on the discussion of *Homerding* in *Mores-Harvey*. The former asserted requirement is not entirely accurate. Rather, the injury must be sustained "within a reasonable time before or after work." *Dukich*, 2017 IL App (2d) 160351WC, ¶ 40; see also *Hiram Walker & Sons, Inc. v. Industrial Comm'n*, 41 Ill. 2d 429 (1968) (affirming award where employee arrived 40-50 minutes early and slipped in parking lot before proceeding to breakfast at a nearby café). In this case, Petitioner's shift began at 7:00 a.m. He arrived on Respondent's campus at approximately 6:45 to 6:50 a.m. A gap of 10 to 15 minutes is within a reasonable time before or after Petitioner's shift.

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[1] This first exception was recently discussed by the Illinois Appellate Court in *Walker Brothers, Inc. v. Illinois Workers' Compensation Comm'n*, 2019 IL App (1st) 181519WC. The *Walker Brothers* court observed that "'[t]he decisive issue in parking lot cases usually is whether or not the lot is owned by the employer, or controlled by the employer, or is a route required by the employer.'" *Id.* ¶ 22 (quoting *Maxim's of Illinois, Inc. v. Industrial Comm'n*, 35 Ill. 2d 601, 604 (1966)). Here, the lot was controlled by Respondent.

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Respondent notes Petitioner was not required to keep his lunch or coffee in the courthouse. This objection is consistent with Respondent's reliance on *Illinois Bell Telephone Co.*, but, as noted above, that case involved the second exception to the "general premises" rule, not the first. In a "hazardous condition" case, "[t]he rationale for awarding compensation is that the employer-provided parking lot is considered part of the employer's premises." *Mores-Harvey*, 345 Ill. App. 3d at 1038 (citing L. Larson, Larson's Workers' Compensation Law § 13.04[2][a], [b], at 13--40-13--41 (2002)).

The amount of control Respondent exercised over Petitioner's lunch arrangements, however, is relevant to establish that Petitioner's depositing of his lunch and coffee in the courthouse before parking in the main lot was a reasonably necessary act of personal comfort.

The personal comfort doctrine provides:

> "'Employees who, within the time and space limits of their employment, engage in acts which minister to personal comfort do not thereby leave the course of employment, unless the * * * method chosen is so unusual and unreasonable that the conduct cannot be considered an incident of the employment.'" *Karastamatis v. Industrial Comm'n*, 306 Ill. App. 3d 206, 211 (1999) (quoting 2 A. Larson & L. Larson, Workers' Compensation Law § 21.00, at 5-5 (1998)).

Moreover:

> "'If the employee voluntarily and in an unexpected manner exposes himself to a risk outside any reasonable exercise of his duties, the resultant injury will not be deemed to have occurred within the course of the employment. [Citation.] The employer may, nevertheless, still be held liable for injuries resulting from an unreasonable and unnecessary risk if the employer has knowledge of or has acquiesced in the practice or custom,'" *Karastamatis*, 306 Ill. App. 3d at 211 (quoting *Eagle Discount Supermarket v. Industrial Comm'n,* 82 Ill. 2d 331, 340 (1980)).

The personal comfort doctrine generally encompasses acts such as eating and drinking, obtaining fresh air, seeking relief from heat or cold, showering, resting, and smoking. *Karastamatis*, 306 Ill. App. 3d at 211 (citing 2 A. Larson & L. Larson, Workers' Compensation Law § 21.10, at 5-5 (1998)).

In this case, Petitioner sought relief from the cold for himself, his coffee and food during the short period before his shift. Using the nearest dual-use parking lot was foreseeable, not unreasonable or unexpected; parking south or west of the courthouse was metered while the east side was bounded by a major thoroughfare with no parking. The risk of ice in the area is not outside any reasonable exercise of Petitioner's duties; his department is responsible for clearing

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snow and ice in the parking area. Petitioner's morning routine was not so unusual and unreasonable that the conduct cannot be considered an incident of the employment. Rather, it was a reasonably foreseeable act of personal comfort.

Lastly, Respondent argues Petitioner was not exposed to a risk greater than that to which the general public was exposed. This is again either dependent on *Illinois Bell Telephone Co.* (which involved the common area of a mall, not a parking lot controlled by an employer) or on characterizing this case as involving a "neutral risk." Accordingly, the Commission rejects the argument for the reasons stated above. Moreover, as Petitioner notes, he was accessing the courthouse using an employee entrance from an area where the public also was permitted to park, but would not be expected to park, given that the public entrance was on the other side of the courthouse.

For all of the aforementioned reasons, the Commission concludes that Petitioner proved by a preponderance of evidence that he sustained an accident which arose out of and in the course of his employment.

B. Causal Connection

The Commission next considers whether Petitioner's current condition of ill-being is causally related to the accident. In his narrative report, Dr. Choi opined with a reasonable degree of medical certainty that the fall on December 30, 2015 in the workplace parking lot did cause the acute rotator cuff tear on Petitioner's left shoulder. In his IME report, Dr. Weiss does not offer a contrary view. Petitioner testified regarding his continuing weakness and limitations at work. Given this record, the Commission concludes Petitioner's current condition is causally connected to the accident.

C. Temporary Total Disability

Petitioner claims he was entitled to temporary total disability benefits in the amount of $508.39 per week for the 39-week period from January 4, 2016 through October 3, 2016, pursuant to §8(b) of the Act. The parties stipulated in the Request for Hearing that Petitioner's average weekly wage, calculated pursuant to section 10 of the Act, was $762.59. Accordingly, Petitioner's claim represents the statutory two-thirds of his average weekly wage. See 820 ILCS 305/8(b)1 (West 2018). Respondent disputed this claim by denying the accident arose out of the course of Petitioner's employment. Having found Petitioner's accident compensable, the Commission awards Petitioner the claimed temporary total disability benefits.

D. Medical Expenses

Petitioner claims Respondent should pay outstanding reasonable and necessary medical expenses of $12,172.74 pursuant to the fee schedule and reimburse him $225.00 for out-of-pocket medical expenses pursuant to §§8(a) and 8.2 of the Act. Petitioner also acknowledges

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Respondent should be given a credit of $92,699.94 for medical benefits paid by its group medical carrier and hold Respondent harmless for any claims for which it receives credit, pursuant to §8(j) of the Act. Respondent again disputed this claim by denying the accident arose out of the course of Petitioner's employment. Having found Petitioner's accident arose out of his employment, the Commission awards Petitioner the claimed medical expenses, and awards Respondent the credit under §8(j) of the Act as stipulated by the parties in the Request for Hearing.

E. Permanent Partial Disability

Petitioner further seeks permanent partial disability benefits representing a 15% loss of the person as a whole. Subsection (b) of section 8.1b of the Act lists five factors upon which the Commission must base its determination of the level of permanent partial disability benefits to which a claimant is entitled, including: (i) the level of impairment contained within a permanent partial disability impairment report; (ii) the claimant's occupation; (iii) the claimant's age at the time of injury; (iv) the claimant's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. 820 ILCS 305/8.1b(b) (West 2018). However, "[n]o single enumerated factor shall be the sole determinant of disability." *Id.* § 305/8.1b(b)(v).

Regarding the level of impairment contained within a permanent partial disability impairment report, the Section 12 examiner, Dr. Weiss, provided ratings according to the AMA guidelines of a 7% upper extremity impairment, equivalent to a 4% whole person impairment. Petitioner did not submit an impairment rating. The Commission gives some weight to this factor.

Regarding the claimant's occupation, Petitioner is employed by Respondent as a maintenance worker, a position which involves lifting and moving heavy objects such as file boxes, copy paper, and bags of ice melt or water softener salt. Some of these items weigh over 50 pounds. Petitioner's occupation also involves climbing vertical ladders to perform maintenance checks. Petitioner additionally performs light plumbing and electrical work, and shovels snow. The Commission places greater weight on this factor.

As for the claimant's age, Petitioner was 56 years old at the time of his injury. This is an age at which it may be expected that not only is Petitioner truly at MMI and unlikely to recover further, but also young enough that he may be expected to work for a number of years with lingering symptoms and the limitations he has imposed upon himself to complete his job duties. The Commission places some weight on this factor.

The claimant's future earning capacity appears to be undiminished. Petitioner has returned to his full job as a maintenance worker, earning slightly more than he did prior to his injury. Accordingly, the Commission places some weight on this factor.

Lastly, the Commission considers the evidence of Petitioner's disability corroborated by the treating medical records. Petitioner was diagnosed by Dr. Choi with left shoulder massive

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rotator cuff tear supraspinatus, infraspinatus, subscapularis. Dr. Weiss also diagnosed Petitioner with a full-thickness rotator cuff tear of the left shoulder. To treat this condition, Petitioner underwent a left shoulder arthroscopic double row subscapularis repair and supraspinatus repair, subacromial decompression and biceps tenodesis. Petitioner then participated in approximately eight months of physical therapy and rehabilitation. Petitioner's medical records are entirely consistent with his lingering difficulty with job duties which include lifting and moving heavy objects, climbing vertical ladders, and shoveling snow. The Commission places greater weight on this factor.

Weighing the five factors pursuant to Section 8.1b of the Act, which does not simply require a calculation, but rather a measured evaluation of which no single factor is conclusive on the issue of permanency, the Commission agrees that Petitioner sustained a 15% loss of use of the whole person.

F. Penalties and Fees

Petitioner sought penalties from Respondent under section 19(k) of the Act, which provides:

> "In case[s] where there has been any unreasonable or vexatious delay of payment or intentional underpayment of compensation *** then the Commission may award compensation additional to that otherwise payable under the Act equal to 50% of the amount payable at the time of such award." 820 ILCS 305/19(k) (West 2018).

Petitioner also sought an award of attorney fees pursuant to Section 16 of the Act which provides for an award of attorney fees when an award of additional compensation under section 19(k) is appropriate. 820 ILCS 305/16 (West 2018). Section 19(k) penalties and section 16 fees are intended to address situations where the delay is deliberate or the result of bad faith or improper purpose. *Jacobo v. Illinois Workers' Compensation Comm'n*, 2011 IL App (3d) 100807WC, ¶ 24. The imposition of penalties under section 19(k) and fees under section 16 is discretionary. *Id.*

The Commission has in the past vacated an award of penalties and fees where the Respondent had a good faith argument regarding liability for a fall in a parking lot, in part due to the sometimes confusing state of the law regarding such injuries. See, *e.g.*, *Plucinski v. White Castle Systems, Inc.*, 5 IWCC 456. Given the record in this case, Respondent had a good faith argument regarding liability. Accordingly, the Commission declines to award penalties and fees in this case.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 14, 2017, is hereby reversed for the reasons stated above.

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19IWCC0712

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner proved he sustained an accident arising out of and in the course of his employment with Respondent on December 30, 2015.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner proved his current condition of ill-being is causally connected to the accident.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner the temporary total disability benefits that have accrued from January 4, 2016 through October 3, 2016 at the rate of $508.39 per week, pursuant to §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is liable to pay Petitioner's outstanding reasonable and necessary medical expenses of $12,172.74 pursuant to the fee schedule and also to reimburse Petitioner $225.00 for out-of-pocket medical expenses pursuant to §§8(a) and 8.2 of the Act. Respondent is awarded a credit of $92,699.94 for medical benefits paid by its group medical carrier and is held harmless for any claims for which it receives credit, pursuant to §8(j) of the Act.

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

No county, city, town, township, incorporated village, school district, body politic or municipal corporation is required to file a bond to secure the payment of the award and the costs of the proceedings in the court to authorize the court to issue such summons. 820 ILCS 305/19(f)(2). Based upon the named Respondent herein, no bond is set by the Commission. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DEC 31 2019

DATED:
d: 12/19/19
BNF/kcb
045

Barbara N. Flores

Deborah L. Simpson

Deborah L. Simpson

Marc Parker

Marc Parker

SIVOOHIdI

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

LUDTKE, LEONARD
Employee/Petitioner

Case# **16WC009295**

COUNTY OF DeKALB
Employer/Respondent

19IWCC0712

On 6/14/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.10% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0657 TURNER & SACKETT LLC
RICHARD L TURNER JR
107 W EXCHANGE ST
SYCAMORE, IL 60178

0563 WILLIAMS McCARTHY LLP
CAROL A HARTLINE ESQ
120 W STATE ST 4TH FL
ROCKFORD, IL 61105

19MCC0712

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

LEONARD LUDTKE
Employee/Petitioner

v.

COUNTY OF DEKALB
Employer/Respondent

Case # **16** WC **9295**

Consolidated cases: ___

19IWCC0712

An *Application for Adjustment 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 **May 11, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ 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 ___

19IWCC0712

FINDINGS

On **12/30/15**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**39,654.68**; the average weekly wage was $**762.59**.

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

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

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

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

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

ORDER

Petitioner failed to prove that he sustained an accident arising out of and in the course of his employment. Therefore 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

6/13/17
Date

JUN 14 2017

19IWCC0712

FINDINGS OF FACT

19IWCC0712

This claim involves a Petitioner alleging injuries sustained while working for the Respondent on December 30, 2015. Respondent disputes Petitioner's claims raising the following issues: 1) accident; 2) causation; 3) medical expenses; 4) TTD; 5) nature and extent; and 6) penalties and attorney fees.

Petitioner worked for Respondent as a maintenance worker. His job duties consisted of building maintenance and snow removal. His work hours were from 7:00 a.m. to 3:30 p.m. On December 30, 2015 he was assigned generally to the DeKalb County courthouse, however he could be called to assist others or fill in at other locations.

The courthouse is on a town square surrounded on four sides by a public sidewalk and roads. Respondent Exhibit #2 depicts the lay out of the courthouse, and surrounding areas. Two sides of the court have metered parking and another side has an open non-metered parking lot. The non-metered lot is open to the public until approximately 8:00- 8:30 a.m., and then after 4:30 p.m. During other times, it is restricted to court house personnel, such as the judges. The Petitioner is not allowed to park in that lot during his work hours. Snow removal, ice removal, and salting of the lots was performed by the facilities department which involved plowing snow, shoveling, and putting down ice melt.

On December 30, 2015, the Petitioner drove from his home to work, and stopped to drop his lunch and coffee off at the courthouse. At approximately 6:45-6:50 a.m. the Petitioner parked his vehicle in the north side parking area (non-metered) of the courthouse, which at the time was open to the public. When he got out of his vehicle he was able to walk across the parking lot without any problem. He then crossed the curb area and public sidewalk. He believes his shoes got wet on the area between the parking lot and the public sidewalk. He entered the courthouse at the northwest entrance, which is an employee only entrance controlled by a code keypad. The building also has an entrance on the south side, which is open to the public, which was also available to the Petitioner. After the Petitioner went into the building, he dropped off his lunch and coffee, and returned to the parking lot. As he walked over the same area he used going in, he slipped on ice in the parking stall. His feet came out from under him and he landed heavily on his left shoulder and arm. He noticed nothing other than the ice that caused him to fall. There was no crack or defect in the parking stall that caused the fall. He was not carrying anything at the time of the fall.

The weather the morning of December 30, 2015 was cold and icy. There was a thin layer of ice over the parking lot pavement. It did not appear that the lot had been salted. Ice Melt had been applied to the sidewalks. It was icy through the city. The general public was exposed to the same cold, icy conditions throughout the city that day.

The Petitioner was not in a designated parking spot at the time of the accident, and he had not been instructed to be there. The lot he was in was open to the public, and he could have parked in any public lot and used any entrance at the time of the accident. There were other public parking spaces open at the time of the accident.

He testified he had not been called into work early, nor had he begun work at the time of the accident. He was not paid for that time.

East of the courthouse, and across the street are the legislative building, and public safety building. The Petitioner normally parked his vehicle for the workday in the main public lot located behind the legislative

19IWCC0712

building near the public safety building. The maintenance office is not located in the courthouse, but rather in the public safety building.

His normal routine was to park in the lot behind the legislation building, go the maintenance office to fill out his time card around 7:00 a.m., and then walk over to the courthouse. The Petitioner testified that he could have taken his lunch and coffee with him while he did this. It was his personal preference not to. It was his preference to routinely drop these off at the courthouse, because his coffee would be cold by the time he got around to drinking it.

Petitioner generally ate lunch at 12:30-1:00 at the courthouse. He can eat lunch wherever he wanted, and does not have to stay on County property. He can go to a restaurant. He on occasion eats in his car, or the maintenance break room in the public safety building.

After the slip and fall, the Petitioner noticed pain in his left shoulder and went to the emergency room. He was seen for follow up at Midwest Orthopaedic Institute on January 4, 2016. He had left shoulder surgery on February 11, 2016, which consisted of arthroscopic double row subscapular and supraspinatus repair, subacromial decompression and biceps tenodesis. (PX.1 at pgs. 47-48). He was taken off work from January 4, 2016 through October 3, 2016. After surgery he was seen for follow up treatment, including physical therapy before he was ultimately discharged to return to work without restrictions on October 3, 2016. He was last seen for treatment on October 28, 2016, and at that time he had been back to work and had little to no discomfort.

The Petitioner returned to work as a maintenance worker, and is currently earning slightly more than he did prior to the accident. He is right arm dominant. He testified that as a result of the injury to the left shoulder he has difficulty performing job duties that require lifting and moving things weighing fifty pounds or more; such as stacking cases of copy paper, lifting salt bags, and placing boxes on high shelves. He also has difficulty climbing ladders, and pain with shoveling snow. The Petitioner described his difficulties as self-limiting. As a result, he has made accommodations to his job by making sure that loads are balanced, and that he puts heavier boxes on lower shelves. He confirmed he performs his job duties on his own, without assistance.

He was seen for an independent medical examination on February 13, 2017 by orthopedic surgeon, Dr. Stephen Weiss and was given an AMA rating of 7% upper extremity impairment, equivalent to 4% whole person impairment. (RX. 1).

CONCLUSIONS OF LAW

1. With regard to the issue of accident, the Arbitrator finds that the Petitioner has not met his burden of proof. In support of this finding, the Arbitrator relies on the Petitioner's testimony, the investigative information placed into evidence, and the relevant case law. The Illinois Supreme Court has found that an employee may be in the course of his employment if he is in the employer's parking lot within a reasonable time before or after work, however the mere presence of the employee in the parking lot alone does not establish that the accident in question arose out of the employment. See Rogers v. Industrial Comm'n, 83 Ill.2d 221, 223 (Il S.Ct. 1980); Kimes v. Illinois Department Transportation, 14 W.C. 17750, 16 I.W.C.C. 0473 (July 13, 2016). To prove the accidental injuries arose out of the petitioner's employment, he must show the accident resulted from a risk incidental to the employment. See Rogers v. Industrial Comm'n, 83 Ill.2d 221, 223 (Il S.Ct. 1980); See also, Quarant v. Industrial Comm'n, 38 Ill.2d 490,492, 231 N.E.2d 397 (1976). An injury does not arise out of the employment unless the danger causing the injury is peculiar to the work, and the exposure to the risk is greater

19IWCC0712

than that for which the general public is exposed. See Piercy v. Royal Oaks Nissan, 97 Il.W.C. 9109, 2001 95708 (2001); Kimes v. Illinois Department Transportation, 14 W.C. 17750, 16 I.W.C.C. 0473 (July 13, 2016).

In the present case, Petitioner's fall occurred before he started his work shift. He was not acting in the furtherance of his job duties or performing activities incidental to his job at the time of the accident. As part of his normal routine, the Petitioner parked in a lot located behind the legislation building for the workday, and then went to the maintenance office to fill out his time card around 7:00 a.m. After doing so, he walked over to the courthouse. The Petitioner testified that he could have taken his lunch and coffee with him while he did this, but it was his personal preference not to. In explaining why he stopped at the courthouse to drop off his lunch and coffee before going to the maintenance office to fill out his time card, Petitioner stated his coffee would be cold by the time he got around to drinking it. He was not in a designated parking spot at the time of the accident, nor had he not been instructed to be there. Although he testified that he routinely stopped and dropped his lunch and coffee off at the courthouse, this was simply his personal preference. He was not required to take lunch at the location, but rather he was free to leave work for lunch.

There is no dispute that the Petitioner was in a lot maintained by the Respondent at the time he slipped and fell on the ice. Although the lot is restricted at times, it was open to the public at the time of the accident. There was no evidence that the parking lot in question was more prone to icy conditions, as the Petitioner testified that the general public was exposed to the same cold, and icy conditions not only in that parking lot, but throughout the City on the morning of the accident. The Petitioner did not identify any cracks or other pavement defects that contributed to or caused the accident. Further, he was not carrying anything work related at the time of the fall. Therefore general public was exposed to the same risk of slipping and falling as the Petitioner.

Based on the above, the Arbitrator concludes that the Petitioner failed to prove that he sustained an accident arising out of and in the course of his employment with Respondent on December 30, 2015.

2. Based on the Arbitrator's findings with regard to the issue of accident, all other issues are rendered moot.

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STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Joseph Kocovsky,

Petitioner,

vs. No. 06 WC 32024

Elkay Manufacturing Company,

Respondent.

ORDER

This matter comes before the Commission on Petitioner's petition for penalties and attorney fees, with due notice given. For the reasons that follow, the Commission is of the opinion that penalties and attorney fees are not appropriate under the circumstances of the instant case.

This matter was previously before us on Petitioner's motion to enforce a settlement contract, which an arbitrator approved on April 2, 2013. The settlement contract, for a lump sum of $90,000.00 plus a Medicare set-aside, states Respondent has *not* paid all medical bills. The contract further states no unpaid medical bills were known and "[t]he petitioner agrees to assume liability for *** all past medical and hospital expenses not specifically authorized by the Respondent's third party administrator." Subsequently, Petitioner discovered unpaid medical bills in excess of $17,000.00 for spinal injections and related treatment he underwent in 2007 through 2009. Petitioner, who was 70 years old, testified during the prior hearing that when he reviewed the settlement contract before signing it, he "read it incorrectly that all bills had been paid which they hadn't been." The reason Petitioner believed all bills had been paid was because he understood from speaking with the doctor's office the injections "were covered by insurance" and he "was able to get the shots." The Commission ruled it did not have jurisdiction and the matter belonged in the circuit court.

During the pendency of this matter on review in the circuit court, the appellate court issued a decision in *Millennium Knickerbocker Hotel v. Guzman*, 2017 IL App (1st) 161027WC, holding that while the Commission has jurisdiction to assess penalties and attorney fees for failure to comply with the terms of a final settlement contract, the Commission lacks jurisdiction to enforce payment of a settlement or award. The appellate court disapproved of "a procedure whereby a party may seek before the Commission the enforcement of a final award in conjunction with a petition for attorney fees and penalties pursuant to sections 16, 19(k), and 19(l) of the Act." *Millennium Knickerbocker Hotel*, 2017 IL App (1st) 161027WC, ¶ 29. "Rather, the only method to enforce a final award of the Commission is in the circuit court

pursuant to section 19(g) of the Act." *Millennium Knickerbocker Hotel*, 2017 IL App (1st) 161027WC, ¶ 22. The circuit court in the instant case confirmed the Commission's order, further stating: "Nothing contained in this Order of the Circuit Court shall preclude the Plaintiff from filing a Petition for Penalties before the Workers' Compensation Commission pursuant to Section 19(k) of the Workers' Compensation Act." Petitioner then promptly filed a petition for penalties and attorney fees for failure to pay the medical bills.

On September 19, 2018 and April 17, 2019, Commissioner Stephen Mathis held a hearing on the petition for penalties and attorney fees. Petitioner testified as follows:

> "Q. What was your understanding of the approval process for the payment of your medical bills in your Workers' Compensation case?
>
> A. I was scheduled for certain treatments, and those treatments were several weeks in series; and I called to verify if these are okay for me to come in, and I was told by the clinic, DuPage Medical, that yes, come on in and we will give you the treatments.
>
> Q. And what was your understanding of the statements, the alleged statements made to you by the medical providers when they would say come on in for the treatment? What was your understanding of what that meant?
>
> A. That they weren't covered because it was over a year of Workmen's Comp coverage and it was the same illness or the same injury.
>
> Q. *** [D]id you ever have a situation where any one of these medical providers ever told you not to come in?
>
> A. No.
>
> * * *
>
> Q. And just to confirm, ultimately when you were provided with medical treatment, what was your understanding of what that meant in terms of the treatment being approved?
>
> * * *
>
> A. If it wasn't covered, they wouldn't treat me. It was as simple as that. That's all I understood, that they said come on in and it was covered."

In his brief in support of the petition for penalties and attorney fees, Petitioner maintains the parties intended for Respondent to pay the medical bills, as "[t]here is no evidence that the bills were 'not specifically authorized' before the fact. Based on his understanding of the procedure involved, [Petitioner] himself thought that these services had been authorized, otherwise the providers would not have provided the medical services." Respondent counters that the settlement contract clearly states Respondent has not paid all medical bills and places responsibility for unpaid medical bills on Petitioner.

We turn for guidance to the appellate court's decision in *Paluch v. UPS*, 2014 IL App

(1st) 130621, wherein the court noted that a workers' compensation settlement agreement is a release governed by contract law. If the words in the contract are clear and unambiguous, we must give them their plain, ordinary and popular meaning. However, if as here the language of the contract is ambiguous, we may look to extrinsic evidence to determine the parties' intent. *Paluch*, 2014 IL App (1st) 130621, ¶ 13. The evidence before us demonstrates Respondent drafted the settlement contract incorrectly, failing to list unpaid medical bills. Petitioner then read the settlement contract incorrectly ("that all bills had been paid") and signed it based on his belief that Respondent had authorized the treatment and paid the medical bills. Thus, there was no meeting of the minds regarding the subject medical bills. In determining whether Respondent acted wrongfully, *Paluch* directs us to consider whether the contract leaves room for good-faith disagreement as to the amount of the payments owed. *Paluch*, 2014 IL App (1st) 130621, ¶ 12. Here, where there was no meeting of the minds, we cannot award penalties and attorney fees.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's petition for penalties and attorney fees is denied.

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: DEC 3 1 2019
SM/sk
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Stephen Mathis

Douglas McCarthy

Deborah Simpson

STATE OF ILLINOIS)
) SS:
COUNTY OF DUPAGE)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Richard Grubb,

Petitioner,

vs.

NO: 09 WC 47900
11 WC 38035

Peacock Colors, Inc.,

Respondent.

ORDER

A Petition for Attorney's Fees having been presented by Petitioner herein, due notice having been given, this cause came before Commissioner Thomas J. Tyrrell for hearing on October 15, 2019, in Chicago, Illinois. The Commission, being fully advised in the premises, hereby grants Grauer & Kriegel's petition for the following reasons.

On November 20, 2009, Grauer & Kriegel, LLC f/k/a Paul W. Grauer & Associates filed an Application for Adjustment of Claim ("Application") alleging a July 14, 2009, date of accident. On October 3, 2011, the firm filed an Application on Petitioner's behalf alleging a January 6, 2010, date of accident. Attorneys Paul W. Grauer and Andrew J. Kriegel were the handling attorneys on Petitioner's cases. Respondent disputed Petitioner's claims and Grauer & Kriegel diligently worked to obtain compensation for Petitioner. Over the years, Grauer & Kriegel filed multiple 19(b) petitions, obtained and reviewed copious medical records, and attended vocational rehabilitation meetings and depositions in these matters.

The parties eventually proceeded to hearing in 2016. In July 2016, after considering the evidence, the arbitrator determined Petitioner is permanently and totally disabled due to his work injuries. Both parties filed Petitions for Review. In November 2017, the Commission affirmed and adopted the Decision of the Arbitrator. Pursuant to the Commission Decision, Petitioner is entitled to permanent total disability benefits in the amount of $469.72 per week for the remainder of his life as well as open medical benefits. Subsequently, the parties entered protracted negotiations and eventually reached an agreement that required Respondent to pay to Petitioner $340,000.00 and to fund a Medicare Set-Aside for prospective medical in the amount of $230,436.00.

Generally, attorneys are entitled to fees in the amount of 20% of the amount of compensation paid to Petitioner. However, pursuant to Section 16a(B), in total disability cases an attorney's fees shall not exceed "...20% of the sum which would be due under this Act for 364 weeks of permanent total disability...unless further fees shall be allowed to the attorney upon a hearing by the Commission fixing fees." Thus, Grauer & Kriegel is statutorily entitled to attorney's fees in the amount of $34,195.62 absent the Commission awarding additional fees. Grauer & Kriegel's petition requests fees in excess of the statutory maximum pursuant to Section 16a of the Act. The firm seeks fees in the amount of $68,000.00 which is 20% of the total settlement amount of $340,000.00. On September 26, 2019, Commissioner Tyrrell approved settlement contracts in this matter. As Grauer & Kriegel's attorney's fee petition was still pending, the Commission also entered an order allowing the dispersal of the statutory attorney's fees in the amount of $34,195.62 and further ordered the firm to hold the additional $33,804.38 in proposed fees in its client trust account.

On October 15, 2019, Commissioner Tyrrell held a hearing regarding the firm's pending request for additional attorney's fees. Petitioner was present as well as Mr. Grauer and Mr. Kriegel. A record was made, and Mr. Grauer presented the numerous boxes that represented the firm's internal case file as a visual example of how much work the firm performed on behalf of Petitioner since November 2009. Grauer & Kriegel's petition included affidavits submitted by both attorneys and Petitioner attesting to the amount of work performed on Petitioner's behalf during the life of the case. During the hearing, the attorneys elaborated in great detail on the extensive time and efforts they made during the past decade to ensure Petitioner received the necessary workers' compensation benefits. Petitioner testified passionately about the diligent efforts the firm made on his behalf. These efforts included the attorneys' constant communication with Petitioner and their tireless efforts to resolve countless disputes with Respondent. Petitioner emphatically testified that his attorneys more than earned the additional $33,804.38 in attorney's fees.

After carefully considering the pending motion, the Commission finds Grauer & Kriegel diligently prosecuted Petitioner's claims. The firm went above and beyond in trying to obtain the best outcome for Petitioner possible for a decade. The firm's efforts resulted in the Commission awarding permanent total disability benefits to Petitioner. The firm then successfully negotiated a settlement that is very favorable to Petitioner. Given the evidence of the amount of work Grauer & Kriegel performed on behalf of Petitioner as well as Petitioner's testimony that his attorneys more than earned the requested additional attorney's fees in the amount of $33,804.38, the Commission finds the firm met its burden of proving an entitlement to the additional attorney's fees. This award of attorney's fees above the statutory limit compensates the law firm for its tireless work while still adequately compensating Petitioner for his permanent disability.

For the foregoing reasons, the Commission grants Grauer & Kriegel's Petition for Attorney's Fees.

IT IS THEREFORE ORDERED BY THE COMMISSION that Grauer & Kriegel, LLC's Petition for Attorney's Fees is hereby granted.

IT IS FURTHER ORDERED that Grauer & Kriegel, LLC, is entitled to attorney's fees in the amount of $68,000.00. Grauer & Kriegel has already received fees in the amount of $34,195.62. The firm is entitled to the additional attorney's fees in the amount of $33,804.38 currently held in its client trust account.

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

DATED: DEC 3 1 2019

Thomas J. Tyrrell

r-10/15/19
TJT/jds
51

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

JENNIFER WILLIAMS,
Petitioner,

vs. NO: 15 WC 035422

VAN MATRE HEALTH SOUTH REHABILITATION,
Respondent.

ORDER

This matter came before Commissioner Barbara N. Flores on November 14, 2019, pursuant to Respondent's Motion for Leave to File Supplemental Petition for Review. Both parties submitted briefs and presented their arguments to Commissioner Flores. Those arguments were made available for the Commission to review by means of a transcript of proceedings. After reviewing the transcript as well as the parties' respective pleadings, the Commission denies Respondent's Motion for Leave to File Supplemental Petition for Review.

The record indicates that the Arbitrator filed a Decision in this matter on June 5, 2019. Counsel for Petitioner and Respondent both represented that they received the Decision by email on the same date.

Respondent filed a Petition for Review of the Decision on June 12, 2019. Counsel for Respondent represented that he also filed a Notice of Motion and Motion to Correct a Clerical Error pursuant to section 19(f) of the Act on the same date. Specifically, Respondent's counsel represented that the Arbitrator had incorrectly inserted the word "not" into a sentence.

On June 26, 2019, Petitioner received a letter dated June 20, 2019 from the Commission by regular mail, indicating the Arbitrator's Decision had been recalled for the purpose of correcting a clerical error and that a corrected Decision would be issued pursuant to section 19(f) of the Act. Respondent's counsel represented that he never received this letter.

On June 21, 2019, the Arbitrator filed a corrected Decision in this matter. On July 10, 2019, Petitioner received the corrected Decision of the Arbitrator in this matter by email. Respondent's counsel represented that Respondent received the corrected Decision on the same date.

On July 22, 2019, Petitioner filed a Petition for Review, contesting the issue of penalties and fees. Petitioner submitted a copy of the cover letter for her Petition for Review, which indicated a copy was to be sent to Respondent's counsel.

Respondent did not file a Petition for Review of the corrected Decision by August 9, 2019. Respondent subsequently filed its Motion for Leave to File Supplemental Petition for Review, based on Respondent not having received the Commission's recall letter. Respondent's counsel acknowledged during the hearing on the motion that Respondent did not file a Petition for Review of the corrected Decision, which was received by Respondent on July 10, 2019.

The Commission's rules mandate that Petitions for Review shall be filed within the time provided by statute. 50 Ill. Admin. Code § 9040.10(a)(1) (2016). Accordingly, the determination of Respondent's Motion for Leave to File Supplemental Petition for Review requires the Commission to consider sections 19(b) and (f) of the Act.

Under section 19(b) of the Act (820 ILCS 305/19(b) (West 2018)), an arbitrator's decision becomes the decision of the Commission and, in the absence of fraud, is conclusive unless a petition for review is filed by either party within 30 days after the receipt by such party of a copy of the arbitrator's decision. *Eddards v. Illinois Workers' Compensation Comm'n*, 2017 IL App (3d) 150757WC, ¶ 11. Absent the filing of a timely petition for review, the Commission is without jurisdiction to review the arbitrator's decision. See *Wiscons v. Industrial Comm'n*, 176 Ill. App. 3d 898, 899 (1988).

Section 19(f) of the Act (820 ILCS 305/19(f) (West 2018)) provides the Commission with the authority to correct any clerical or computational errors. *Residential Carpentry, Inc. v. Kennedy*, 377 Ill. App. 3d 499, 503 (2007). An appeal from a decision of the Commission which is commenced prior to the resolution of a motion to correct is premature. *International Harvester v. Industrial Comm'n,* 71 Ill. 2d 180, 188 (1978). In cases where the Commission recalls a decision upon a motion to correct, the decision is not considered final and appealable until the corrected decision is issued; the time for review begins to run from the date of receipt of the corrected decision. See *Residential Carpentry, Inc.*, 377 Ill. App. 3d at 503; 820 ILCS 305/19(f) (West 2018) ("Where such correction is made the time for review herein specified shall begin to run from the date of the receipt of the corrected award or decision.")

As the Illinois Appellate Court has noted, "[t]he cases are legion that hold that the failure to strictly comply with sections 19(b) and 19(f) of the Act deprives the Commission and the courts of subject matter jurisdiction." *Eschbaugh v. Industrial Comm'n*, 286 Ill. App. 3d 963, 966 (1996) (and cases cited therein).

In this case, Petitioner and Respondent both received the Arbitrator's original Decision by email on June 5, 2019, commencing the 30-day period for filing a Petition for Review. On June 12, 2019, Respondent filed not only a Petition for Review, but also a motion to correct the Decision pursuant to section 19(f) of the Act, thereby suspending the 30-day period and rendering Respondent's Petition for Review premature. The Commission recalled the Decision of the Arbitrator. Accordingly, the decision was not final and appealable until the corrected

decision was issued on June 21, 2019 and the time for review in this matter did not begin to run until the date of receipt of the corrected decision. On July 10, 2019, Petitioner and Respondent both received the corrected Decision of the Arbitrator thereby resetting the 30-day period for filing a Petition for Review.

It is undisputed that Respondent failed to timely file a Petition for Review after receiving the corrected Decision of the Arbitrator. The failure to receive the recall letter does not toll the 30-day period to file a Petition for Review. Rather, sections 19(b) and (f) dictate that the 30-day period commences from the date of receipt of the corrected decision. The parties and the Commission are required to strictly comply with these jurisdictional provisions of the Act.

Nevertheless, Respondent argues it should be permitted to file a late petition, relying on *Wilson-Raymond Constructors Co. v. Industrial Comm'n*, 79 Ill. 2d 45, 56 (1980). In *Wilson-Raymond*, the Illinois Supreme Court observed that because there is no provision for recall other than that provided by section 19(f), Wilson-Raymond's recall motion, which sought reconsideration on the merits rather than correction of a clerical or computational error was a nullity. *Id.* In this case, Respondent sought the correction of a scrivener's error and its recall motion was not a nullity.

Respondent also argues that Petitioner would not be prejudiced by allowing the filing of an untimely Petition for Review. The Commission is without jurisdiction to allow such a filing. Notwithstanding, the Commission notes that Respondent remains entitled to respond to the issues identified in Petitioner's timely-filed petition for review.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent's Motion for Leave to File Supplemental Petition for Review is denied.

DATED: DEC 3 1 2019
r: 11/14/19
BNF/kcb
045

Barbara N. Flores

Deborah L. Simpson

Marc Parker

STATE OF ILLINOIS)
) ss:
COUNTY OF LA SALLE)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JENNIFER WILLIAMS, Petitioner, vs. VAN MATRE HEALTH SOUTH REHABILITATION, Respondent.	No. 15 WC 035422

November 14, 2019

Ottawa, Illinois

TRANSCRIPT OF PROCEEDINGS

before

COMMISSIONER BARBARA FLORES

RENÉE M. TORIBIO, CSR
License No. 084-002923
Official Reporter
Illinois Workers' Compensation Commission

STATE OF ILLINOIS)
) ss:
COUNTY OF LA SALLE)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JENNIFER WILLIAMS,	)	
Petitioner,	)	
vs.	)	
VAN MATRE HEALTH SOUTH	)	
REHABILITATION,	)	No. 15 WC 035422
Respondent.	)	

BE IT REMEMBERED that heretofore, to wit, on the 14th day of November, 2019, the above-entitled matter came on for hearing before **COMMISSIONER BARBARA FLORES** in one of the hearing rooms of the Illinois Workers' Compensation Commission, LaSalle County Courthouse, Ottawa, Illinois;

WHEREUPON, the following proceedings were had herein and evidence taken:

APPEARANCES:

GESMER & REYNOLDS,
BY: **MR. BRAD ALAN REYNOLDS,**
Appeared for Petitioner;

BRYCE DOWNEY & LENKOV, LLC,
BY: **MR. RICHARD W. LENKOV,**
Appeared for Respondent.

RENÉE M. TORIBIO, CSR
License No. 084-002923
Official Court Reporter
Illinois Workers' Compensation Commission

(SESSION OF 11/14/2019)

EXHIBIT INDEX

EXHIBITS RECEIVED IN EVIDENCE PAGE

(NO EXHIBITS ADMITTED)

COMMISSIONER FLORES: We are here in the matter of Jennifer Williams versus Van Matre Health South Rehabilitation, case No. 15 WC 35422, both parties' counsel being present; Mr. Lenkov for the respondent, Mr. Reynolds for the petitioner.

They have submitted to me copies of their briefs in this matter which is brought by respondent's counsel.

So I will turn it over to Mr. Lenkov to, I guess, summarize the purpose of the hearing today.

MR. LENKOV: Thanks, your Honor. Again, our motion sets forth a timeline. But just to reiterate, we received the arbitration decision on 6-5-19. We then filed a petition to review on 6-12-19. We also filed on 6-12-19 a 19(f) petition because there was a minor error. The word "not" was inserted when it should not have been inserted.

COMMISSIONER FLORES: By the arbitrator.

MR. LENKOV: By the arbitrator.

COMMISSIONER FLORES: Okay.

MR. LENKOV: So that did not obviously affect any of the substance of the decision. It was merely a typographical error. It was related to penalties.

The arbitrator then on 6-21-19 issued a corrected arbitration decision in which the word "not" was removed, removing that typographical error.

On 7-10-19, respondent received that corrected decision. Respondent did not receive the recall letter from the Commission even though it's true that the Commission did -- there is a copy of a Commission letter, a recall letter, with both counsel and my address on it. We did not receive it.

Accordingly, we did not file a petition to review the corrected decision. Respondent did, in fact, receive the corrected decision. But again, we did not receive the recall letter.

We're here today to ask the Commission to allow respondent to now file its petition to review instanter, given the fact that we did not recall the -- we did not receive the recall letter.

There is no prejudice to petitioner to allow us to file the petition now. There is nothing in the petition, the would-be petition, that is different from the petition that was originally filed. This is not a substantive -- this would not represent any substantive change nor represent any prejudice to petitioner.

In petitioner's response brief, he cites to case law that he alleges runs contrary to allowing this yet there is no citation to any actual case law.

Counsel also represents in his response brief that his client would suffer prejudice as a result but again doesn't articulate what that prejudice would be. I would submit that's because there is no prejudice to petitioner.

The case law that we cite, Wilson-Raymond, a copy of which we've provided to your Honor this morning, does state in essence that a petition for recall under 19(f) is not a vehicle for reconsideration of the case's merits.

So again, we ask the Court to allow respondent to avail itself of its due process rights by allowing us to appeal the decision of the arbitrator for the reasons set forth today and in our brief.

Thanks, your Honor.

COMMISSIONER FLORES: Thank you, Counsel.

Mr. Reynolds?

MR. REYNOLDS: Thank you, your Honor. The petitioner opposes the motion to file their appeal brief to the Commission instanter on the corrected arbitration decision.

This is all set forth in the brief; but just in terms of the timeline, your Honor, the first thing that happened was our office received a letter from the Commission which is attached as an exhibit to our opposition. And the letter says that the decision had been recalled and that Arbitrator Glaub was going to correct the decision.

Our office was copied on that letter,

and Mr. Lenkov and his office were copied on that letter.

Until our office received the letter, we were unaware that there was a pending petition or request by the respondent to amend the original arbitration decision. It seemed at the time that the Judge had recalled the decision on his own. That's what it seemed to be.

The corrected decision was received by e-mail to both parties on July 10th. And respondent's counsel and respondent have failed to timely review the July 10th, 2019 decision. No review was taken by the respondent 30 days after receipt of the corrected decision.

19(f), which he cites in his brief, makes it clear that when a decision is recalled that the time to file a review is 30 days from receipt of the corrected decision. And the respondent acknowledges that they received the corrected decision.

And until I got their motion, petitioner and her counsel were unaware that the respondent was the one who initiated the request to correct the decision in the first place because the petitioner never received a copy of their motion.

Now, what's significant is if they initiated the request and they received the corrected decision, they were clearly on notice, regardless of whether they received the letter from the Commission recalling the decision or not, that the decision had been corrected. A 19(f) is clear that when the decision was corrected, they had to timely file their review within 30 days of July 10th of 2019.

And so it was their motion, it was then granted, they received the corrected decision with the change; and 19(f) puts them on notice that they had to file a review within 30 days of the corrected decision.

The review they filed on the decision that is no longer the decision of the arbitrator and

the commission is moot.

And then -- and this wasn't mentioned by Mr. Lenkov, but the petitioner filed her own review of the decision; and the petitioner timely filed her own review of the corrected decision because Arbitrator Glaub denied penalties. And when we submitted a copy of our review to counsel, of course, we indicated that we filed the corrected -- we filed a review of the corrected decision, the one that was received by the parties on July 10th.

So in some ways, they were given additional notice because we said, look, we took our review, not of the old decision, but we took our review of the corrected decision from July 10th.

And then the last thing, your Honor, is there's no substantial compliance. This is stricter compliance. All that we're talking about boils down to subject matter jurisdiction. The Commission lost jurisdiction to hear this argument by the respondent and their request when they failed to file the review

within 30 days of the corrected decision.

Subject matter jurisdiction cannot be waived by the parties. It's strict compliance with the deadline. The deadline has not been complied with, and so you're not in a position to even grant the request for relief because the Commission no longer has jurisdiction to entertain their motion. Thank you.

COMMISSIONER FLORES: Before you respond, Mr. Lenkov, let me ask briefly because again I'm coming in and I don't know the history of this case, was the Petition for Review filed by the petitioner on the corrected decision, is that in front of another commissioner currently? Was that heard?

MR. REYNOLDS: That's before you.

COMMISSIONER FLORES: It is before me? Okay. All right.

MR. REYNOLDS: And the transcript has been authenticated. And we don't have --

COMMISSIONER FLORES: Okay. I'm just trying

to figure out where this case has come from because again, as I was saying, there's some cases that have been transferred from other commissioner's offices. And since I hadn't seen this motion yet, I wanted to make sure that I know where it's coming from.

MR. LENKOV: To be clear, we do have a return on review date on that appeal. As far as the Commission is concerned, that appeal is ongoing. So we have a return on review date.

COMMISSIONER FLORES: On the petitioner's petition for review.

MR. LENKOV: On respondent's. Right? It's not petitioner's. It's ours.

MR. REYNOLDS: We filed my own review so... which is still pending for now.

COMMISSIONER FLORES: Okay. I'm sure when I get back to my office, somewhere there might be at the Commission the filings by the parties.

And before, Mr. Lenkov, you say anything additional that you want to say, I just want to note

that because we're here in Ottawa today, I just don't have the file in front of me so I appreciate the additional information.

Mr. Lenkov.

MR. LENKOV: Of course. Just really quickly, just two points.

Counsel said he never received notice of our 19(f) petition. I mean we filed it. We sent a copy. I'd like leave to supplement the record by giving a copy -- by filing a copy of our notice, our petition to correct the decision. We filed that on 6-12-19 so...

COMMISSIONER FLORES: To the extent that you want to submit a courtesy copy to my office of anything that had previously been filed, you are welcome to do so.

MR. LENKOV: Okay.

COMMISSIONER FLORES: Just copy opposing counsel and send it to my administrative assistant, and we'll get that.

MR. LENKOV: Great.

COMMISSIONER FLORES: With respect to anything substantive, is there anything else that you would like to add --

MR. LENKOV: Yes.

COMMISSIONER FLORES: -- other than what's in your written brief?

MR. LENKOV: Just one quick point. And I know it's a little bit complicated to follow the timeline, but it should be noted for the record that while the corrected decision was received by my office by e-mail, the recall letter that we think is at the heart of this situation, that's sent by letter. That's not an e-mail.

And, you know, as an officer of the court and practicing for 25 years, counsel says that we allege that we didn't receive it. We didn't receive it. If we received it, I wouldn't be up here arguing that we didn't receive it. I wouldn't put it into a legal document. We never received it.

Whether that is germane to the issue is up to the Commission. But, you know, we just didn't receive it. And my point is that's a letter. That's a hard copy letter that they mail, not e-mail.

COMMISSIONER FLORES: Okay.

MR. REYNOLDS: And then, I'm sorry, just one more thing.

I meant to address the prejudice, your Honor. This was a case involving a request for TTD, vocational rehabilitation, medical bills. It was a decision in favor of the petitioner. If the motion is denied, the petitioner has the right to withdraw her appeal; and then the award would be due and owing. Now she would, of course, waive her right to pursue penalties which were denied. That was the only aspect of the claim that was not in the petitioner's favor from the arbitrator's decision.

But this is where the prejudice comes. The motion that they filed should be denied or stricken because their appeal is moot and they didn't

file a timely review of the corrected decision, and that's clearly subject matter jurisdiction.

If their appeal is moot, then Ms. Williams can decide to dismiss her review; and then the award would be due. And that's how she's prejudiced, if this motion is granted, and she's going to be denied benefits that she's otherwise entitled to because they failed to take their timely review. Thank you.

COMMISSIONER FLORES: It's clear to me, and I am sure it's very clear to the other commissioners on this panel that it is important to the parties whether or not a petition for review remains or not. So...

MR. LENKOV: And just quickly in response, since counsel raised the prejudice issue, it should be noted that subsequent to this filing of motion, respondent has now initiated some of the award. To move the case forward, we have initiated vocational rehabilitation. We're also paying petitioner benefits.

So I don't want the Commission to think that petitioner's out there not receiving anything. We've actually now done what the Commission -- what the arbitrator awarded, even though we think that the appeal is well found -- that the motion and the appeal are well founded.

So it should be noted that some of that prejudice is not happening because the petitioner is actually receiving benefits.

COMMISSIONER FLORES: Okay. Thank you, both. I will note for the record today that I do have the file stamped copy of the Notice of Motion and Order from respondent's counsel dated October 1st of 2019.

I have been provided file stamped copy of respondent's -- the actual motion for leave and supplemental documents also filed October 1st of 2019 as well as I will be receiving an e-mail copy of -- excuse me. I will be printing out what was e-mailed to my office, which is petitioner's counsel's November 12th, 2019 letter and response to the motion.

It's not yet file stamped because petitioner's counsel has not yet received back file stamped from the Commission. But I will return this copy to you.

And thank you, both. You may -- since there is a petition for review on file from the petitioner and it's assigned to my office, I will inquire at the Commission as to when it's being scheduled for.

But I've seen you both for many years. If you haven't heard from my office in the next -- or haven't seen a notice within the next 45 days, we're coming up on the end of the year, you can feel free to e-mail my administrative assistant. I'm happy to let you know where it is in the process. Okay?

MR. LENKOV: Thanks, Judge. One more thing. May I submit courtesy copies for the other commissioners of my packet?

COMMISSIONER FLORES: Sure. We're going to print out --

MR. LENKOV: Save the State some printing.

COMMISSIONER FLORES: I'm sure they'll be happy for it. And we'll get yours, Counsel, printed. Okay. Thank you.

(WHICH WERE ALL THE PROCEEDINGS HAD.)

TRANSCRIPT AUTHENTICATED:

_____

Attorney for Petitioner

_____

Attorney for Respondent

ILLINOIS WORKERS' COMPENSATION COMMISSION

Illinois Workers' Compensation Commission, Insurance Compliance Division,	)	
Petitioner,	)	No. 12 INC 677
v.	)	
Janusz Wojicik individually and as owner of JKM Construction, Inc.	)	
Respondent.	)	

ORDER

Upon the oral request by the Petitioner, The Illinois Workers' Compensation Commission – Insurance Compliance Division, by and through its attorney, the Office of the Illinois Attorney General, this matter is dismissed. The Office of the Attorney General has advised this Commission it no longer seeks to proceed in this matter against Respondent.

FEB 10 2020

Commissioner Barbara Flores

JAN 3 - 2020

Dated:_____

ILLINOIS WORKERS' COMPENSATION COMMISSION

Illinois Workers' Compensation Commission, Insurance Compliance Division, Petitioner, v. Mastafa Talib individually and as President of Motek Auto & Truck Repair Respondent.	)	No. 15 INC 50

ORDER

Upon the oral request by the Petitioner, The Illinois Workers' Compensation Commission – Insurance Compliance Division, by and through its attorney, the Office of the Illinois Attorney General, this matter is dismissed. The Office of the Attorney General has advised this Commission it no longer seeks to proceed in this matter against Respondent.

Commissioner Barbara Flores

Dated:_____

JAN 7 - 2020

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

ERIC WHITECOTTON,
Petitioner,

vs. NO: 17 WC 018007

JERICHO PROPERTY MANAGEMENT
and JIM RIZQALLAH,
Respondent.

ORDER

This matter came before Commissioner Barbara N. Flores on November 14, 2019, pursuant to Petitioner's Petition for Additional Compensation, Penalties, and Attorney's Fees under sections 16 and 19(k) of the Act. Petitioner's counsel presented his arguments to Commissioner Flores. Respondents did not appear in person or by counsel. Petitioner's arguments were made available for the Commission to review by means of a transcript of proceedings. After reviewing the record, the Commission grants Petitioner's petition.

The record indicates that on January 29, 2019, Arbitrator Anthony Erbacci approved a Settlement Contract between Petitioner and Respondents. The agreement provides for a lump-sum payment of $3,125.00 from Respondents to settle Petitioner's claims arising from an alleged accident occurring on or about January 15, 2017, while Petitioner allegedly was fixing sewer lines at Respondents' mobile home park. Both parties to the agreement were represented by counsel.

On October 22, 2019, Petitioner filed his Petition for Additional Compensation, Penalties, and Attorney's Fees. Petitioner alleged that Respondents had failed to provide proof of Workers' Compensation insurance at the time of the accident and thereafter. Petitioner also alleged that Respondents had failed to pay the sums agreed upon in the Settlement Contract. Petitioner further alleged that on July 18, 2019, Commissioner Flores granted Respondents' counsel's motion to withdraw.

Petitioner's counsel appeared at the hearing on the petition. Respondents did not appear in person or by counsel. Commissioner Flores confirmed that Respondents' counsel had withdrawn, with the instruction at that time to notify Respondents that they should contact

Petitioner's counsel directly or would be expected to hear from Petitioner's counsel directly. A copy of a certified letter from Petitioner's counsel to Respondents, notifying them that the petition for penalties would be heard in Ottawa, Illinois on November 14, 2019, was admitted into evidence. At the direction of Commissioner Flores, Petitioner's counsel inquired outside the hearing room to determine that no representative of Respondent was present. Petitioner's counsel then represented that no settlement funds had been received by his office on behalf of Petitioner.

Petitioner requests penalties from Respondents under section 19(k) of the Act, which provides:

> "In case[s] where there has been any unreasonable or vexatious delay of payment or intentional underpayment of compensation * * * then the Commission may award compensation additional to that otherwise payable under the Act equal to 50% of the amount payable at the time of such award." 820 ILCS 305/19(k) (West 2018).

Petitioner also requests an award of attorney fees pursuant to Section 16 of the Act which provides for an award of attorney fees when an award of additional compensation under section 19(k) is appropriate. 820 ILCS 305/16 (West 2018). Section 19(k) penalties and section 16 fees are intended to address situations where the delay is deliberate or the result of bad faith or improper purpose. *Jacobo v. Illinois Workers' Compensation Comm'n*, 2011 IL App (3d) 100807WC, ¶ 24. The imposition of penalties under section 19(k) and fees under section 16 is discretionary. *Id.*

In this case, Respondents have failed to pay the sum to which they agreed in the Settlement Contract. Respondents, having been sent notice of the hearing on the instant petition, also failed to appear before Commissioner Flores to provide any explanation for their failure to abide by the terms of the Settlement Contract. Therefore, the Commission concludes Respondents have deliberately and intentionally delayed payment of compensation to Petitioner. Accordingly, the Commission concludes Petitioner is entitled to penalties and attorney's fees pursuant to sections 16 and 19(k) of the Act.

The remaining question is the calculation of the penalties and fees to which Petitioner and Petitioner's counsel are entitled. As noted above, section 19(k) of the Act provides that the Commission may impose a penalty "equal to 50% of the amount payable at the time of such award." 820 ILCS 305/19(k) (West 2018). Accordingly, the Commission awards Petitioner penalties in the amount of $1,562.50.

Regarding the request for attorney fees:

> "With respect to any and all proceedings in connection with any initial or original claim under this Act, no claim of any attorney for services rendered in connection with the securing of compensation for an employee or his dependents, whether secured by agreement, order, award or a judgment in any court shall exceed 20% of the amount of compensation recovered and paid, unless further fees shall be allowed to the attorney upon a hearing by the Commission fixing fees, and subject to the other provisions of this Section."

820 ILCS 305/16a(B) (West 2018).

In this case, Petitioner's counsel has secured an additional penalty of $1,562.50. Accordingly, the Commission awards Petitioner's counsel additional attorney's fees in the amount of $312.50.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's Petition for Additional Compensation, Penalties, and Attorney's Fees pursuant to Sections 19(k) and 16 of the Act is hereby granted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondents pay to Petitioner additional compensation of $1,562.50 as provided in Section 19(k) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondents pay to Petitioner's attorney additional compensation of $312.50 as provided in Section 16 of the Act.

Bond for the removal of this cause to the Circuit Court by Respondents is hereby fixed at the sum of $5,100. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: DEC 3 1 2019
d: xx/xx/19
BNF/kcb
045

Barbara N. Flores

Deborah L. Simpson

Marc Parker

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

DONALD SUTTON,

Petitioner,

vs. NO: 14 WC 20169

GRACELAND FAIRLAWN FUNERAL HOME,

Respondent.

ORDER

This matter coming before Commissioner Douglas McCarthy on December 11, 2019 pursuant to Petitioner's timely-filed Petition under Section 8(a) of the Act, and due notice provided to all parties, Commissioner McCarthy, after considering the issues of causal relationship and prospective medical care, and being advised of the facts and the law, hereby grants Petitioner's Section 8(a) Petition and awards the right knee nerve ablation procedure and right total knee arthroplasty as recommended and deemed necessary by Petitioner's treating physician.

Procedural History

The parties had previously proceeded to arbitration on the sole issue of Nature and Extent; the hearing took place before Arbitrator Nancy Lindsay on August 22, 2016. The Arbitrator, in her Decision dated October 24, 2016, awarded Petitioner 25% loss of use of the right leg pursuant to Section 8(e) of the Act. (PX1).

On June 27, 2017, Petitioner filed with the Illinois Workers' Compensation Commission his Petition for Review Under Section 19(h) or Section 8(a) of the Act. (AX1).

The matter proceeded to hearing on December 11, 2019 before Commissioner McCarthy. Petitioner's counsel confirmed at hearing that the parties were proceeding to hearing on the Section 8(a) Petition. Specifically, the disputed issue pertained to prospective medical by way of a nerve ablation procedure for the right knee and possible knee replacement. (T.9). Section 8(a) of the Act provides for a review by the Commission if additional medical expenses are incurred.

Findings of Fact

Petitioner, then 51 years old, had been employed by Respondent as a funeral assistant. On November 14, 2013, Petitioner was working for Respondent washing cars, when he tripped and fell on a hose. Petitioner struck and injured his right knee. (T.12-13; T.29; PX1).

Petitioner, under the care and supervision of Dr. Stephen Huss, underwent arthroscopic surgery to his right knee on February 17, 2014. Specifically, Dr. Huss performed a partial medial meniscectomy, chondroplasty of the medial tibial plateau and medial femoral condyle. Petitioner's post-operative diagnoses were medial meniscus tear, chondral defect of the medial condyle and medial plateau, and chondromalacia of the femoral trochlea. (T.13-14; PX1).

Despite surgery, Petitioner remained in pain and in fact had subsequent falling incidents during post-operative physical therapy. Following an MRI on May 20, 2014 and a course of Synvisc injections, Petitioner underwent a second surgery to his right knee on January 16, 2015. Dr. Huss performed the surgery and found a cyst on the front portion of the lateral meniscus. Petitioner's post-operative diagnoses were small chondral defect chronic of the medial condyle and an anterior horn degenerative cyst of the lateral meniscus. The procedure performed was a debridement of the anterior horn of the lateral meniscus with a thorough exploration and diagnostic examination of the knee. (T.13-14; PX1). By January 11, 2016, Dr. Huss determined that Petitioner had reached MMI and Petitioner could return for treatment as-needed. (T.32; PX1).

At the December 11, 2019 hearing before Commissioner McCarthy, Petitioner testified that following the second surgery and through the arbitration hearing and Decision in 2016, he had continued to experience complaints and symptoms in his right knee. (T.14-15). During this time period, Petitioner managed his pain through medication prescribed by his primary care physician. (T.15-16).

On April 21, 2017, Petitioner consulted with board-certified orthopedic surgeon, Dr. Jacob Sams, at Decatur Orthopedic Center. (T.16; PX4; PX7, pg. 5). Between Petitioner's last appointment with Dr. Huss and his initial appointment with Dr. Sams, Petitioner testified that his right knee was gradually worsening. (T.16). Dr. Sams' evidence deposition was taken on October 10, 2019; he testified consistent with his medical records. (PX7).

Dr. Sams noted Petitioner's previous partial meniscectomy and meniscal cyst excision with Dr. Huss. Dr. Sams further noted on examination that Petitioner had pain at the extremes of his range of motion. Petitioner also had pain with palpation of the right medial and lateral joint lines.

X-rays of the right knee revealed mild joint space narrowing of the medial and lateral compartments. Dr. Sams diagnosed Petitioner with right knee pain and osteoarthritis. He administered a cortisone injection. (T.16-17; PX4). Dr. Sams recommended that Petitioner stay active without restriction, use over-the-counter anti-inflammatories, and return as needed. (PX4).

Petitioner followed-up with Dr. Sams on September 8, 2017 and reported that the injection had not relieved his right knee symptoms. (T.17; PX4). Dr. Sams next ordered an MRI. (T.17; PX4). Petitioner testified that his new primary care physician, Dr. Ahmed Elrakhawy, had referred him to Millennium Pain Center for pain medication; the physicians at the Pain Center had also recommended a course of physical therapy. (T.18-19; PX6).

Petitioner completed the MRI of the right knee on September 29, 2017. (T.17-18; PX2; PX3; PX4). The impression suggested an anterior cruciate ligament (ACL) tear with intact attachments but severe edema within the substance of the tendon and there was an anterior root attachment tear of the lateral meniscus. (PX2; PX3; PX4). On October 10, 2017, Petitioner reviewed the results of the MRI with Dr. Sams. Dr. Sams indicated that the MRI demonstrated a near complete loss of the medial meniscus as a result of the previous surgeries, and he believed Petitioner's pain stemmed from this loss. Dr. Sams was not concerned about the ACL tear and did not recommend an ACL reconstruction. (PX4). Instead, Dr. Sams recommended a Gel-One injection. (T.20; PX4). The medical record stated that given the level of meniscal loss, Petitioner would need a total knee arthroplasty in the future. (PX4).

Dr. Sams testified at his deposition with respect to the causal relationship between Petitioner's current pain and the November 14, 2013 work injury as well as the prior right knee surgeries.

> Whenever you have some of the meniscus taken out, you are effectively taking away some of the shock absorbing functions of the meniscus. Now, he was having more aching pain. He had medial and lateral joint line tenderness, which is indicative of meniscal issues, but his aching pain can absolutely be attributed to three years prior he had meniscal surgery. (PX7, pg. 11; 13-14).

Dr. Sams further testified: "The loss of the medial meniscus will ultimately result in increased forces going across the cartilage in that medial compartment, and in time you will find degenerative changes, such as cartilage loss and progressing to straight arthritis." (PX7, pgs. 14-15).

Petitioner underwent the Gel-One injection on December 19, 2017; Petitioner testified that the injection provided very little relief. (T.20; PX4). By now, despite the injection, pain medication, and physical therapy, Petitioner remained symptomatic. (T.20). He returned to Dr. Sams on February 20, 2018; Dr. Sams recommended a nerve ablation procedure in hopes of controlling Petitioner's pain. (T.20-21; PX4). Dr. Sams noted that the knee pain was affecting Petitioner's quality of life, especially Petitioner's ability to sleep and walk for a long period of

time. (PX4). As of the December 11, 2019, hearing, Petitioner has not received approval to proceed with the nerve ablation and he has therefore not yet had the procedure. (T.21).

Petitioner's next appointment with Dr. Sams was on October 19, 2018; he reported worsening right knee complaints. (T.21; PX4). Dr. Sams recommended another MRI of the right knee which Petitioner completed on November 12, 2018. (T.22; PX4; PX5). The impression indicated a new or enlarged ganglion cyst, and stable appearance of the menisci with diminutive appearance of the medial meniscus, which could be the result of a combination of tearing, postsurgical changes, and degeneration tearing of the anterior horn and root of the lateral meniscus. The ACL appeared stable, and there was near full-thickness articular cartilage thinning of the weightbearing portion of the medial joint space. (PX4; PX5). On November 16, 2018, Dr. Sams reviewed the recent MRI results and recommended a right total knee arthroplasty. (T.22; PX4).

Respondent sent Petitioner for a Section 12 examination with board-certified orthopedic surgeon, Dr. Brian Cole. (T.22-23; RX1, pg. 4). Dr. Cole's evidence deposition was taken on August 27, 2019. (RX1). Dr. Cole had written three Section 12 reports with two addendums. (RX1, Respondent's Deposition Exhibits 1-3). The most recent report was dated April 4, 2019 and addressed the present issue of prospective medical. (RX1, pg. 7; Respondent's Deposition Exhibit 3). Dr. Cole's testimony as to Petitioner's history of injury and treatment was consistent with the record. (RX1, pgs. 8-11). Dr. Cole testified that Petitioner had presented on April 4, 2019 with complaints of right knee pain. Petitioner reported that his right knee felt unstable, it was locking and catching, and he had difficulty with twisting, pivoting, sitting or lying down, bending, and walking on flat surfaces. (RX1, pg. 11; Respondent's Deposition Exhibit 3).

Dr. Cole examined Petitioner on April 4, 2019; he noted limited range of motion and tenderness on the outer side of the biceps femoris; Petitioner had ligamentous stability, and x-rays taken at the Section 12 examination revealed mild arthritis medially. (RX1, pgs. 13-14; Respondent's Deposition Exhibit 3). Dr. Cole reviewed the images from the November 12, 2018 MRI. (RX1, pg. 15; Respondent's Deposition Exhibit 3). Based on all the information he had reviewed and his examination, Dr. Cole concluded that Petitioner had minor to moderate arthritis. His Section 12 report stated that Petitioner had persistent aggravation of right knee osteoarthritis with lateral meniscal cyst. (RX1; Respondent's Deposition Exhibit 3). At his deposition, he retracted this statement. (RX1, pgs. 31-32).

Dr. Cole opined that Petitioner did not require a total knee replacement as a result of the effects of the November 14, 2013 work accident. (RX1, pg. 17). If Petitioner did require a knee replacement in the future, Dr. Cole stated that it would be related "to the underlying arthritis that would progress on its own independent of the accident ever happening." (RX1, pg. 18). Dr. Cole further opined that the likelihood of Petitioner getting better now with knee replacement surgery was not very high. (RX1, pgs. 15-16; Respondent's Deposition Exhibit 3). "The basis of that opinion is that the subjective complaints do not line up with osteoarthritis. The severity of the disease is minor to moderate at best." (RX1, pgs. 17-18).

In his April 4, 2019 Section 12 report, Dr. Cole had recommended benign neglect, continued monitoring of Petitioner's right knee condition, or a repeat arthroscopy with debridement and meniscal cyst decompression. (RX1; Respondent's Deposition Exhibit 3). Dr. Cole defined benign neglect: "That means despite having symptoms, it's best to minimize surgical or nonsurgical intervention given the low likelihood of success in a situation where you have a patient who has profound symptoms that don't line up with anything pathologically." (RX1, pgs. 28-29). Dr. Cole added:

> He does not have bone-on-bone arthritis. He complains primarily of lateral-sided knee pain. He has no arthritis laterally. Knee replacements are meant to treat arthritis. He has moderate arthritis medially. He is not bone on bone, and he has lots of other confounding issues in a case like this. The likelihood of success is less than 20 percent. (RX1, pgs. 29-30).

Petitioner returned to Dr. Sams on May 10, 2019. Dr. Sams noted Dr. Cole's opinions in his Section 12 report. Dr. Sams stated that he disagreed with Dr. Cole's recommendation for a repeat arthroscopic procedure. (PX4). Dr. Sams testified:

> [Y]ou can't add cartilage to the medial compartment. You can't add meniscus. If you take away further meniscus, it's only going to exacerbate his problem. He didn't mention anything about repairing the lateral meniscus, the root tear of that. I don't think that his – his findings are focal enough to have an arthroscopic procedure be of benefit. (PX7, pg. 24).

At his deposition, Dr. Cole also retracted his recommendation for a repeat arthroscopy. Dr. Cole agreed with Dr. Sams that the procedure was not warranted. (RX1, pgs. 35-36). Dr. Sams also disagreed with Dr. Cole's opinion that Petitioner did not need a knee replacement:

> Because he has an anterior horn lateral meniscus root tear. So if we focus on the lateral meniscus for a second, when you have a root tear, the meniscus, its entire function is lost. Okay. A root tear is kind of saying, you've lost your anchor, and when you put your force through it, it gets out of the way and all the pain – or all the force can be going through the lateral femoral and tibial cartilage. So to say that it wouldn't address that, and then to say his posterior – posterolateral pain, when we have an irritant in our knee, whether it be a medial meniscus, whether it be medial arthritis, whether it be any source of pain somewhere in the knee, a lot of times patients will feel that pain posteriorly. The joint capsule is weakest posteriorly. . .

> That's not where the problem is, but that's where they perceive it, because that's where the joint is being distended first. So that's where we get the name popliteal cyst or a Baker's cyst or things that go along with that. That's not the problem. The problem is elsewhere in the knee. So to say would a total knee replacement address that, an emphatic yes. (PX7, pgs. 25-26).

Dr. Sams testified further as to Petitioner's need for the recommended treatment:

> I have a patient who has tried a long list of very reasonable conservative measures, and we have not yet been successful at controlling his pain. He's dealing with pain on a daily basis. So I don't have benign neglect as an option when I know there are solutions out there that can help him. (PX7, pg. 24).

In summary, Dr. Sams confirmed at his deposition that he still recommended that Petitioner undergo the nerve ablation. If the ablation failed to improve Petitioner's condition, then Dr. Sams recommended proceeding with the right total knee replacement. (PX7, pg. 29).

During cross-examination, Dr. Sams admitted that he had not reviewed the previous treatment records from Dr. Huss. (PX7, pgs. 31-32). He also conceded that many of Petitioner's findings on physical examination were either negative or normal, and Petitioner's x-rays did not reveal extensive or severe arthritic change. (PX7, pgs. 32-34). However, Dr. Sams explained: "[P]ain is subjective, but they have their own response to pain. And so it would not be fair for me to say that his symptoms aren't real because his x-rays aren't bad enough or anything like that." (PX7, pg. 44).

As of the hearing date of December 11, 2019, Petitioner continued to follow-up with the pain center regarding his medication. (T.24-25). Dr. Sams had provided two more cortisone injections; the last one was administered on August 30, 2019. The injections again provided temporary to no relief. Petitioner had last treated with Dr. Sams on August 30, 2019. (T.23-24; PX4).

Petitioner testified that most of the pain was located on the outside of the knee, but he also had pain involving the entire knee joint. (T.34). Petitioner stated that he had difficulty standing for a long period of time, he was uncomfortable at night, and had difficulty sleeping and playing with his grandchildren; Petitioner also stated that he took Tramadol in order to get through his work day; Tramadol provided about 30-percent relief. Petitioner also took Meloxicam which provided about 15 to 20-percent relief. (T.25-27).

Petitioner further testified that he continued to work as a funeral assistant as of the date of hearing. (T.29). His current duties included setting up rooms for visitations and funerals, driving the hearse, cleaning Respondent's fleet of vehicles, and serving as a pallbearer. (T.30-31). He

stated that his right knee was problematic while at work. "I have to do a lot of lifting and pulling and tugging and being a crematory operator I have to place bodies in there and pushing and things putting weight on that knee." (T.26-27). Petitioner also served as a pastor; standing for more than 30 to 45 minutes at a time affected his right knee. (T.39).

Conclusions of Law

Under Section 8(a) of the Act, a claimant is entitled to recover for all necessary medical services rendered and thereafter incurred which are reasonably required to cure or relieve the claimant from the effects of the accidental injury. *820 ILCS 305/8(a)*. Respondent confirmed at hearing that they were not disputing causal connection; Respondent's dispute was whether the treatment recommended by Dr. Sams was necessary. (T.41). The parties further confirmed on the record that they agreed to proceed on this matter without submitting Briefs or requesting oral argument. The parties also agreed that the matter did not have to be decided by a full panel, and on the record agreed to have Commissioner McCarthy decide the issue of prospective medical. (T.42-43).

Our Supreme Court has long held that it is the Commission's province "to assess the credibility of witnesses, resolve conflicts in the evidence, assign weight to be accorded the evidence, and draw reasonable inferences from the evidence." *City of Springfield v. Indus. Comm'n*, 291 Ill. App. 3d 734, 740 (1997) (citing *Kirkwood v. Indus. Comm'n*, 84 Ill. 2d 14, 20 (1981)). Interpretation of medical testimony is particularly within the province of the Commission. *A. O. Smith Corp. v. Indus. Comm'n,* 51 Ill. 2d 533, 536-37 (1972). Having considered the record in its entirety, including all the testimony and exhibits submitted by the parties, and the Commission having jurisdiction over this claim, the Commission finds the opinions of Petitioner's treating physician, Dr. Sams, more persuasive than Respondent's Section 12 examiner, Dr. Cole.

Dr. Cole did not address the reasonableness nor necessity of the recommended right knee nerve ablation procedure, and his opinion relative to Petitioner's need for right total knee arthroplasty is not persuasive in light of the medical evidence in its entirety. Petitioner credibly testified that he remained symptomatic in his right knee from the time Dr. Huss released him in January 2016 on an as-needed basis to the time Petitioner began treating with Dr. Sams in April 2017. Petitioner had been managing his pain with medication prescribed by his primary care physician. Although Dr. Sams had not reviewed the previous treatment records from Dr. Huss, he was well aware of Petitioner's previous partial meniscectomy and meniscal cyst excision with Dr. Huss. Dr. Sams testified as to how Petitioner's injury and past surgeries resulted in his current condition of ill-being that now necessitated additional treatment. Dr. Sams explained that the "loss of the medial meniscus will ultimately result in increased forces going across the cartilage in that medial compartment, and in time you will find degenerative changes, such as cartilage loss and progressing to straight arthritis." (PX7, pgs. 14-15).

Dr. Cole's opinion that Petitioner's need for a knee replacement would be related "to the underlying arthritis that would progress on its own independent of the accident ever happening" is

simply unsubstantiated. (RX1, pg. 18). Dr. Cole not only testified inconsistent with parts of his Section 12 report dated April 4, 2019, his opinion did not take into consideration Petitioner's continuous and consistent complaints of pain or Petitioner's attempt at conservative care. As Dr. Sams noted,

> I have a patient who has tried a long list of very reasonable conservative measures, and we have not yet been successful at controlling his pain. He's dealing with pain on a daily basis. So I don't have benign neglect as an option when I know there are solutions out there that can help him. (PX7, pg. 24).

Dr. Cole had testified similarly to Dr. Sams in that both physicians noted that many of Petitioner's findings on physical examination were either negative or normal, and Petitioner's diagnostic images did not reveal extensive or severe arthritic change. However, Dr. Sams explained, "[P]ain is subjective, but they have their own response to pain. And so it would not be fair for me to say that his symptoms aren't real because his x-rays aren't bad enough or anything like that." (PX7, pg. 44). The Commission assigns greater weight to the opinions of Petitioner's treating physician Dr. Sams as he not only has consistently observed and treated Petitioner, but his opinions are wholly supported by the record. The Commission thus finds Dr. Sams' recommendation for a nerve ablation in an effort to control Petitioner's pain to be necessary, reasonable and causally related to the November 14, 2013 work injury. The Commission also finds that if the ablation fails to cure or relieve Petitioner's right knee condition, then Petitioner is additionally entitled to the recommended right total knee replacement.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's Petition pursuant to Section 8(a) of the Act is hereby granted.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner is entitled to the recommended right knee nerve ablation procedure followed by, if deemed necessary by Petitioner's treating physician, right total knee arthroplasty.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall make payments for reasonable, necessary and related medical expenses pursuant to Sections 8(a) and 8.2 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 other 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 the Circuit Court.

DATED: JAN 2 - 2020

D Douglas McCarthy

Commissioner D. Douglas McCarthy

DDM/pm
H: 12-11-19
052

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Larry Needham,
Petitioner,

vs.

No. 15 WC 32115

20IWCC0001

Keystone Steel & Wire,
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, temporary total disability and permanent partial disability, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Arbitrator awarded Petitioner, *inter alia,* "22-3/7 weeks TTD at the rate of $712.72 totaling $15,979.18 minus any group benefits paid which qualify under the Act." On the Request for Hearing sheet, the parties stipulated to an average weekly wage of $1,068.54; and also, that the period of time Petitioner was off work was, "8/16/14 to 1/18/15, representing 22-3/7 weeks." (Arbitrator's Exhibit #3.)

The Commission finds the correct TTD rate to be $712.36 per week ($1,068.54 AWW x 2/3). The Commission also finds that the period between August 16, 2014 and January 18, 2015 totals 22-2/7 weeks, not 22-3/7 weeks. Accordingly, the Commission modifies the Arbitrator's award of TTD to: 22-2/7 weeks, at a weekly rate of $712.36, for a total of $15,875.45.

All else is affirmed and adopted.

20IWCC0001

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 16, 2018, is hereby modified as stated herein and otherwise affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $41,800.00. 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: JAN 3 - 2020

Marc Parker

Barbara N. Flores

o-11/07/19
mp/mcp
68

DISSENT

I respectfully dissent from the decision of the majority, which affirmed the Decision of the Arbitrator with minor modifications. The Arbitrator/Commission found that Petitioner proved he sustained a work accident on August 15, 2014, which caused a current condition of ill-being of his right shoulder. I would have reversed the Decision of the Arbitrator, found that Petitioner did not sustain his burden of proving that he sustained a work-related accident or that his condition of ill-being was related to his work activities, and denied compensation.

Petitioner was a crane operator. He had seven prior workers' compensation claims, all of which were accepted by his employer. He also had a non-occupational bicycle accident which resulted in a broken collar bone and distal clavicle fracture. He claimed that on August 15, 2014 he was loading a 2,400 pound billets (steel bars) onto a flatbed truck using a crane-mounted magnet. He testified that he had his right hand on the billets to keep them steady and putting pressure on his hand as they were being lowered. The billets fell faster than he expected and he felt a pop in his shoulder. Respondent has a regulation prohibiting touching billets as they were being loaded.

20IWCC0001

Respondent's Senior Safety and Health Specialist, Chester Barker, testified that he never saw a worker place his hand on billets as they were being loaded and there was no reason for a crane operator to use their hands to steady the billets. In addition, immediately after Petitioner reported his injury, Mr. Barker specifically asked Petitioner whether he had placed his hand on the billets or applied any force on the billets, and he answered that he did not. Petitioner reported to him that he felt a pop in his shoulder simply as he raised his arm. On cross examination, Petitioner was evasive on whether he made the statement to Mr. Barker and seemed to acknowledge that he did. In addition, Russel Hewit, Respondent's workers' compensation adjuster, testified that Petitioner reported he placed his hand on the billets but did not apply any force. Petitioner also made a similar statement to a treating doctor, Dr. Pena.

Finally, Respondent's Section 12 medical examiner, Dr. Karlsson, viewed the MRI and intraoperative report. He noted that there was no tear in the rotator cuff or large flap tear of the labrum, but only fraying of the labrum. He opined these findings were evidence of a chronic, long-developing degenerative condition and there was no evidence of any acute injury whatsoever. Petitioner's treating surgeon, Dr. Johnson, testified that he based his opinion that the incident caused Petitioner's condition of ill-being, on his report of applying force on the billets. If no such force was actually applied, his causation opinion would change. Based on the entire record before us, I find Petitioner to be patently not credible and would hold that he neither proved accident nor causation.

For the reasons stated above, I would have reversed the Decision of the Arbitrator, found that Petitioner did not sustain his burden of proving that he sustained a work-related accident or that his condition of ill-being was related to his work activities, and denied compensation. Therefore, I respectfully dissent from the decision of the majority.

Deborah L. Simpson

Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

NEEDHAM, LARRY
Employee/Petitioner

Case# **15WC032115**

KEYSTONE STEEL & WIRE
Employer/Respondent

20IWCC0001

On 5/16/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.03% 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:

1465 LAW OFFICE OF DOC HALLIDAY
5901 N PROSPECT RD
SUITE #7A
JUNCTION CITY PEORIA, IL 61614-4337

0507 RUSIN & MACIOROWSKI LTD
JOHN A MACIOROWSKI
10 S RIVERSIDE PLZ SUITE 1925
CHICAGO, IL 60606

20IWCC0001

STATE OF ILLINOIS)
)SS.
COUNTY OF Peoria)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

LARRY NEEDHAM
Employee/Petitioner

v.

KEYSTONE STEEL & WIRE
Employer/Respondent

Case # 15 WC 32115

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Douglas McCarthy**, Arbitrator of the Commission, in the city of **Peoria**, on **April 11, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **August 15, 2014**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did*** 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's average weekly wage was **$1,069.44**.

On the date of accident, Petitioner was **55** years of age, ***married*** with **0** dependent children.

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

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

Respondent shall be given a credit of $_____ for TTD, $_____ for TPD, $_____ for maintenance, and **$7289.29** in non-occupational indemnity disability benefits.

Respondent is entitled to a credit for all medical paid under its group medical plan for which credit may be allowed under Section 8(j) of the Act.

ORDER

Wherefore, the Arbitrator finds in favor of the Petitioner. Petitioner is hereby awarded the following:

1) Respondent shall pay to the Petitioner $1018.46, which represent out of pocket medical paid by the Petitioner. Respondent is entitled to credit for the remaining medical paid by its group provider pursuant to Section 8 (j) of the Act.

2) Petitioner is awarded 22-3/7 weeks TTD at the rate of $712.72 totaling $15,979.18 minus any group benefits paid which qualify under the Act; and

3) Petitioner is awarded 10% MAW at the PPD rate of $641.12 per week or a total of $32,056.00.

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

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

20IWCC0001

D. Douglas McCarthy

Signature of Arbitrator

5/8/2018
Date

ICArbDec p. 2

MAY 16 2018

In support of the arbitrator's findings relating to (C) Accident and (F) Causation, the arbitrator makes the following findings of fact :

Petitioner testified that, on August 15, 2014, he was a billet yard worker at Keystone Steel & Wire and had worked in that position for 5-10 years.

Petitioner had worked at Keystone Steel & Wire for over 40 years.

One of the jobs that Petitioner did on a daily basis would be to load a semi flatbed with billets. Many times, he would do this all day long and load many trucks with billets.

Petitioner further testified that he knew how to load these trucks with billets and he loaded them routinely as he had been taught to do over the years and always used the utmost caution in loading these billets.

On the day of the accident, August 15, 2014, Petitioner was working the day shift which starts at 6:00 a.m. On that particular day, he started to work at approximately 5:50 a.m. and he had already loaded these billets on a truck and completed his first job.

Petitioner was injured when he was working on the second truck he was assigned to at around 6:30 a.m. He said that he was loading a semi flatbed with billets. Billets are 5-inch square 50-foot long pieces of steel that weigh 4,200 pounds each. Petitioner testified that when you load a truck with billets you usually load 11 billets on the truck. They usually load 6 at first so that they can center the first set of billets and then put the remaining 5 next to them for a total of 11 billets.

Petitioner further testified that this is a one-man job. Petitioner testified that they use 3 magnets to latch onto the billets and lift them off of the ground. The magnets are on an overhead crane with a remote control. The magnets and overhead crane are run by the operator.

Petitioner testified that he would use a remote control to go about loading the billets onto the trucks. He would set the magnets on the billets and then engage the magnets using the buttons on his remote control. One button on the remote control would engage the magnets and another button would disengage the magnets.

Petitioner testified that the remote control was a small box that was approximately 4.5 inches by 6 inches. It has handles on it and the operator (in this case, the Petitioner) would carry it around with him.

Petitioner testified that he got the billets onto the magnets using his remote control and then moved them toward the front of the flatbed. He testified that the magnets would have the billets raised up approximately 15 feet in to the air and then he would use the remote control to move them over to the flatbed truck. Petitioner further testified that, once you move them over to where they are over the flatbed truck, he then moves them to get the billets positioned and lower them so that they are properly positioned in the front. Petitioner further testified that after he gets the billets positioned on the front of the truck, he goes to the back of the truck so that he can

position the back end of the billets onto the truck properly. Petitioner testified that sometimes, because of the unevenness of the ground or the flatbed, the front of the billets sometimes load properly in front and that the back of the billets are then sometimes still up in the air and have to be lowered down into the proper position.

Petitioner testified that was the situation with this particular truck as the back of the billets were still not fully on the flatbed part of the truck and were partially in the air and needed to be let down so that the entire billets were on the flatbed.

Petitioner testified that he walked to the back of the truck with the remote to position those billets that had the back end of them still hanging in the air. The front had already been down, but the back was still sticking up which he testified happened on a regular basis. Petitioner testified, as such, he got the billets in a position where he needed them so that he could then lower the back part of the billets onto the truck.

Petitioner testified that there were 6 billets that were still in the air towards the back of the truck and that each billet weighed approximately 4,200 pounds and was 50-feet long. The billets were grouped together so Petitioner was lowering approximately 25,000 pounds of steel with his remote control.

Petitioner testified that, in order to steady the billets, he went to the back of the truck so that he could use his remote control with his left hand to lower the back parts of the billets down onto the flatbed. Petitioner testified that he put his right hand up to steady the billets. He had gloves on and he reached up with his arm straight out in front of him but at an upward angle of 100 to 120 degrees. His arm was straight out, but it was at an angle such that it was just above his head.

Petitioner testified that he had done this many times and that it was common practice for him to put his hand on the edge of the billets to steady them when they were still in the air and hanging from the magnets so that they did not rock out of position prior to being lowered.

Petitioner testified that he had done this many times with the remote control, which had both an up and down device. When he hit the down button, the billets unexpectedly went down very quickly. As his right arm went in a downward motion, he felt a pop with pain in the right shoulder.

Petitioner further testified that he did have his gloved right hand on the billets to steady them. However, he did not push them or move them in any way but had only put his arm up there to steady them.

Petitioner testified that everything happened so quick, he does not know whether his glove caught on the billets which have jagged metal edges, or if something else happened.

Petitioner further testified that he had been using that remote control for numerous years. On cross examination, he was asked whether or not he was not supposed to touch the billets at any time. Petitioner denied that he was ever taught that he could not touch the billets. In fact,

Petitioner testified that 2 or 3 different trainers told him he could put his hand on the side of the billets.

He testified that he touched the billets as many as several times a week to steady the billets. He had been doing this for the 5 years or more that he had been loading the flatbed trucks. He also stated that everyone else that worked with him in loading the billets did the same thing. He denied that he had to push on them but stated that his hand was up there touching the billets so as to steady them.

Petitioner testified he had never been warned about touching the billets or received any safety violation. He testified the billets slamming down so quickly had never happened before.

After the billets unexpectedly slammed down so quickly, he felt the pop in his arm. As Petitioner testified earlier, he was not pushing on the billets but was steadying the billets as he had done many times before.

Petitioner testified that he reported his injury immediately. He called his foreman and told him he was going to first aid. At first aide, he was met by Chester Barker, a senior safety and health specialist employed by the Respondent. Mr. Barker testified that the Petitioner told him he had raised his right arm and as he was lowering the billets, he felt his right shoulder pop. Barker prepared a written report on the alleged accident date which was admitted into evidence. (PX 9) In the report he said that the Petitioner reported that as he was getting ready to lower the billets down, he was going to try and "tweak them" around. He wrote that the Petitioner felt pain when he had raised his arm up to steady the billets. Mr. Barker further testified that the Petitioner told him that he did not have his right hand on the billets when they dropped down in an unexpected manner.

In the First Aid department, he was seen by a registered nurse who authored a one page report which was admitted into evidence. (PX 12) The history from the Petitioner was that he put his right hand on the billets to steady them as he was loading them into a truck. He said that his right shoulder popped and went numb, and he was unable to raise his right arm.

He was also seen that morning by Rusty Hewitt, the on-site claims adjuster for the Respondent's Workers Comp carrier, CCMSI. While there, the Petitioner completed an accident report which was signed by Dale Stookey who apparently worked in the Respondent's safety department. Mr. Hewitt testified that the Petitioner told him that he had placed his right hand on a load of billets and, as he was lowering them, felt right shoulder pain. He said that the Petitioner said he did not use any force on the billets as he was performing this task. The accident report, done at around the same time the morning of August 15, said that the Petitioner had raise his right arm straight out, putting his right hand on the billets to steady them. As he started to lower them, he felt his right shoulder pop. The Petitioner said that he placed his hand on the billets so that they would not swing when they were being lowered. (PX 1A)

Petitioner was then sent to OSF Occupational Health on Randolph. The initial intake sheet prepared by the nurse stated that Petitioner was loading a truck with billets and he put his right hand on the billets to steady them when his right shoulder popped and went weak and numb. The nurse noted that Petitioner was unable to raise his arm (Respondent's Exhibit 4).

Petitioner also told Dr. Peña, the OSF doctor, that he put his right hand on the back and side of the 52-feet 25,000-pound billets to steady them. He stated he had his right upper limb extended forward approximately 100-120 degrees and he was not putting any pressure on them but steadying them as he stated earlier. Petitioner testified earlier this was a position his arm was in when the 25,000 pounds of billets went down and landed at an unexpectedly very fast pace and that is when he felt the pop in his shoulder. He said that he noticed a painful crepitation and his arm went numb.

On examination, Dr. Peña noted radiation of pain to the right biceps and anteriorly and medially on the arm and noted a burning quality to his pain at the superior shoulder. Dr. Peña further noted a slight droop to the right shoulder on observation and that he was tender to the right acromioclavicular joint right anterior shoulder including the bicipital groove and also the axillary area medially. The Petitioner had decreased range of motion in the shoulder as well as decreased strength when compared with the left shoulder. He was noted to have right biceps pain against resistance. (PX 4)

Dr. Peña's assessment was a suspicion for a possible right proximal biceps tear and also the possibility of a rotator cuff tear. Dr. Peña took him off work on the date of injury.

An MRI of the right shoulder without contrast was ordered that day and showed a possible tear of the superior glenoid labrum (PX 7).

Petitioner was next seen by Dr. Braun of the OSF Occupational Health Center four days later on August 19, 2014. The history recorded in Dr. Braun's office note was that the Petitioner felt a pop with a burn in the superior portion of the right shoulder as he was lowering his right arm from above shoulder height to shoulder height as he was guiding a billet that was being loaded onto a truck. Dr. Braun reviewed the MRI results, and diagnosed the Petitioner with an acute labral tear. Dr. Braun referred the Petitioner to Dr. Johnson for further evaluation. (PX 5)

Petitioner then went under the care of Dr. Brent Johnson at Midwest Orthopaedic Center on August 22, 2014. Dr. Johnson noted two possible tears on the labrum, tightness and aching on the top of the shoulder, and sharp stabbing pain to the front of the shoulder as well as further pain at times on the lateral side of the shoulder. The pain rated from 7-10 out of 10. Petitioner advised difficulty with moving his shoulder as well as difficulty to eat, dress, and care for himself (Respondent's Exhibit 8).

After a course of physical therapy, Dr. Johnson performed surgery on October 30, 2014. He had diagnosed a right shoulder SLAP tear with adhesive capsulitis. The procedures that Dr. Johnson performed were a right shoulder arthroscopy, capsular release and manipulation as well as biceps tenodesis (Respondent's Exhibit 10).

Dr. Johnson testified that the accident of August 15, 2014 caused the injury to Larry Needham or aggravated any pre-existing condition in Larry Needham's shoulder resulting in the need for the surgery described above. That testimony was given to a reasonable degree of medical and surgical certainty (Petitioner's Exhibit 1, p. 17).

On cross-examination, he was asked if an old clavicle fracture sustained 15 years prior could in and of itself cause an individual to experience a popping sensation. Dr. Johnson replied it would be unlikely (Petitioner's Exhibit 1, p. 20). He was also asked if the clavicle fracture could cause pain or clicking and Dr. Johnson replied possibly but unlikely (Petitioner's Exhibit 1, p. 20).

Dr. Johnson was then asked that since he had noted significant fraying of Petitioner's anterior and superior labrum, could the fraying indicate a more degenerative chronic condition. Dr. Johnson answered that no it would not, stating further that if you have your labrum tore or you have a tissue tear in your shoulder, sometimes it appears frayed and torn (Petitioner's Exhibit 1, pp. 24-25).

On further questioning by counsel for the Respondent, Dr. Johnson was asked whether an individual could develop a labral tear with an activity of normal life just by raising the arm up and lifting something. Dr. Johnson's response was it's possible but unlikely (Petitioner's Exhibit 1, p. 28).

Dr. Johnson went on to testify further regarding the possibility of developing a labral tear by merely raising the arm. Dr. Johnson responded as follows: "So there's different types of labral tears. You can get what we call a Type I labral tear, which is fraying of the labrum, which everybody eventually gets from normal life wear and tear. HE HAD MORE WHAT WE CALL A TYPE II SLAP TEAR WITH THE PEEL-BACK SIGN, WHICH WAS INSTABILITY OF THE LABRUM. I THINK THAT'S LESS LIKELY WITH JUST EVERYDAY DAILY ACTIVITIES." (Petitioner's Exhibit 1, pp. 28-29; emphasis added).

Counsel for the Respondent went on to ask further "Well if reaching up and lifting something wouldn't cause it, why would him merely putting his hand on a billet to guide it cause a tear?" Dr. Johnson replied, "so if he had his hand on the billet and there was a significant force applied and he had his arm in a certain position, yes I feel it could cause it." Counsel then asked:

> "Q: But that assumes there was a significant force.
>
> A: Yes.
>
> Q: And what type of force would that need to be as far as significant?
>
> A: I can't quantify for you in terms of units or anything, but I think it would have to be more that just lifting up your arm. If he was pushing it or had a force push back against his arm, I think it could cause it." (Id at 29)

Dr. Johnson further testified that the force would come from either the Petitioner pushing the billets or a force back against him from the billets, it could be causative to the injuries. (Id)

He further testified that if Petitioner had placed his right hand on the back and side of the 52-foot 25,000-pound billets to steady them as they were hanging there by the magnet, would it have still caused the injury? Dr. Johnson replied "so, yes, if he had his hand up there on the billets to steady, yes, I would feel that would require some force and could cause the injury that has been described." (Petitioner's Exhibit 1, p. 31).

Respondent submitted evidence from Dr. Troy Karlsson, an orthopedic surgeon who did a records review and later an examination pursuant to Section 12 of the Act. On the issue of causation, Dr. Karlsson, who also testified by way of deposition, said that force was required. He said that the Petitioner did not have the requisite force to cause his injuries, as he was not pulling or pushing something and the material itself did not apply a force to him. (RX 8 at 15) He further opined that the surgical findings by Dr. Johnson were more consistent with a degenerative as opposed to a traumatic injury. (Id at 21-22) Finally, on cross examination, Dr. Karlsson testified that the act of raising one's arm to 100 to 120 degrees to steady a two-ton load of steel was not something that most people were doing on an everyday basis. (Id at 46)

Conclusions of Law on accident and causation:

The evidence clearly shows that on the day in question, the Petitioner was performing his regular job in the regular way he performed it. While there was some dispute as to whether the Petitioner had his right hand on the billet load as it was being lowered into the truck, the Arbitrator believes a preponderance of the evidence establishes that it was.

His histories on the accident date to Rusty Hewitt, Dale Stookey and Dr. Pena were consistent. He told them all that his right hand was against the billets when they unexpectedly dropped down to the truck bed. All of the subsequent histories to the Petitioner's medical providers also are consistent. He told all of them his right hand was on the billets. Only the testimony from Chester Barker details a different history. He says the Petitioner denied touching the billets when they first talked immediately after the occurrence. However, at a subsequent meeting Barker said that the Petitioner did report that his right hand was on the side of the billets as he was lowering them down.

The Arbitrator finds it much more likely that the Petitioner did have his hand on the billets as he was lowering them into the truck. Clearly the front end of the billets was in the truck bed while the back end was not. While the Petitioner said that the back end was not swaying, he said it was his normal practice to reach with his gloved right hand onto the back of the billets to prevent said swaying as they were being lowered.

The evidence further shows that while the Petitioner was lowering the billets, he felt symptoms in the right shoulder. The really difficult question is whether this activity was causally related to his injuries. Both doctors who testified, Dr. Johnson and Dr. Karlsson, said that some level of

force against the shoulder was required before it could be concluded within a reasonable degree of medical certainty that causation was present. It is clear from the evidence that the Petitioner, while he was lowering the heavy load of billets, did not apply force with his right hand. He testified to that fact, as well as telling virtually everyone else associated with this claim that he didn't apply force while the billet was being lowered. As an aside, the Arbitrator feels the Petitioner was a very credible witness because of his consistency on the issue of force. It would have been easy for him to say that he was pushing on the billet to some degree to prevent it from swaying, but he did not.

On the other hand, both doctors said that force could have been placed on the shoulder from the billets themselves pushing back as they were being lowered. Dr. Johnson felt it significant that while the Petitioner was lowering the billet, his arm was in a raised position. (PX 1 at 26) As stated above, there is really no disputing the fact that the Petitioner had his right arm extended out from his body to a height above head level. There is also no dispute that this billet bundle, which weighed over two tons, dropped rapidly and unexpectedly when the Petitioner pushed the operating paddle with his left hand. As stated above, the evidence established that the Petitioner's right hand was on the billets to steady them before they were lowered.

The Arbitrator believes the above evidence allows him to draw two reasonable inferences. First, it is reasonable to infer that the Petitioner maintained hand contact with the billets while they quickly and unexpectedly dropped down to the truck bed. The reason his hand was on the billets was to steady them as they were being lowered. Secondly, it is reasonable to infer that this two-ton bundle provided some push back as it was dropping. It wouldn't take much of a sway for the heavy load to provide some level of force against the Petitioner's right arm.

Also, the chain of events favors causation. The Petitioner worked for many years for the Respondent without having any ongoing symptoms or treatment involving the right shoulder. While he did have an old, ununited distal clavicle fracture, there was no evidence presented to show that it was giving him any problems. After the accident, he immediately went to his foreman to report it. He was sent to First Aide and then to OSF, where he was seen by Dr. Pena. His exam findings were consistent with a traumatic event. He noted tenderness throughout the shoulder along with decreased motion and strength. He diagnosed a possible biceps tear. An MRI was performed which showed a torn labrum. Four days later he saw Dr. Braun, who termed the labral tear as being acute. Just one week after the accident, the Petitioner saw Dr. Johnson, an orthopedic specialist. Dr. Johnson found decreased ranges of motion, weakness of abduction and external rotation and tenderness to palpation. Again, all of these findings are reflective of a recent trauma. After a trial of therapy, surgery was performed.

It is likely that some of what Dr. Johnson found in surgery pre-existed the events of August 15. However, the law allows for compensation if an accident aggravates a pre-existing condition. Based upon the testimony of Dr. Johnson as well as the chain of events analysis, the Arbitrator finds that the accident as alleged is causally related to the Petitioner's condition of ill being.

In support of the arbitrator's findings relating to (J) Medical, the arbitrator makes the following findings of fact and conclusions of law:

All of Petitioner's medical bills were paid by Respondent's group carrier with the exception of out of pocket expenses totaling $1,018.46. Petitioner's claim for reimbursement of medical expenses is granted in light of the Arbitrator's finding as to causation.

In support of the arbitrator's findings relating to (K) TTD, the arbitrator makes the following findings of fact and conclusions of law:

Petitioner was off work from August 16, 2014 through January 18, 2015, a period of 22-3/7 weeks, during which period of time he received group disability benefits from Respondent totaling $7,289.29.

Petitioner's claim for temporary total disability is granted in light of the Arbitrator's findings as to accidental injury and causation. In light of Petitioner's average weekly wage of $1,068.54, Petitioner is entitled to 22 and 3/7 weeks TTD at the rate of $712.72 totaling $15,979.18 minus any group benefits paid which qualify under the Act.

In support of the arbitrator's findings relating to (L) Nature and Extent, the arbitrator makes the following findings of fact and conclusions of law:

With respect to the five factors listed in Section 8.1b of the Act, the Arbitrator first notes that Dr. Karlsson did an AMA evaluation on June 7, 2016. The doctor found a 2 % impairment of the right arm which equates to a 1 % impairment of the whole body. The Arbitrator gives moderate weight to the doctor's findings.

The Petitioner has worked for the Respondent for the past forty years, working as a laborer in the billet yard for the past five to ten years. The job is somewhat strenuous in nature, as evidenced by the accident in question. The Arbitrator gives moderate weight to occupation.

The Petitioner was 55 years old when the accident occurred. As such, he will not have to work as long as would a younger individual with the post-surgery symptoms which he testified to at arbitration. The Arbitrator gives moderate weight to this factor..

The Petitioner was released to full duty work on January 15, 2015 and there is no evidence to support any wage diminution. The Arbitrator gives no weight to this factor.

Finally, Dr. Johnson testified that he last saw the Petitioner on April 24, 2015. This would have been three months after his return to work. Dr. Johnson noted no pertinent findings on examination, and said the Petitioner reported slight pain with extended activity. (PX 1 at 12) The Arbitrator gives considerable weight to this factor.

After consideration of the five factors set forth above, the Arbitrator awards 10 % person as a Whole under Section 8 (d) (2) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF SANGAMON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Kelley Smith,
Petitioner,

vs. No. 17 WC 00531

State of Illinois,
Department of Corrections,
Respondent.

20IWCC0002

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Respondent, and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical expenses, and permanent partial disability, and being advised of the facts and law, reverses in part 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 did not file a Petition for Review but urges the Commission to modify the Arbitrator's Decision to include 25% loss of use of the right thumb as part of the permanency award.

The Arbitrator determined that Petitioner proved that her slip and fall on ice in the employer's parking lot on December 19, 2016 constituted an accident that arose out of and in the course of her employment. He found that Petitioner proved that she suffered injuries to her back and right thumb and awarded medical benefits and 3% loss of use of the body as a whole for Petitioner's back strain. However, the Arbitrator determined that Petitioner's right thumb injury resolved without any permanent disability and made no permanency award for that injury. Petitioner did not seek temporary total disability benefits. The Commission affirms the Arbitrator's finding that Petitioner's accident arose out of and in the course of her employment and the award of medical expenses and permanency as to Petitioner's back strain. However, the Commission reverses the Arbitrator's finding that Petitioner's right thumb condition was causally related to her work accident and his award of medical expenses related thereto.

20IWCC0002

On December 19, 2016, Petitioner, an office support staff member at Respondent's Decatur Correctional Center, received permission from her supervisor to go to her vehicle during her break and slipped on ice in Respondent's parking lot. Shortly after the accident, Petitioner's supervisor completed a Supervisor's Report of Injury wherein he noted Petitioner's injury was to her "back and right hip." Petitioner completed an Employee's Notice of Injury and Incident Report and indicated therein that she injured her "Back & RT Hip & Neck." Petitioner's Application for Adjustment of Claim, filed on January 5, 2017, listed "back" as the part of the body injured in the work accident.

On December 20, 2016, the day following her alleged accident, Petitioner reported to Dr. Newlin with right hip, back, and neck complaints from her fall. She did not mention a right hand or thumb injury. Petitioner returned to Dr. Newlin on December 28, 2016. The note indicates Petitioner complained of neck and back pain. Not until her January 26, 2017 appointment, over a month after her accident, did she report to Dr. Newlin constant thumb pain since the fall. Dr. Newlin ordered x-rays of Petitioner's right hand; results were negative, except for some degenerative changes.

Petitioner consulted with PA-C Gregoire in Dr. Wottawa's Springfield Clinic office on April 12, 2017 on referral from Dr. Newlin. She complained of locking and catching in her right thumb and reiterated that she had suffered constant pain in her thumb since her work-related slip and fall in December. The doctor's assistant noted that Petitioner was unable to explain to him the mechanism of the fall. Petitioner recalled only that she had fallen on her right side and that her thumb pain was 10 on a scale of 1-10. PA-C Gregoire ordered physical therapy and anti-inflammatories.

Petitioner returned to Dr. Wottawa's office on June 8, 2017. PA-C Purves performed the exam and offered Petitioner a steroid injection, which she declined. He noted that Petitioner's thumb condition might or might not be causally related to her fall. Dr. Wottawa performed a trigger thumb release on June 29, 2017.

Petitioner testified at hearing that she had noted pain in her back and hip and felt a "pop" in her right thumb immediately at the time of her fall. However, she also testified that she did not notice anything about her thumb at first and that it had not begun to hurt or swell until a week and a half after her fall.

At hearing, Respondent disputed that Petitioner had suffered a compensable work accident but stipulated that Petitioner's low back injury was caused by her fall. Respondent denied that Petitioner's trigger thumb was causally related and maintains this denial on appeal.

The Arbitrator found that Petitioner's fall arose out of and in the course of her employment with Respondent and that she suffered injuries to both her low back and right thumb. Petitioner was awarded reasonable and necessary medical services and 3% loss of use of the body as a whole for Petitioner's low back injury. The Arbitrator declined to award any permanency for Petitioner's right thumb complaints, concluding that "whatever problems Petitioner may have had with her right thumb are resolved without PPD." Arb. Dec., p. 6.

20 IWCC0002

Petitioner bears the burden to prove by a preponderance of credible evidence all the elements of her workers' compensation claim. *Martin v. Industrial Comm'n*, 91 Ill.2d 288, 294 (1982). This includes proof of a causal connection between the work accident and Petitioner's alleged injury.

In this case, Petitioner has not presented credible evidence that her right thumb condition was causally related to her work accident. She testified that she immediately heard a "pop" in her right thumb. She later testified that she noticed nothing about her thumb for a week and a half after her fall. She did not report her alleged thumb injury to her supervisor, nor does "thumb" appear on any accident report or on her Application for Adjustment of Claim. Not until over a month had passed since her accident did she complain to Dr. Newlin of right thumb pain, which she said had been constant since the accident.

In light of the totality of the record, the Commission finds that Petitioner failed to prove that her right trigger thumb was causally related to her work accident on December 19, 2016. The Commission therefore reverses the Decision of the Arbitrator as it pertains to Petitioner's right thumb injury and treatment and otherwise affirms and adopts the Arbitrator's Decision.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator, finding that Petitioner proved that she suffered an accident on December 19, 2016 that arose out of and in the course of her employment and that her lower back injury is causally related to that accident, is hereby affirmed with the above change.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to Petitioner the reasonable and necessary medical bills related to the care and treatment of her lower back injury, as provided in Sections 8(a) and 8.2 of the Act, and subject to any credit pursuant to Section 8(j).

IT IS FURTHER ORDERED BY THE COMMISSION that payment for medical bills related to the care and treatment of Petitioner's right thumb injury is denied.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is ordered to pay Petitioner the sum of $755.37 per week for a total period of 15 weeks, as provided in Section 8(d)2 of the Act, for the reason that the injuries sustained caused a 3% loss of use of Petitioner's body as a whole.

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

20IWCC0002

Pursuant to §19(f)(1) of the Act, claims against the State of Illinois are not subject to judicial review. Therefore, no appeal bond is set in this case.

DATED: JAN 3 - 2020

Marc Parker

Barbara N. Flores

Deborah L. Simpson

o-11/07/19
mp/dak
68

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SMITH, KELLEY
Employee/Petitioner

Case# **17WC000531**

IL DEPT OF CORRECTIONS
Employer/Respondent

20IWCC0002

On 4/2/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.89% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1727 LAW OFFICES OF MARK N LEE LTD
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SPRINGFIELD, IL 62704

0502 STATE EMPLOYEES RETIREMENT
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1350 CENTRAL MANAGEMENT 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 2 - 2018

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

20IWCC0002

STATE OF ILLINOIS)
)SS.
COUNTY OF Sangamon)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Kelley Smith
Employee/Petitioner

v.

IL Dept of Corrections
Employer/Respondent

Case # 2017 WC 000531

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 **Springfield**, on **December 20, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **December 19, 2016**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**70,980**; the average weekly wage was $**1,365.00**.

On the date of accident, Petitioner was **52** 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.

ORDER

Based on the above, the Arbitrator concludes Petitioner sustained 3% loss of use of Man, 15 weeks at a rate of $755.37 as a whole under §8(e)12 of the Act.

Respondent shall pay reasonable and necessary medical services, as provided in Sections 8(a) and 8.2 of the Act and per the stipulation of the parties, subject to any credit pursuant to Section 8(j).

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

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

3/29/18
Date

APR 2 - 2018

Findings of Fact

Petitioner Kelley Smith is a current State of Illinois employee who works for the Illinois Department of Public Health Division of Long Term Care/Quality Assurance. On December 19, 2016, she was still employed with the State of Illinois but worked for the Department of Corrections at that time. In both positions she primarily worked in the office and duties were clerical in nature.

On December 19, 2016, the Petitioner testified she asked for permission to go to her car and Petitioner suffered a slip and fall on the ice in the parking lot at her correctional facility as she was entering her vehicle. Petitioner testified that her car was parked in an employee handicap spot and she fell getting into the vehicle. Petitioner testified she had sought and was granted permission to go to her vehicle from her supervisor.

Petitioner testified that when she fell she only noted pain in her back and hip but she also felt a pop in her right thumb. The report filled out by Deborah Shannon, Petitioner's supervisor, indicated that the Petitioner hurt her back and right hip with no mention of a wrist injury. There was also a narrative completed that confirmed that Petitioner was given permission by a Denise Jones to go to Petitioner's vehicle. Petitioner also filled out an injury report that was consistent with her testimony and the other reports submitted at the time of trial but her report at the time also did not note that Petitioner suffered a right thumb injury.

On December 20, 2016, Petitioner reported to a Dr. Newlin with complaints to her right hip, back, and neck. During the exam, Petitioner described that her feet slipped and onto her buttocks. The impression at that time was neck and worsening lumbar. Petitioner was given a light duty work slip.

Petitioner's second exam was on December 28, 2016, she complained of lower back pain due to her fall, she was referred to physical therapy for whiplash.

Petitioner attended physical therapy at Decatur Memorial Hospital on January 6, 2017.

Petitioner returned to Dr. Newlin on January 26, 2017, with new complaints of right thumb pain, and complained that it occurred on December 19, 2016 injury.

When Petitioner returned to Dr. Newlin on February 17, 2017, she requested a referral for her thumb. Petitioner still had back complaints and was to continue therapy for her lower back.

The final time Petitioner saw Dr. Newlin was on March 6, 2017. Petitioner testified that she returned to work soon after this point full duty and then switched positions at the State of Illinois.

Petitioner underwent an MRI on her lower back and pelvis on March 19, 2017, due to low back pain. No acute findings were found on Petitioner's pelvis.

Petitioner testified that she underwent two injections and could have a third for her lower back but that she had not scheduled it as of the date of trial.

The records reflect that Petitioner had her first right SI joint injection on April 20, 2017, and her second on August 3, 2017. Petitioner continued to work full duty regarding her back since her release. Petitioner continues to have some minor problems with her lower back, including some ache due to overuse and long periods of sitting at her desk.

Petitioner was referred to Springfield Clinic with Dr. Wottowa's office for her right thumb injury. Petitioner was initially seen on April 12, 2017. It was noted that Petitioner suffered a fall in middle of the last December on to her right side but did not tell him the exact mechanism of the fall. It was noted that Petitioner evaded serious bony injury to her right hand Petitioner was to undergo therapy and follow up in 6-8 weeks.

Petitioner returned to Dr. Wottowa's office on June 8, 2017. A David Purves was the attending medical examiner at that time who explained that her injury may not be related at all. It was decided that Petitioner undergo a right trigger thumb release with Dr. Chris Wottowa.

Petitioner saw Dr. Wottowa for the first time on June 26, 2017. Petitioner declined injection in her thumb but wanted to proceed with surgery, which Dr. Wottowa ordered at that time. The operation was performed on June 29, 2017, on Petitioner's right thumb.

Petitioner followed up with Dr. Wottowa on July 12, 2017, and was released on an as needed basis with good results at that time regarding her thumb injury.

Petitioner testified that her right thumb is in good condition and she had a good result from the surgery.

Conclusions of Law

In regard to disputed issues (C), the Arbitrator makes the following conclusions of law:

The Arbitrator concludes that Petitioner did suffer an injury that both arose out of and in the course of his employment. This is based upon the following reasoning:

Respondent disputed accident on this claim and for Petitioner to prove accident that must prove that the injury in question both arose out of and in the course of her employment with Respondent. Petitioner's un-rebutted testimony established both issues.

Per Material Service Corp., Division of General Dynamics v. Industrial Commission, 53 Ill. 2d 429, 292 N.E.2d 367 (1973). When an employer acquiesced to activities by the Petitioner the injury, even if personal in nature, with Respondent's permission can be compensable. In the above cited claim the injured employee went out to warm up her car, with permission of her employer and her vehicle slid into a body of water and she died as a result. The court ruled that due to the permission of the employer her activity, though personal in nature, was in the course of her employment. The Arbitrator finds the facts similar to the claim in question with the Petitioner asking for permission which was granted by her supervisor for her to attend her vehicle in the employer controlled parking lot.

The Arbitrator also notes that the Petitioner suffered a fall at an employee designated parking spot, in an employer controlled parking lot and a fall due to ice. None of this was disputed at the time of trial. Petitioner fell due to a hazard, ice, on the employer's premise, in a zone designated for employees. These factors made her injury also arise out of her employment.

In regard to disputed issues (F), the Arbitrator makes the following conclusions of law:

Respondent stipulated that Petitioner's low back injury was caused by her employment at the time of trial so no findings regarding that injury will be made.

The Arbitrator concludes that Petitioner's right thumb current condition is related to her 12/19/2016 injury. This is based upon the following reasoning.

Petitioner testified that she did not initially notice that her right thumb was injured when she fell but the mechanism described was falling backwards and on to her right side. It was noted by the Arbitrator that Petitioner fell on her right side as noted in the initial medical records and Petitioner's hand injury was also to her right thumb. It is persuasive that due to Petitioner's back complaints she would not notice her thumb injury.

In regard to disputed issues (L), the Arbitrator makes the following conclusions of law:

The Arbitrator takes note of Section 8.1(b) which sets forth the criteria for determining permanent partial disability.

1) The parties did not submit an impairment rating. The Arbitrator gives this no weight.

2) Petitioner is an office worker for the Respondent. Throughout her injury Petitioner continued to work full duty and light duty. However, the Petitioner testified that she had difficult with long periods of sitting which was required of her employment; the arbitrator affords this some weight in favor of the Petitioner.

3) The employee was 52 years old at the time of his injury. Petitioner has a long career and many more years of employment ahead of her, the Arbitrator gives this less weight in favor of the Petitioner.

4) This injury did not affect the employee's future earning capacity. The arbitrator gives this some weight in favor of the Respondent.

5) The Petitioner's ongoing subjective complaints were corroborated in the medical records. Petitioner is still having on-going pain regarding her lower back and may require a third injection for manage her back complaints. The Arbitrator gives this greater weight in favor of the Petitioner.

Based on the above, the Arbitrator concludes Petitioner sustained 3% loss of use of Man as a whole under §8(e)12 of the Act. Furthermore, the Arbitrator finds whatever problems Petitioner may have had with her right thumb are resolved without PPD.

In alternative even if the Arbitrator rules against Petitioner in regards to her right thumb injury Respondent should still be found liable for Petitioner's back injury due to the findings regarding accident and their stipulation to her low back injury.

Edward Lee, Arbitrator

3/29/18
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

Chris Kaloudis,
Petitioner,

vs. No. 17 WC 28481

20IWCC0003

Cook County Sheriff's Office,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, 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 July 27, 2018, is hereby affirmed and adopted.

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

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

20IWCC0003

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.

There is no bond for the removal of this cause to the Circuit Court by Respondent pursuant to §19(f)2 of the 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: JAN 3 - 2020

Marc Parker

Deborah L. Simpson

Barbara N. Flores

mp-wj
o-12/19/19
68

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

KALOUDIS, CHRIS
Employee/Petitioner

Case# **17WC028481**

COOK COUNTY SHERIFF'S OFFICE
Employer/Respondent

20IWCC0003

On 7/27/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.14% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0139 CORNFIELD & FELDMAN LLP
JIM M VAINIKOS
25 E WASHINGTON ST SUITE 1400
CHICAGO, IL 60602

0132 COOK COUNTY STATE'S ATTORNEY
CYNTHIA ASHFORD-HOLLIS
500 RICHARD J DALEY CTR 5TH FL
CHICAGO, IL 60602

20IWCC0003

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) & 8(A)

CHRIS KALOUDIS
Employee/Petitioner

v.

COOK COUNTY SHERIFF'S OFFICE
Employer/Respondent

Case # **17** WC **28481**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Kurt Carlson**, Arbitrator of the Commission, in the city of **Chicago**, on **June 14, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] Is Petitioner entitled to any prospective medical care?
L. [ ] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [ ] TTD
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [x] Other **Prospective cervical fusion surgery at C6-C7.**

FINDINGS

On the date of accident, **August 28, 2017**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$72,999.68**; the average weekly wage was **$1,396.40**.

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

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

Respondent shall be given a credit of **$17,687.68** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$17,687.68**.

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

ORDER

Medical benefits
Respondent shall pay reasonable and necessary medical services of **$23,027.22**, as provided in Sections 8(a) and 8.2 of the Act.

Prospective Medical benefits
Respondent shall pay reasonable and necessary medical services for the prescribed anterior cervical discectomy and fusion at C6-7 per Dr. Shapiro.

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

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

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

Signature of Arbitrator

07-26-18
Date

ICArbDec19(b)

JUL 27 2018

STATEMENT OF FACTS

On August 28, 2017, Petitioner was employed by the Respondent as a Deputy Sheriff at the Skokie Courthouse. He has been employed by the Respondent for the last 18 years. His work shift is from 8:00am to 4:00pm. His work duties include transporting inmates around the courthouse. On the date of the accident, Petitioner was transporting three inmates from the courtroom to the male lockup. On the way to the lockup, Petitioner's duties required that he feed the inmates in the lunch room. The lunch room was a square room measuring 10'x 10'. Petitioner testified that he had the 3 inmates lined up against the wall of the lunch room. On another wall, the lunch was on a table. The sandwiches were in a plastic bag placed on a Styrofoam plate. As Petitioner was picking up one of the plates to hand to the inmates, he had his back to the inmates. At that point one of the inmates stepped away from the wall and approached the Petitioner as he was turning back towards them. That inmate used his fist to strike Petitioner in his left chin in an upper-cut swing motion. The Petitioner credibly testified that he was struck with such force that his neck snapped back, he felt pain immediately in his neck and head, and spit a portion of a tooth out of his mouth. Petitioner's knees buckled but he did not fall to the floor. The inmate took another swing at Petitioner but Petitioner was able to block the punch. Other officers entered the room to stop the inmate. Petitioner was taken by ambulance to the emergency room complaining of an extreme headache.

On August 28, 2017, Petitioner was treated at Northshore Medical Group emergency room. The intake records indicate that Petitioner was bleeding from the mouth and had jaw and dental pain. The records also show that Petitioner had neck pain. The CT of the neck taken that day showed that Petitioner's neck fusion was solid at C4-5 and C5-6. Petitioner had testified that he had a previous neck surgery in 2016. The previous CT performed on May 14, 2016 showed a solid fusion also.

On August 31, 2017, Petitioner treated with his primary care physician, Dr. Zofakis. The history of the assault at work was consistent in the medical records. Petitioner had increased pain from the neck. The records indicate Petitioner was complaining of stiffness in the neck and numbness in both hands. He was diagnosed with cervical radiculopathy. He was prescribed Naproxen, time off from work, and referred to the spinal specialist, Dr. Gary Shapiro. Dr. Shapiro was the surgeon that performed Petitioner's neck fusion in 2016.

On September 13, 2017, Petitioner saw Dr. Shapiro. The medical records clearly points out that Petitioner had not seen Dr. Shapiro since July 13, 2016 over 14 months prior to the accident in question. Dr. Shapiro's records indicate that Petitioner's symptoms are suggestive of a C7 distribution. Dr. Shapiro kept Petitioner off work. Dr. Shapiro reviewed the CT of August 28, 2017 and determined that there was a solid fusion at C4-6. Dr. Shapiro further explains that there appeared to be a small central calcified disc herniation at C6-7. Dr. Shapiro prescribed Medrol Dosepak and Norco. He mentioned that if his symptoms do not improve, then he would prescribe a MRI.

On September 14, 2017, Petitioner treated with the dentist, Dr. Trambas. He repaired the 2 fractured teeth.

On September 20, 2017, Petitioner started physical therapy at Athletico.

On September 27, 2017, Petitioner was seen by the IME, Dr. Butler. He diagnosed Petitioner with acute strain of the neck muscle and cervical radicular pain. Dr. Butler opined that there was a causal connection between the current complaints and the assault that occurred on August 28, 2017. He kept Petitioner off work and ordered a MRI.

On October 4, 2017, Dr. Shapiro saw Petitioner and documented Petitioner's continuing complaints of headaches, neck pain, and left arm pain with weakness.

On October 30, 2017, Petitioner had the C-spine MRI performed. The radiologist impression is "Central disc protrusion/spur formation C6-7".

On November 7, 2017, Dr. Shapiro met with Petitioner and reviewed the MRI film. Dr. Shapiro's assessment confirmed a central disc herniation at C6-7 with continued headaches, neck pain, and bilateral arm pain. Dr. Shapiro prescribed a cervical discectomy with fusion at C6-7. He continued to keep Petitioner off work.

On November 22, 2017, Dr. Butler, the IME, reviewed the same MRI without examining the Petitioner. Dr. Butler opined that the MRI showed that Petitioner merely strained his neck. Dr. Butler disagreed with Dr. Shapiro as to protrusion/herniation and the need for a fusion. He returned Petitioner to work full duty and released him from care at MMI.

On May 14, 2018, Dr. Shapiro wrote a letter of Medical Necessity. He explained that Petitioner had been doing very well since the first fusion in 2016 and was released to full duty at MMI on July 13, 2016. Dr. Shapiro had a detailed understanding of the new assault that occurred on August 28, 2017. He explained the immediate onset of neck pain, jaw pain, and right arm pain. He once again confirmed that there was an objective finding of a central disc herniation in the MRI of October 30, 2017. He stated that the mechanism of injury is consistent with the herniation seen at C6-7. The disc herniation was either rendered symptomatic or caused by the work related injury. He continued to prescribe a fusion at C6-7.

Petitioner testified that he was paid temporary total disability benefits while off work from August 29, 2017 through January 8, 2018. He testified that he while he has been waiting for the surgery to be approved he continues to have headaches and pain in the left arm. He testified that he has not had any subsequent injuries to his neck since the assault.

CONCLUSIONS OF LAW

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

The Arbitrator finds that Petitioner had an injury arising out of and in the course of employment and that the injury caused the need for surgery prescribed by Dr. Shapiro. The Arbitrator finds that Petitioner's testimony was credible as to the assault that occurred on August 28, 2017. There was no contrary opinion from the Respondent concerning the assault. All the histories in the medical records were consistent with the history given by the Petitioner.

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

The Arbitrator finds that the medical opinion of Dr. Shapiro is more persuasive and factually correct. The Arbitrator notes that Dr. Shapiro was Petitioner's treating surgeon from a previous fusion. Dr. Shapiro knew Petitioner's history and was able to show that the previous fusion was solid and that Petitioner had no medical visits for over 14 months before the new assault at work on August 28, 2017. Dr. Shapiro also confirmed the assessment of the radiologist that the MRI showed a herniation/protrusion at a new level of C6-7. Dr. Shapiro provided conservative care for Petitioner which did not alleviate the symptoms, and, in fact, the symptoms have become worse. While it may be true that the MRI findings were like a pre-accident MRI on May 15, 2015 and the doctor discussed future surgery at that level at that time. It also appears from the record that the accident, more likely than not, accelerated the need for the fusion surgery at C6-C7 and as a result, the claim is compensable under the Act.

The Arbitrator fully recognizes that it would be better if a physician had opined the acceleration theory, but the accident speaks for itself.

The Arbitrator finds that Dr. Butler's opinion is less compelling than Dr. Shapiro's assessment.

"J" (Were 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, having found in Petitioner's favor for accident and causation, finds that Respondent is liable for the medical bills incurred per the fee schedule and 8.2.

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

The Arbitrator, having found in Petitioner's favor for accident and causation, also finds that Respondent is liable for the neck fusion surgery prescribed by Dr. Shapiro including related follow up care.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Gary J. Rizza,
Petitioner,

vs. No. 16 WC 07757

20IWCC0004

Monterrey Security Consultants,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 24, 2018, is hereby affirmed and adopted.

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

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

Document Control

20IWCC0004

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 removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $ 47,000.00. 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: JAN 3 - 2020

Marc Parker

Deborah L. Simpson

Barbara N. Flores

mp-wj
o-12/19/19
68

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

RIZZA, GARY J
Employee/Petitioner

Case# **16WC007757**

20IWCC0004

MONTERREY SECURITY CONSULTANTS INC
Employer/Respondent

On 7/24/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.14% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5238 COLLISON LAW OFFICES
ANTONIO JEFFREY
134 N LASALLE ST SUITE 1200
CHICAGO, IL 60602

2623 LITCHFIELD CAVO LLP
MICHAEL P LATZ
303 W MADISON ST SUITE 300
CHICAGO, IL 60606

20IWCC0004

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)

GARY J. RIZZA
Employee/Petitioner

v.

MONTERREY SECURITY CONSULTANTS, INC.
Employer/Respondent

Case # **16 WC 07757**

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 **Brian T. Cronin**, Arbitrator of the Commission, in the city of Chicago, on **1/23/18** and **1/26/18**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ 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/Modified Duty ☐ Maintenance ☒ TTD
M. ☒ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☒ Other: Does Respondent have the right to obtain a second Section 12 examination?

FINDINGS

On the date of accident, **10/11/15**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$60,053.76**; the average weekly wage was **$1,154.88**.

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

Respondent ***has not*** provided all reasonable and necessary medical services to Petitioner.

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

Respondent is entitled to a credit in the amount of **$1,416.38** for other benefits paid, pursuant to *Messamore v. Indus. Comm'n*, 706 N.E.2d 44 (4th Dist. 1999).

ORDER

Respondent shall pay Petitioner's temporary total disability benefits of **$769.92**/week for **29** weeks, commencing **7/5/17** through **1/23/18**, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner an amount equal to the unpaid medical bills for the reasonable, necessary and related medical care rendered to him: **$948.00**, from Ingalls Memorial Hospital for dates of service 10/11/15 through 11/6/15; **$5,163.03** from Dr. Harvey/Riverside Medical Center for dates of service 11/23/15 through 12/14/17; and **$383.21** as a reimbursement for out-of-pocket payment of prescription medications. All of the above charges are to be made pursuant to Section 8(a) and subject to Section 8.2 of the Act.

Respondent shall authorize and pay for the revision surgery that Dr. Harvey has recommended, pursuant to Section 8(a) and subject to Section 8.2 of the Act.

Respondent shall pay Petitioner **$11,163.84** in penalties, as provided in Section 19(k).

Respondent shall pay Petitioner **$6,090.00** in penalties, as provided in Section 19(l).

Respondent shall pay Petitioner **$2,232.77** in attorney's fees, as provided in Section 16.

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

7-22-2018
Date

ICArbDec19(b)

JUL 24 2018

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

GARY J. RIZZA, PETITIONER,	)	
v.	)	No. 16 WC 007757
MONTERREY SECURITY CONSULTANTS, INC., RESPONDENT.	)	20IWCC0004

FINDINGS OF FACT

Petitioner's Testimony:

Petitioner, Gary Rizza, testified that on 10/11/15, while in the course and scope of his employment, he injured his right ring finger and lower back while apprehending a shoplifter. He broke the finger and experienced back pain and sciatica in both legs.

Petitioner sought treatment for his right ring finger and lower back that day at Ingalls Memorial Hospital. He was given an injection and prescribed an MRI. The doctor also referred him to Dr. Miz for his low back and Dr. Labana for his right hand. He had the MRI at Open MRI in Homer Glen. He was taken off work.

When he presented to Dr. Labana, his right hand was very sore. His right ring finger was still purple and swollen. A splint was applied to the finger. He later underwent occupational therapy and was released from care.

When he presented to Dr. Miz, he reported that his back pain was severe and that he could not sit or stand for very long. Dr. Miz told him that he could not return to work until he completed a course of physical therapy. Petitioner was in excruciating pain.

In November 2015, a friend referred him to Dr. Hasan. Dr. Hasan sent Petitioner to Physical Therapy & Sports Injury Rehabilitation for treatment. Over the course of three months, Dr. Hasan administered three injections to his back. Each injection helped for a little while, but the pain came back. Then, Dr. Hasan referred him to Dr. Harvey.

When he presented to Dr. Charles Harvey, he told him that the pain was in his lower back on both sides, but the back pain and the sciatica was much more dominant on the left side. Dr. Harvey examined him. He told Dr. Harvey that he did not receive lasting pain relief from the injections, and Dr. Harvey told him that he felt surgery would be the only step that would provide him with some type of permanent relief.

On July 18, 2016, he saw Dr. Jesse Butler for a second opinion. He told Dr. Butler about the problems with his mainly left-sided lower back pain and about how his sciatica was never ending. Dr. Butler reviewed the MRI, and also recommended surgery.

Petitioner further testified that after this injury - - sometime about the end of 2015 - - he has experienced heart palpitations. Dr. Harvey told him that high blood pressure was a concern of his and that he would like Petitioner to see a cardiologist before the surgery. Petitioner takes medication for his blood pressure.

On May 11, 2016, which was approximately one month after Dr. Harvey suggested surgery, Respondent arranged for Petitioner to be examined by their IME physician, Dr. Citow. From the time he walked into Dr. Citow's office until the time he left, five minutes or less had passed. During the examination, Dr. Citow did not touch him. Dr. Citow wrote a report, about which Petitioner learned two months later. It is Petitioner's understanding that Dr. Citow's opinions were not consistent with those of Dr. Harvey, Dr. Hasan, and Dr. Butler.

On October 12, 2016, Dr. Harvey performed surgery on Petitioner. Such surgery consisted of a lumbar laminectomy and discectomy at L4-L5. After the incision healed, Dr. Harvey prescribed a course of physical therapy. Dr. Harvey ordered an MRI, which was done on December 30, 2016. Dr. Harvey continued to keep Petitioner off work. After Dr. Harvey reviewed the MRI, he suggested that Petitioner undergo another surgery on the right side in order to provide some type of permanent relief.

Petitioner also attempted to do work hardening, which Dr. Hasan had recommended. As the work hardening progressed and more weights were added, Petitioner could no longer do it. The pain got to be too much.

On April 3, 2017, at the request of Respondent, Petitioner presented to Dr. Singh. Based on Petitioner's knowledge, Dr. Singh agreed that Petitioner injured himself on October 11, 2015. So, Dr. Harvey had made a recommendation for a revision surgery, and both Dr. Hasan and Dr. Singh agreed with such recommendation. Dr. Singh gave Petitioner a light-duty status.

On July 10, 2017, Petitioner testified, he was finally able to get another injection approved, which Dr. Hasan had recommended. The injection provided only temporary relief on the right side.

Petitioner testified that he wants the surgery that Dr. Hasan, Dr. Harvey and Dr. Singh have recommended.

The first time Respondent contacted Petitioner about light-duty work was in June 2017. They requested that Petitioner go to a teen center on July 10th, which Petitioner did not do because he was at Riverside Medical Center getting the fourth injection to his back. Petitioner testified that he notified this off-duty site, or Respondent, that he would not be appearing on July 10, 2017. Specifically, he notified three different people to let them know he would not be appearing that day: the Workbox representative, who put this modified-duty job together, the nurse, who is affiliated with the insurance company, and the representative of the teen center. He told the three of them on July 7th that he would be glad to go there on the following Monday. Amanda, a representative of Workbox, left a voice mail message for Petitioner on the 17th of July. Amanda was one of the three individuals he contacted regarding work at this modified-duty job.

In September 2017, Petitioner was notified of a second off-duty job site. This one was at the Salvation Army in Blue Island. Petitioner went there and met the people from there but did not actually do any work there. He did not begin working there because he was not able to do what they wanted. They wanted him to work in the kitchen, but the lady there made the determination that Petitioner could not do that work.

On November 20, 2017, there was an off-duty job offer from Vitas Hospice Care. Petitioner started working there on November 20, 2017, continues to work there, but has not been paid for the work he has done there.

TTD benefits were terminated on July 5, 2017, and he has not received any TTD benefits since that time.

Petitioner recalled that he may have outstanding medical bills as a result of this injury. There is an outstanding bill from Central Illinois Radiological Associates in the amount of $478.00. He also has a bill from University Pathologists with a balance of $89.70, on the next page, a balance of $11.50, and on the third page a balance of $23.00. Then, there is a $65.00 balance from Physical Therapy and Sports Injury Rehabilitation.

Petitioner then testified as to pharmacy bills that he paid out-of-pocket, all of which he claimed were related to work injury of October 11, 2015.

On cross-examination, Petitioner testified that he was seeing Dr. Patel for his high blood pressure. Also, Dr. Balthazor prescribed hydrocodone and lorazepam. Dr. Hasan also prescribed hydrocodone for pain. He had also prescribed hydrocodone for Petitioner earlier that year. Petitioner testified that he submitted these prescriptions to the employer's insurance company; he

was told by Walgreen's that his prescriptions were denied. Petitioner list of prescription bills that he is presenting are just those that he paid for out-of-pocket. Petitioner underwent another MRI and x-rays in December 2017; a doctor from Dr. Harvey's office ordered these tests. Petitioner thought that new MRI showed three bulging discs on the right side instead of two. That was a change in circumstance. Petitioner saw Dr. Hasan on September 18, 2017. At that point, Dr. Hasan prescribed another epidural steroid injection.

Petitioner testified that there was a point after the revision laminectomy surgery was recommended that he did not want to have it.

Prior to the accident, Petitioner was never diagnosed with a degenerative disease or degenerative condition of the lumbar spine. Prior to the accident, he "sort of" experienced symptoms of pain in his lumbar spine. He would experience soreness if he did spring clean-up of the house where he went out and did all the work himself or if he was painting. The soreness would result if he was doing something that he would not normally do. So, he never had treatment for his lumbar spine until the accident.

On July 10, 2017, he received the fourth epidural steroid injection at Riverside Medical Center. He received pain relief for a week to a week and a half. Dr. Hasan has prescribed a fifth injection.

Dr. Singh examined him in March or April of 2017. Dr. Singh was with him for over a half hour. First, they talked, and then he examined Petitioner.

When Dr. Citow examined him on May 11, 2016, he did not ask Petitioner to ambulate, did not conduct range of motion exercises - - he did not conduct an examination of Petitioner with his hands at all.

Some money from Monterrey Security was deposited directly into his account in the last week or so, but he has no idea of the purpose of this money.

To the best of Petitioner's knowledge, the surgery that Dr. Harvey performed on him has been paid according to the fee schedule. Petitioner further testified that the first, second, third and fourth injections have not been paid for. Some things, however, have been paid for. Petitioner assumes that some money has been paid for the injections, but he has not seen the schedule that the attorneys are talking about.

The amounts of the unpaid bills that he is claiming are listed on the petition that Petitioner's Counsel filed today. He has been treating at Riverside Medical Center since 2015.

He testified on direct that about 15 years ago, he filed a workers' compensation claim against Joe Rizza Ford, but did not file another claim against Terry's Lincoln Mercury.

Petitioner would agree with Respondent's Counsel that temporary total disability benefits were paid by the employer from the time of the injury to July 5, 2017.

Petitioner testified that his doctor at Riverside Medical Center stated that he is totally incapacitated. Petitioner does not know if the doctor made such statement on November 9, 2017 because he has not seen the doctor's note. Most recently, he saw his doctor at Riverside Medical Center in December 2017, and at that time the doctor said to him that he is totally incapacitated.

On redirect examination, Petitioner testified that Dr. Balthazor is a physician's assistant who works with Dr. Harvey. To reiterate, Petitioner testified that that the prescriptions that are included in Exhibit L are all for the October 11, 2015 incident.

Petitioner testified that the reason that he did not want to have the revision surgery at one point was that the insurance company wasn't giving him any help. So, he testified, if they are not paying his benefits at the time, and he goes under the knife, and he's off work another year without help from them, and now he has a big bill, he is not doing himself any favor. After they discussed that he was not ready to get that surgery, they discussed additional injections as an alternative.

Dr. Harvey did tell him that he was totally incapacitated, but to Petitioner's knowledge, neither Dr. Harvey nor Dr. Hasan has completed treatment. He does not have any permanent restrictions.

Monterrey Security is his employer. The amount of money that was deposited in his account was $1,416.38. Since his benefits were terminated on or about July 4, 2017, the only money he has received from Respondent other than this 1400 and some odd cents was a check he received for one penny.

On recross examination, Petitioner testified that he recalls receiving and reviewing Dr. Singh's IME report, but he did not recall when. Petitioner's testimony was that he did not have the revision surgery because he was not getting any help from his employer anymore. His testimony is also that he received TTD until July 5, 2017.

Summary of Medical Treatment:

On the date of accident, 10/11/15, Petitioner presented to Ingalls Memorial Hospital. (T. 28; P. Ex. "A") He reported he was at work and caught someone and now has pain in his right hand, 4th digit, and lower back. (P. Ex. "A", p. 7) X-rays of the lumbar spine and right fourth finger were taken. X-ray of the fourth finger revealed a comminuted nondisplaced fracture of the fourth distal phalanx; the lumbar report revealed mild disc space narrowing at L2-3, L3-4 and L5-S1 and mild spondylosis. (P. Ex. "A", p. 23-26).

On 10/13/15, Petitioner was diagnosed with non-displaced fracture of distal phalanx of the right ring finger, pain, lumbar spine, and other spondylosis with radiculopathy, lumbar region. He was referred to ortho/hand for the fracture. An MRI of the lumbar spine was ordered and it was recommended that he apply ice. He was also prescribed Hydrocodone and Cyclobenzaprine, and taken off work. He was scheduled to follow-up in one week. (P. Ex. "A", p. 40-56)

Per the referral, Petitioner presented to Premier Orthopaedic & Hand Center, Dr. Neal Labana, where he was treated for his finger fracture (including splint, therapy, and home exercise) until being released on 12/29/15. (P. Ex. "C") During treatment of his hand, he was released to work with restrictions of no use of the affected extremity until his full-duty release on 12/29/15.

Petitioner followed-up on 10/16/15, at which time he complained of throbbing pain in the right ring finger and lower back, with radiating pain. He was kept off work and recommended continued use of his cane. (P. Ex. "A", p. 57-67) The MRI of the lumbar spine was performed at Homer Glen Open MRI & Imaging on 10/21/15. The MRI revealed multilevel spondylosis, disc bulges causing neural foraminal stenosis, disc bulges at L2-L5 causing impingement of the exiting nerve roots, mild central canal stenosis at L2-5. (P. Ex. "B")

On 11/6/15, Petitioner returned to Ingalls Memorial Hospital with complaints of severe back pain. He was referred to Dr. George Miz at Bone and Joint Physicians. He ultimately saw Dr. Miz on 11/3/15, at which time he complained of low back pain after the work-related injury. Since the date of the accident, he experienced pain and numbness that radiates down his legs. After performing a physical examination and reviewing Petitioner's lumbar MRI, Dr. Miz determined Petitioner has lumbar radiculopathy related to his disk herniation and recommended initial treatment with physical therapy, noting other options such as injections and surgical decompression depending on the progress. Petitioner was to stay off work until he finished the recommended physical therapy. (T. 37; P. Ex. "D") At the recommendation and referral of Dr. Miz, Petitioner presented to Physical Therapy & Sports Injury Rehabilitation, LLC on 11/12/15, where he continued therapy until 2/11/16.

However, on 11/18/15, Petitioner presented to Dr. Ashraf Hasan at Oak Orthopedics for a second opinion. Dr. Hasan agreed with Dr. Miz's diagnosis. Petitioner was scheduled for left L4 and left L5 transforaminal ESI. Petitioner was to continue physical therapy. (P. Ex. "F") The injection was performed on 11/23/15 at Riverside Medical Center (P. Ex. "G"; T. 41) The pain

improved but returned as severe as ever. (T. 41) He had another injection on 12/9/15, with the same results. (P. Ex. "G" & "F"; T. 42) A third injection was performed on 1/11/16. Again, there was initial relief, then the pain returned. (P. Ex. "G" & "F"; T. 42) Ultimately, on 3/9/16, after recommending work hardening and a few additional visits without improvement, Dr. Hasan referred Petitioner for a neurosurgical evaluation. (P. Ex. "F"; T. 43)

At the referral of Dr. Hasan, and on 4/5/16, Petitioner presented to Dr. Charles Harvey at Riverside Medical Center, at which time he was diagnosed with lumbar disc herniation. Dr. Harvey recommended an MRI of the lumbar spine and prescribed medications. He opined surgery was likely a left L4-5 laminectomy and microdiscectomy. Petitioner was to follow up after the MRI (P. Ex. "G") On 4/21/16, the MRI of the lumbar spine revealed moderate-sized disk herniation at L4-5 resulting in moderate to severe left lateral recess narrowing, and moderate to severe central canal narrowing. (P. Ex. "O")

On 4/20/16, Respondent had Petitioner evaluated by Dr. Jonathan Citow, pursuant to Section 12 of the Act, who rendered a report dated 5/11/16. Dr. Citow recommended obtaining the lumbar MRI before giving opinions on diagnosis, further treatment, and MMI. (R. Ex. "A")

On 5/5/16, Dr. Harvey recommended lumbar laminectomy and discectomy L4-5 left with medial facetectomy and foraminotomy. (P. Ex. "G")

On 7/6/16, Dr. Citow prepared an Addendum, wherein he recommended an ESI, opining if Petitioner remains symptomatic after that, a left-sided L4-5 microdiscectomy can be considered. He released Petitioner to return to work without restrictions and opined MMI would be one month post-injection. (R. Ex. "B")

On 7/18/16, Petitioner presented to Dr. Jesse Butler at Spine Consultants, LLC for a second opinion regarding Dr. Harvey's recommendation for surgery. (T. 44) Dr. Butler examined Petitioner and diagnosed him with lumbar disc herniation with radiculopathy and stenosis. (P. Ex. "I") He recommended a lumbar laminectomy at the L4 level with discectomy on the left at L4-5. (P. Ex. "I")

Therefore, on 10/12/16, Dr. Harvey performed a lumbar laminectomy and discectomy, L4-5 left, with medial facetectomy and foraminotomy. (P. Ex. "G", p. 364; T. 51) Petitioner continued to present for post-operative, follow-up visits, with complaints of weakness, numbness and tingling in both legs. On 11/22/16, he was recommended for physical therapy for lumbar strengthening and range of motion exercises. He was kept off work as well. (P. Ex. "G")

On 12/15/16, a new MRI of the lumbar spine was ordered to rule out recurrent disc herniation. Physical therapy was put on hold until MR images were taken and results reviewed. Again, Petitioner was kept off work. (P. Ex. "G") On 12/30/16, it was determined Petitioner did not have a recurrent disc herniation but does have scar tissue at the site of his left L4-5 laminectomy as well as stenosis bilaterally at L3-4 and L4-5 that could be contributing to his symptoms. Prior

to considering additional surgical intervention, he was referred to interventional pain management to try injections. He was kept off work. (P. Ex. "G" & "O")

On 1/12/17, Petitioner returned with imaging for further evaluation of the back and leg pain. He was referred to pain management and ordered to follow up after injections. On 3/22/17, Petitioner complained of heart palpitations. He did not have a history of these problems prior to the subject work incident. He was recommended for testing. (P. Ex. "G")

On 4/3/17, Respondent had Petitioner evaluated by Section 12 physician, Dr. Kern Singh. Dr. Singh opined Petitioner's condition of ill-being is residual L3-4 and L4-5 spinal stenosis; that as a result of the 10/11/15 incident, Petitioner sustained an L4-5 disk herniation as well as an aggravation of an underlying stenosis at L3-4 and L4-5; that there is a causal relationship between the mechanism of injury as described by Petitioner and the condition of ill-being; that the treatment provided to Petitioner has been medically necessary and reasonable; that Petitioner is not at MMI; and that he recommends a revision L3-4 and L4-5 laminectomy. (P. Ex. "P", p. 6-7) Dr. Singh also opined Petitioner's residual stenosis is currently symptomatic, which necessitates the surgery. (P. Ex. "P", p. 6, under "Causality and Apportionment")

On 6/28/17, Petitioner returned to Dr. Hasan, with continued complaints of pain. Dr. Hasan recommended another lumbar injection and that he continue with work restrictions per Dr. Harvey. (P. Ex. "F") On 7/10/17, Petitioner underwent another lumbar injection. (P. Ex. "O")

On 7/31/17, Petitioner reported some initial relief, but the pain returned in the same distribution as previously. Dr. Hasan recommended that he be re-enrolled in the directed physical therapy and to continue restrictions per Dr. Harvey. (P. Ex. "F")

On 11/9/17, Petitioner returned to Dr. Harvey for further evaluation of ongoing low back and leg pain. His low back pain was radiating to his right leg worse than the left leg. A second injection was recommended prior to consideration of the revision surgery. Another MRI and dynamic study was ordered for surgery planning for the possible lumbar decompression surgery. Petitioner was kept off work. (P. Ex. "G")

On 12/9/17, MRI revealed multilevel spondylosis superimposed upon a developmentally mildly shallow spinal canal. There is moderately severe spinal canal stenosis at L3-4. Stable postsurgical changes left hemilaminectomy and microdiscectomy at L4-5.

On 12/11/17, an echocardiogram was performed, which showed normal LV size and function; no significant valvular pathology was noted. (P. Ex. "O")

To date, Petitioner continues to see Dr. Harvey, who continues to recommend the revision surgery. (P. Ex. "G")

CONCLUSIONS OF LAW

In support of his decision with regard to issue (F) "Is Petitioner's current condition of ill-being causally related to the injury?", the Arbitrator finds as follows:

The Arbitrator finds that Petitioner is credible.

The Arbitrator finds, by a preponderance of the evidence, that Petitioner has proven that his current condition of ill-being of his lumbar spine is causally related to the injury. The parties have stipulated to the accident. Moreover, the treating physician and Respondent's Section 12 Examiner agree that his current condition of ill-being of his lumbar spine is causally connected to Petitioner's 10/11/15 work injury. Treating physician, Dr. Charles Harvey, opined Petitioner's condition is "secondary to a work related injury." Dr. Harvey even added that Respondent's IME physician, Dr. Kern Singh, "agreed that [Petitioner] sustained a work-related injury that caused his left L4-5 disc herniation as well as exacerbated his underlying spondylosis and stenosis at L3-4 and L4-5;" that Dr. Singh "agreed that [Petitioner] was not yet at MMI and continued to require additional treatment." (P. Ex. "G", office visit, 11/9/17). Thus, in his April 3, 2017 report, Dr. Singh (Respondent's Section 12/IME physician) opined Petitioner's condition of ill-being is residual L3-4 and L4-5 spinal stenosis; that as a result of the 10/11/15 incident, Petitioner sustained an L4-5 disk herniation as well as an aggravation of an underlying stenosis at L3-4 and L4-5; that there is a causal relationship between the mechanism of injury as described by the Petitioner and the condition of ill-being; that the treatment provided to Petitioner has been medically necessary and reasonable; that Petitioner is not at MMI; and that he recommends a revision L3-4 and L4-5 laminectomy. (P. Ex. "P", p. 6-7) Dr. Singh also opined Petitioner's residual stenosis is currently symptomatic, which necessitates the surgery. (P. Ex. "P", p. 6 *under* "Causality and Apportionment") Further, the Arbitrator notes that Dr. Hasan's treatment and recommendations have been consistent with those of Dr. Harvey and Dr. Singh. Additionally, there is no evidence that Petitioner received treatment for any back complaints or problems prior to his work-related injury of 10/11/15. (T. 26-27)

In support of his decision with regard 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:

The Arbitrator finds Petitioner has proven, by a preponderance of the evidence, that the medical treatment rendered to him for injuries that resulted from the accident of 10/11/15 was reasonable, necessary, and causally related to such accident. Therefore, the Arbitrator finds that Respondent is liable for payment for such treatment, including reimbursement to Petitioner of out-of-pocket prescription costs. Petitioner's testimony and the treating records support the

Arbitrator's finding. Even Respondent's Section 12/IME physician, Dr. Kern Singh, stated that all of Petitioner's treatment has been reasonable and necessary. (P. Ex. "P")

Specifically, Respondent shall pay $948.00 for the reasonable and necessary medical services rendered to Petitioner by Ingalls Memorial Hospital for dates of service 10/11/15 through 11/6/15 (P. Ex. "A"); shall pay $5,163.03 for the reasonable and necessary medical services rendered to Petitioner by Dr. Harvey/Riverside Medical Center for dates of service 11/23/15 through 12/14/17 (P. Exhibits "G" & "O"); and shall reimburse Petitioner $383.21 for the out-of-pocket prescription costs that he paid (P. Ex. "L"). From the total prescription charges claimed of $719.93, the Arbitrator has deducted charges for Metoprolol as this medication is used to treat high blood pressure and is unrelated to the accident. He also deducts the $112.68 charge for DOS 6/16/16, the $35.39 charge for DOS 12/5/16, and the $59.39 charge for DOS 1/28/17, because he does not know what all these medications are. All of the above charges are to be made pursuant to Section 8(a) and subject to Section 8.2 of the Act.

In support of his decision with regard to issue (K) "Is Petitioner entitled to any prospective medical care?", the Arbitrator finds as follows:

The Arbitrator finds that Petitioner has proven by the preponderance of evidence that he is entitled to prospective medical care and, which consists of a revision surgery that has not only been recommended by Petitioner's treating physician, Dr. Harvey, but has been recommended by Respondent's Section 12 Examiner, Dr. Singh. Furthermore, Dr. Hasan's treatment and opinions have been consistent with the recommended surgery.

Respondent argues that at one point, Petitioner indicated that he did not want the revision surgery and discussed the possibility of additional injections. Petitioner testified that it is true, at one point he did not want the revision surgery. He explained that the reason he did not want to have the revision surgery was that the insurance company wasn't giving him any help. So, he testified, if they are not paying his benefits at the time, and he goes under the knife, and he's off work another year without help from them, and now he has a big bill, he is not doing himself any favors. So, after he discussed with his doctor that he was not ready to have that surgery, they discussed additional injections as an alternative.

Petitioner clearly testified at trial that he wants to proceed with the surgery. (T. 69)

Petitioner has had ongoing symptoms and treatment recommendations, including a revision surgery, as a result of his 10/11/15 accident.

Section 8(a) of the Act states that, subject to Section 8.2, the employer shall provide "all the necessary first aid, medical and surgical services, and all necessary medical, surgical and

hospital services thereafter incurred, limited, however, to that which is reasonably required to cure or relieve from the effects of the accidental injury ..."

Petitioner's treating physicians and Respondent's IME physician all agree that another surgery is reasonable and necessary. Dr. Singh recommended a revision L3-4 and L4-5 laminectomy. (P. Ex. "P"). Dr. Harvey agreed (P. Ex. "G", office visit, 11/9/17). Therefore, the Arbitrator finds that the prescribed revision surgery is clearly within the scope of Section 8(a), and orders Respondent to authorize and pay for such surgery, subject to Section 8.2 of the Act.

In support of his decision with regard to issue (K) "What temporary benefits are in dispute? TTD and TPD/Modified Duty", the Arbitrator finds as follows:

Arbitrator's Exhibit 1 indicates that Petitioner claims that he was temporarily totally disabled from 7/5/17 through 11/19/17, and that Petitioner seeks payment for modified-duty work from 11/20/17 through 1/23/18.

The Arbitrator finds Petitioner has proven by a preponderance of evidence that he is entitled to TTD from 7/5/17 through the date of the hearing, 1/23/18. There are two periods of temporary total disability that are before the Arbitrator:

TTD from 7/5/17 through 11/19/17: Petitioner's TTD benefits were terminated on 7/5/17. During this period, Petitioner cooperated with Respondent with regard to their modified-duty job program. (T. 70-88). As requested, Petitioner reported to the Salvation Army where it was unilaterally determined by that facilities manager that they "did not feel comfortable bringing on Mr. Rizza to do volunteer time in our kitchen." (P. Ex. "Q", bottom p. 2). He was also turned away from the Bridge Teen Center. The representative from that facility stated, "the Bridge Teen Center cannot accommodate Mr. Rizza based on restrictions." (P. Ex. "Q", bottom p. 20) Finally, Petitioner was allowed to start a modified job position at VITAS Healthcare of Chicagoland South on 11/20/17, where he has continued to work light duty without pay (as of the date of the trial before the Arbitrator). Petitioner is entitled to TTD benefits for the entire first period, 7/5/17 through 11/19/17, which is 19-5/7 weeks.

TPD/Modified Duty from 11/20/17 through 1/23/18: There is no dispute as to Petitioner's entitlement to benefits during this period. At the direction of Respondent, Petitioner worked at VITAS Healthcare of Chicagoland South for over two months (at the time of the trial before the Arbitrator), complying with the modified-duty work, without being paid. This is supported by Petitioner's testimony and documentary evidence. (*See* T. 87-89; P. Ex. "Q", p. 21-27) Besides, Respondent provided no evidence at trial, live or otherwise, to dispute Petitioner's entitlement to payment for modified-duty work, as provided under the Act. In fact, in its response to Petitioner's 19(b) Petition, filed on 12/19/17, Respondent clearly states, "Respondent is not disputing an obligation to pay TPD for the modified duty work. Respondent has or will issue a check for the

modified-duty work." (P. Ex. "N", p. 2, ¶2) TTD, as opposed to TPD, is appropriate in that Petitioner was never paid anything for the modified-duty work. Thus, Petitioner is entitled to TTD benefits for the entire second period, 11/20/17 through 1/23/18, which is 9-2/7 weeks.

Therefore, the Arbitrator finds Petitioner is entitled to TTD benefits from 7/5/17 through 1/23/18, which is 29 weeks.

In support of his decision with regard to issue (M) "Should penalties or fees be imposed upon Respondent?", the Arbitrator finds as follows:

After the accident but prior to July 5, 2017, Respondent paid Petitioner TTD benefits for which Respondent claims a credit. (AX 1, Section 9) Such credit is to be applied to the pre-July 5, 2017 periods of TTD paid, which are not in dispute.

Inexplicably, effective 7/5/17, Respondent terminated TTD benefits to Petitioner despite the fact that no doctor or other medical professional had released him to return to full-duty work. Dr. Harvey and Dr. Hasan have limited Petitioner to performing light-duty work.

In the 4/3/17 report of Dr. Singh, Respondent's Section 12/IME physician, he states: "I do believe he is capable of returning to work at light duty as delineated above." (P. Ex. "P")

Prior to 7/5/17, Dr. Harvey, Dr. Hasan, and Dr. Singh have all recommended revision surgery for Petitioner's lumbar spine, which Petitioner wishes to undergo. (T. 69)

The Arbitrator finds that Petitioner made a good faith effort to participate in the modified-duty work that Respondent requested during a period of time that Petitioner was temporarily totally disabled. (T. 70-88)

After hearing Petitioner's uncontested testimony and after reviewing the evidence, the Arbitrator finds that it was through no fault of Petitioner that he failed to begin working the modified-duty assignments prior to working at VITAS Healthcare.

Petitioner testified that Respondent first requested that he perform light-duty work in June 2017.

Petitioner's unrebutted testimony was also that Respondent requested that he report to a teen center for modified-duty work on 7/10/17, that Petitioner was unable to meet at the teen center on that day, and that he notified three people on 7/7/17, including the nurse case manager, the contact at the teen center, and Amanda of Workbox, that he was unable to do so because he would be receiving an epidural steroid injection on 7/10/17. He testified that he offered to report to the teen center the following Monday, and that on 7/17/17, Amanda left a voice mail message for him.

It appears that that Respondent requested that he report to Bridge Teen Center a second time, on Monday, 10/16/17 at 2:45 p.m. It was determined that the Bridge Teen Center could not accommodate Petitioner's restrictions. (P. Ex. "Q")

Petitioner's Exhibit Q includes three letters from Monterrey Security to Petitioner with regard to the Modified Duty Off-Site (MDOS) Program. Petitioner testified that he received these letters. The Arbitrator admitted this exhibit over Respondent's objection. Each letter is an admission by a party opponent and a statement against interest. (P. Ex. "Q").

Petitioner testified that he reported to the Salvation Army, but it was unilaterally determined by that facilities case manager that they "did not feel comfortable bringing on Mr. Rizza to do volunteer time in our kitchen." (P. Ex. "Q"). Respondent failed to submit any evidence to the contrary.

Finally, at the direction of Respondent, Petitioner was allowed to start working a modified-duty job at VITAS Healthcare of Chicagoland South on 11/20/17 and continued to work there through 1/23/18. However, Respondent has not paid Petitioner for his work there, despite Respondent's statements in the 11/1/17 letter to Petitioner. (T. 87-89; P. Ex. "Q")

Respondent provided no evidence at trial, live or otherwise, to dispute Petitioner's entitlement to payment for modified-duty work, as provided under the Act. In fact, in their response to Petitioner's 19(b) Petition, filed on 12/19/17, Respondent clearly states: "Respondent is not disputing an obligation to pay TPD for the modified-duty work. Respondent has or will issue a check for the modified duty work." (P. Ex. "N", p. 2, ¶2) However, as of the first date of trial before the Arbitrator, 1/23/18, and over a month after Respondent's representation that it is not disputing an obligation to pay, and more than two months since Petitioner started the modified-duty assignment, Respondent had yet to pay Petitioner the benefits to which he is entitled under the Act.

Petitioner did testify on 1/23/18 that some money from Monterrey Security was deposited directly into his account in the last week or so, but he had no idea of the purpose of this money. Petitioner further testified that Monterrey Security is his employer, and that the exact amount of money deposited in his account was $1,416.38. Respondent is entitled to a credit in this amount.

Notwithstanding the deposit by Respondent of $1,416.38 into Petitioner's account a week before trial, the Arbitrator finds that Petitioner is entitled to penalties under Sections 19(l) and 19(k) of the Act for the period 7/5/17 through 1/23/18 (29 weeks), and is also entitled to attorney's fees under Section 16 of the Act.

Given Respondent's unreasonable and vexatious delay in issuing benefits to Petitioner to which he is entitled, the Arbitrator awards the following 19(k) penalties that are equal to 50% of the TTD due and owing: $769.92 x 29 x .50 = $11,163.84.

Then, pursuant to the non-discretionary Section 19(l) "late" penalties, the Arbitrator awards an amount equal to 203 days (which are the number of days in 29 weeks) x $30.00/day = $6,090.00.

Next, pursuant to Section 16, the Arbitrator awards attorney's fees in the amount of $11,163.84 x .20 = $2,232.77.

Therefore, the Arbitrator awards Petitioner total penalties and fees of $19,486.61.

In support of his decision with regard to issue (O) "Does Respondent have the right to obtain a second Section 12 examination?", the Arbitrator finds as follows:

The Arbitrator denies Respondent's request for a second independent medical examination with Dr. Kern Singh. The Arbitrator's denial of Respondent's request comes after Respondent exercised its right to a Section 12 examination as provided in the Act (P. Ex. "P") and after the Arbitrator conducted a pre-trial on the issue. (T. 11)

Respondent argued that they are entitled to a second examination with their IME physician, Dr. Singh, because Petitioner's condition had changed. (T. 9-17) Further, Respondent argues that when Petitioner is "seeking additional medical treatment and benefits that Respondent has a statutory right to obtain a Section 12 examination." (T. 10-11) However, nine and a half months before the trial, Respondent *did* obtain its Section 12 examination, as is their right under the Act, at which time Dr. Singh examined Petitioner and prescribed revision surgery. In fact, it is on the basis of that Section 12 physician's opinion, along with the treating physician's recommendations, that Petitioner requests his statutory right to medical treatment, including the revision surgery. Dr. Singh's based his recommendation for revision surgery in part on the fact that Petitioner "has residual stenosis at L3 to L5 that is currently symptomatic and requires a formal lumbar decompression." (P. Ex. "P", p. 6, *under* "Causality and Apportionment")

As to a change in his condition, Petitioner, on cross-examination, "interpreted" the 12/9/17 MRI of the lumbar spine as showing three disc bulges to the right as compared with two bulges, which he previously had.

The radiologist's impression of the 12/9/17 MR images is the following:

1. No acute abnormality demonstrated. No significant interval change.
2. Multilevel spondylosis superimposed upon a developmentally mildly shallow spinal canal. There is moderately severe spinal canal stenosis at L3-4.
3. Stable post-surgical changes left hemilaminectomy and microdiscectomy at L4-5. (P.Ex. "O", p. 369)

On 12/9/17, before Petitioner underwent the MRI, he completed a form entitled "Riverside MRI Patient Safety Information Form." In such form, Petitioner described his symptoms as follows: "BACK EXTREAM PAIN AND EXTREAM SCIATICA PAIN IN MY RIGHT LEG. INJURY DATE 10/11/2015." (P. Ex. "O", p. 378)

After a careful review of the records and Petitioner's testimony, the Arbitrator notes that Petitioner's condition has not changed since Dr. Singh examined him.

The Arbitrator further finds that Petitioner credibly explained his reasons for considering, at one point, not to proceed with the revision surgery.

The fact of the matter is that the records indicate Petitioner is in extreme pain, Dr. Singh has recommended the revision surgery, Dr. Harvey continues to recommend it, Dr. Hasan's recommendations are consistent with those of Dr. Harvey, Petitioner testified that he wishes to undergo such surgery, and the Arbitrator finds that this surgery comports with treatment contemplated by Section 8(a) since it is "reasonably required to cure or relieve [him] from the effects of the accidental injury."

The Arbitrator denies Respondent's request for a second Section 12/IME evaluation by Dr. Singh. To allow the same would cause unnecessary and undue delay.

Brian T. Cronin

Arbitrator

7-22-18

Date

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Martha Endres,
Petitioner,

vs. No: 12 WC 12947

20IWCC0005

State of Illinois,
Illinois River 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, temporary total disability, permanent partial disability, and medical expenses and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 16, 2018 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.

20IWCC0005

Pursuant to §19(f)(1) of the Act, claims against the State of Illinois are not subject to judicial review. Therefore, no appeal bond is set in this case.

DATED: JAN 3 - 2020

Marc Parker

Barbara N. Flores

Deborah L. Simpson

mp-wj
o-12/19/19
68

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ENDRES, MARTHA Case# **12WC012947**
Employee/Petitioner

ST OF IL-ILLINOIS RIVER C C 20IWCC0005
Employer/Respondent

On 5/16/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.03% 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:

5354 STEPHEN P KELLY
ATTORNEY AT LAW
2710 N KNOXVILLE AVE
PEORIA, IL 61604

0502 STATE EMPLOYEES RETIREMENT
2101 S VETERANS PARKWAY
PO BOX 19255
SPRINGFIELD, IL 62794-9208

6140 ASSISTANT ATTORNEY GENERAL
JOSEPH L MOORE
500 S SECOND ST
SPRINGFIELD, IL 62706

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

1350 CENTRAL MANAGEMENT SERVICES
BUREAU OF RISK MANAGEMENT
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

MAY 16 2018

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

20 IWCC0005

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

MARTHA ENDRES
Employee/Petitioner

v.

STATE OF ILLINOIS – ILLINOIS RIVER CC
Employer/Respondent

Case # **12** WC **012947**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Douglas McCarthy**, Arbitrator of the Commission, in the city of **PEORIA**, on **04/13/2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ 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 **01/25/2010**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident ***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 $**54,855.84**; the average weekly wage was $**1,054.92**.

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 $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 $N/A under Section 8(j) of the Act.

ORDER

Petitioner has failed to meet her burden of proving by a preponderance of the evidence that she sustained an accidental injury which arose out of and in the course of her employment and thus shall be barred from recovery. Claim denied.

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

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

D. Dylan McCarty

Signature of Arbitrator

5/11/2018
Date

MAY 16 2018

STATE OF ILLINOIS)
) SS
COUNTY OF PEORIA)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

MARTHA ENDRES,
Employee/Petitioner,

20IWCC0005

v.

Case No. 12 WC 012947

STATE OF ILLINOIS – ILLINOIS RIVER CC,
Employer/Respondent.

STATEMENT OF FACTS

Petitioner testified she was employed by the State of Illinois at the Illinois River Correctional Center. The Petitioner was a correctional officer. Petitioner worked for the State of Illinois for approximately 22 years at the time of her alleged work place injury. Petitioner has alleged bilateral carpal and cubital tunnel syndrome caused by repetitive trauma.

Petitioner's primary care physician Dr. Ben Phillips referred the Petitioner to Dr. Yibing Li for an EMG. Dr. Li performed an EMG on January 25, 2010, with a result of mild right carpal tunnel, no left carpal tunnel and no cubital tunnel. Petitioner presented to Dr. Jeffery Garst on September 21, 2010, with complaints of bilateral hand pain and numbness. (PX2) Another EMG was performed, this time by Dr. Xuan Truong on October 22, 2010, which showed severe right carpal tunnel syndrome, moderate left carpal tunnel syndrome and bilateral cubital tunnel syndrome. (PX4). Dr. Garst diagnosed bilateral carpal and cubital tunnel on October 20, 2010, and recommended surgery. (PX2).

Petitioner underwent a left carpal tunnel release and left ulnar nerve transposition performed by Dr. Garst on November 24, 2010. Petitioner underwent a right carpal tunnel release and right ulnar nerve transposition by Dr. Garst on February 3, 2011. (PX2). Petitioner continued her medical treatment with a successful course of treatment in physical therapy. (PX5). Petitioner's treatment concluded with her final visit with Dr. Garst on August 1, 2011. (PX2).

Petitioner underwent an independent medical exam with Dr. James Williams on September 5, 2012. Dr. Williams' impression was Petitioner was status post bilateral carpal and cubital tunnel syndrome and found the treatment provided by Dr. Garst to be reasonable and appropriate. (RX2). Dr. Williams was of the opinion that turning keys, pulling doors, writing, and pushing buttons was neither causative of and/or aggravating to the condition of bilateral carpal and/or tunnel syndrome. (RX2).

CONCLUSIONS OF LAW

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

In order to obtain compensation under the Act, a claimant bears the burden of showing, by a preponderance of the evidence, that he/she was suffered a disabling injury which arose out of and in the course of the employment. *Sisbro, Inc. v. industrial Comm'n,* 797 N.E.2d 665, 671 (2003

In repetitive trauma claims, a claimant must show that "a work-related accidental injury aggravated or accelerated the preexisting [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 Hosptial v. Workers' Compensation Commission*, 371 Ill.App.3d 882 (5th Dist. 2007). Each of those factors is variable and highly dependent on the work being performed. In other words, repetitive trauma claims the accident a work activity, which when performed at a specific frequency and intensity over certain duration carries the potential of causing, and in fact causes the injury in question. In repetitive trauma claims medical testimony is incredibly important regarding the issue of causation because inquiry focuses on whether Petitioner's work activities were, over a period of time, sufficient to cause or aggravate the pre-existing deteriorated condition of ill-being. *See Nunn v. Illinois Industrial Commission,* 157 Ill.App.3d 470 (4th Dist. 1987).

In this case, Petitioner testified regarding her job duties. Petitioner testified that no particular job duty caused her symptoms to be worse. Petitioner could not say that using keys as opposed to using a wand at a metal detector made her condition or pain worse. Petitioner did not know how often she had to use keys during a work day, but Petitioner did state it would vary depending on her assignment. Petitioner testified that she was right hand dominant and testified to the limited job duties requiring use of her left hand and/or arm. Petitioner testified she used her left hand/arm to open doors, answer the telephone, and to use a key toggle on her belt. Petitioner testified that on the date of trial her left hand was in worse condition than her right hand.

Petitioner's treating doctor, Dr. Jeffrey Garst, gave a causation opinion in his testimony. However neither his medical records nor his testimony gave any detailed reasons for his opinion. On cross examination Dr. Garst testified he believed turning keys was the primary job activity performed by Petitioner that led to his causation opinion. (PX2, pages 37-41). However, Dr. Garst, neither in his records nor in his testimony, gave any information about how often Petitioner did any of her job activities and did not know how often, how long, or when Petitioner had to use any type of keys at the facility.

Dr. James Williams completed an independent medical exam of Petitioner on September 5, 2012. Petitioner was post treatment for bilateral carpal and cubital tunnel syndrome. Dr. Williams' medical opinion was that Petitioner's job duties did not cause or aggravate Petitioner's medical condition. Dr. Williams believed Petitioner's hypertension, post-menopausal status,

increased BMI, the 1.5 packs of cigarettes a day, her psoriasis, was more causative of her condition of ill-being. Dr. Williams specifically pointed out the psoriasis as it is systemic as opposed to osteoarthritis which only affects one particular joint. Dr. Williams has toured the facility the Petitioner worked at and is familiar with the keys, including Floger Adams keys, and doors employees have to use at the facility. Dr. Williams explained that Petitioner's activities of opening and closing doors are activities which are intermittent and are not sustained or require significant force. Dr. Williams during his independent medical exam took a detailed job description from the Petitioner. Dr. Williams and Petitioner's doctor, Dr. Jeffrey Garst, differ on their causation opinions. In this case, Dr. Williams had a better understanding of Petitioner's job duties due to his more detailed inquiry of Petitioner's job duties and his familiarity with the facility in question, and so, Dr. Williams' opinion is given greater weight than Dr. Garst's opinion on causation.

The Arbitrator adopts Dr. Williams' opinion finding no causation, and further finds the bilateral nature of Petitioner's injuries show Petitioner's risk factors, as opposed to Petitioner's job duties, were the cause of Petitioner's condition of ill-being. Based on the record as a whole, the Arbitrator finds Petitioner has failed to meet her burden of proving by a preponderance of the evidence that she sustained an accidental injury which arose out of and in the course of her employment. The claim is denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF WILLIAMSON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

VERA RESTIVO, as Representative of
JOHN RESTIVO,

Petitioner,

vs.

NO: 15 WC 13605

MACH MINING, LLC,

Respondent.

20IWCC0006

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 exposure under the Act, disease covered by the Act, accident, last date of exposure, causal connection, nature and extent, legal and evidentiary errors, and issues pertaining to Sections 1(d) to 1(f) of the Occupational Diseases Act, and being advised of the facts and applicable law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission specially writes to emphasize that it has subject matter jurisdiction over this matter. John Restivo died on May 10, 2018 while his claim was pending. Vera Restivo, as John Restivo's widow and an eligible payee under the Act, substituted in this claim at the time of arbitration. The Commission finds Mrs. Restivo's actions proper and sufficient; nothing further and nothing more was required by Mrs. Restivo to act as a party in this claim. The process and procedure before the Commission shall be as simple and summary as reasonably may be. *820 ILCS 305/16.*

In the event of an injured employee's death, the Illinois Workers' Compensation Act provides as follows:

> In a case of specific loss and the subsequent death of such injured employee from other causes than such injury leaving a widow,

> widower, or dependents surviving before payment or payment in full for such injury, then the amount due for such injury is payable to the widow or widower and, if there be no widow or widower, then to such dependents, in the proportion which such dependency bears to total dependency. *820 ILCS 305/8(e)19.*

The Special Concurrence/Dissent in this case argues that we have no jurisdiction until an estate is opened and a personal representative is named by the Court. We disagree. The Act, our Rules, and case law do not require legitimate beneficiaries or dependents of deceased employees, as defined by the Act, to undertake formal probate or other circuit court proceedings before their claim or claims may be heard and considered by this Commission. This requirement would not only undermine the purpose of the Act, but could potentially open a precarious path wherein beneficiaries not recognized by the Act but recognized through probate and other circuit court proceedings may be in a position to obtain awarded compensation. Further, a contrary position would permit additional litigation and delay of benefits due to a legitimate individual or taker. This is not what the Act intended.

The Commission also notes that various sections of the Act allow rights and benefits to flow to an employee or his or her beneficiaries or dependents after death without the requirement of formal probate or other circuit court proceedings. The Act repeatedly underscores this by indicating "an employee or his dependents. . ." *See, e.g., 820 ILCS 305, Sections 1(b)3, 4(d), 5(a), 6(c), 8(a), 8(h), 9, 12, 16(a), and 19(l).* In fact, Section 5(a) of the Act makes a point to separate the entities who may be eligible for compensation under the Act and lists them as follows: employee, any individual wholly or partially dependent upon the employee, the legal representatives of the employee's estate, "or any one otherwise entitled to recover damages for such injury." *820 ILCS 305/5(a).* Beneficiaries and dependents of deceased employees may act on the deceased employee's claim and request compensation under the Act, separate and apart from a legal representative of the employee's estate. *See also 820 ILCS 305/19(j).*

The Special Concurrence/Dissent relies upon two recent Appellate Court opinions as support for her position. We believe both cases are distinguishable.

For example, in *Bell v. Ill. Workers' Comp. Comm'n*, 2015 IL App (4th) 140028WC, the petitioner's attorney named the estate of the deceased injured claimant and properly had the claimant's sister appointed as the administrator. The claimant's sister was not eligible to simply substitute in because she did not qualify as a dependent under the Act. The Court clearly explained the difference in that case where there was no spouse or eligible dependents as defined in our Act. This is not applicable to the case at bar where Mrs. Restivo was the Petitioner's widow, an eligible payee under the Act. In referencing Sections 8(e)(19) and 8(h) of the Act, the Court said "By their plain terms, these provisions merely establish *to whom benefits will be paid* if the employee dies with a spouse or dependents before he has been fully compensated for his work-related injury. They do not limit the ability of a deceased employee's estate to collect accrued, unpaid benefits that were due and owing to the employee when he was alive. *Neither provision addresses what happens when an employee dies without leaving a surviving spouse or any other surviving dependents, as in this case.*" 2015 IL App (4th) 140028WC, ¶ 19 (emphasis added).

20 IWCC0006

In a slightly different case of *Ill. State Treasurer v. Estate of Kormany*, the Appellate Court held that it had no jurisdiction because the petitioner's attorney named the estate of the deceased injured claimant, but unlike *Bell*, there was no personal representative or administrator appointed. 2019 IL App (1st) 180644WC, ¶ 2. Hence, the Court had no jurisdiction until that happened. *Kormany* is distinguishable from the case at bar as there is no evidence that Kormany, the deceased claimant, died with a spouse or dependent as defined by the Act. Again, this scenario does not exist in the instant case.

Thus, although the Commission affirms the Arbitrator's denial of this claim, the Commission finds that it had jurisdiction over this matter. Vera Restivo, as John Restivo's widow and an eligible payee under the Act, was properly substituted in this claim and allowed to continue proceedings in his stead.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 16, 2018, 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.

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 the Circuit Court.

DATED: JAN 3 - 2020

O: 11/6/19
043

D. Douglas McCarthy

Stephen J. Mathis

DISSENT

I respectfully dissent. Unlike the majority, I believe there exists case law directly on point (*Illinois State Treasurer, as ex-officio Custodian of the Injured Workers' Benefit Fund v. Estate of Gyula Kormany, A-Tech Stucco EIFS Company*, 2019 IL App (1st) 180644WC) which compels the Commission to vacate the decision of the arbitrator until such time as a representative of the Estate of John Restivo is properly appointed and substituted. The majority, in arriving at its decision, attempts to distinguish the Court's holding in *Estate of Kormany* in order to find that the need to appoint a legal representative runs counter to the law and the purpose of the Act. To be

20IWCC0006 20IWCC0006

clear, the Commission is an administrative body. As such, it is tasked with applying the law as written by the legislature and subsequently interpreted by the higher courts whether it should agree or not. I believe the Court's holding is clear and should be applied.

In *Illinois State Treasurer, as ex-officio Custodian of the Injured Workers' Benefit Fund v. Estate of Gyula Kormany, A-Tech Stucco EIFS Company*, 2019 IL App (1st) 180644WC, claimant, Gyula Kormany, filed an Application for Adjustment of Claim alleging he sustained certain injuries while employed by A-Tech Stucco EIFS Company. Prior to the arbitration hearing, claimant died of causes unrelated to his claimed work injuries. The Application was amended to substitute the Estate of Kormany. A decision was issued by the arbitrator which was affirmed by the Commission awarding benefits to the Estate of Kormany.

The Appellate Court vacated the Commission's decision finding that until such time as a properly appointed representative of the Estate of Kormany could be substituted as the petitioner, the Commission's jurisdiction was suspended. *Estate of Kormany* at ¶ 2. The Court in rendering its decision relied upon *Washington v. Caseyville Health Care Association*, 284 Ill. App. 3d 97, 100, 672, N.E.2d 34 (1996), which holds "It is axiomatic that for every suit, there must always be a plaintiff, a defendant, and a court. *Mitchell v. King, 187 Ill. 452, 55 N.E. 637 (1899)*. An attorney's employment and his authority is revoked by the death of his client, so an attorney cannot proceed where he does not represent a plaintiff or a defendant. *Mitchell, 187 Ill. 452, 55 N.E. 637*." Once a claimant dies of unrelated causes, a legal representative must be appointed in order to continue the prosecution of the claim for the benefits to which the claimant was entitled prior to his death.

"The commission is an administrative body created by legislative enactment for the purpose of administering the Workmen's Compensation act. It is not a court and has no inherent powers of a court. It is a non-judicial body. It can only make such orders as are within the powers granted to it by the General Assembly, quoting *Trigg v. Industrial Commission*, 364 Ill. 581." *Michelson v. Industrial Commission*, 375 Ill. 462, 466-7, 31 N.E.2d 940 (1941). The Commission does not possess the authority to appoint a legal representative of a deceased claimant whose death is unrelated to his claim for compensation benefits. Certainly, once such representative is properly appointed and substituted, the estate may prosecute the claim and benefits may be awarded as delineated by Sections 8(e)19 and (h) of the Act. As the majority correctly notes, "In referencing Sections 8(e)(19) and 8(h) of the Act, the Court [in *Bell v. Illinois Workers' Compensation Commission*, 2015 IL App (4th) 140028WC, ¶ 19] said "By their plain terms, these provisions merely establish *to whom benefits will be paid* if the employee dies with a spouse or dependents before he has been fully compensated for his work-related injury." *Supra*, ¶ 7.

The majority mistakenly frames the issue in terms of subject matter jurisdiction, but as the Supreme Court of Illinois noted in *Mitchell v. King*, 187 Ill. 452, 458-9, 55 N.E. 637 (1900), "the court acquired jurisdiction of him and of the subject matter, but at his death had not acquired jurisdiction of defendant." The Commission unquestionably maintains subject matter jurisdiction under the Act over Mr. Restivo's claim for benefits via his Estate; the Commission's jurisdiction is temporarily suspended pending the appointment of the legal representative.

More importantly, the majority in noting "that various sections of the Act allow rights and benefits to flow to an employee or his or her beneficiaries or dependents after death without the requirement of formal probate or other circuit court proceedings" fails to appreciate that the Act creates two separate causes of action. As the Supreme Court of Illinois noted in *Board of Education v. Industrial Commission*, 57 Ill. 2d 307, 312, 312 N.E.2d 227 (1974), "Two causes of action are created by Section 8 of the Workmen's Compensation Act (Ill. Rev. Stat. 1969, ch. 48, par. 138.8) – one in favor of the employee for nonfatal injuries and another in favor of his dependents for fatal injuries. [citation omitted]." The Act specifically allows for a separate cause of action in favor of a deceased claimant's dependents to prosecute *their* claim for benefits where a claimant's work-related injury results in his death. As the Act creates a separate cause of action, the Commission merely recognizes the same, and as the majority notes "no formal probate or circuit court proceedings" are necessary; unlike a claimant's cause of action which abates upon his death until such time a representative is appointed and substituted for a claimant's estate. The Act contains no provision for the Commission to make such appointment/substitution.

As such, pursuant to the Court's holding in *Estate of Kormany*, I would vacate the decision of the arbitrator until such time as a representative of the Estate of John Restivo is properly appointed and substituted.

In arriving at my decision, I rely heavily on *Illinois State Treasurer, as ex-officio Custodian of the Injured Workers' Benefit Fund v. Estate of Gyula Kormany, A-Tech Stucco EIFS Company*, 2019 IL App (1st) 180644WC. This opinion was issued on March 29, 2019 and posted to the Appellate Court site on June 5, 2019 as a NRel. Since this posting, the Appellate Court has issued its mandate which has been transmitted to the circuit court and the Commission.

"A withdrawn opinion has no precedential value, since it does not express the views of the court. [citation omitted]." *Nationwide Bank & Office Management v. Industrial Commission*, 361 Ill. App. 3d 207, 210, 836 N.E.2d 120 (2005). As such, if the Appellate Court withdraws its opinion, I concur with the majority's decision to affirm and adopt the decision of the arbitrator in its entirety.

L. Elizabeth Coppoletti

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

RESTIVO, VERA AS REPRESENTATIVE OF RESTIVO, JOHN
Employee/Petitioner

Case# **15WC013605**

MACH MINING LLC
Employer/Respondent

20IWCC0006

On 11/16/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.46% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0755 CULLEY & WISSORE
KIRK CAPONI
300 SMALL ST SUITE 3
HARRISBURG, IL 62946

1662 CRAIG & CRAIG LLC
KENNETH F WERTS
115 N 7TH ST PO BOX 1545
MT VERNON, IL 62864

STATE OF ILLINOIS)
)SS.
COUNTY OF Williamson)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

VERA RESTIVO as Representative of JOHN RESTIVO
Employee/Petitioner

v.

MACH MINING, LLC
Employer/Respondent

Case # 15WC 013605

Consolidated cases: N/A

20IWCC0006

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Herrin**, on **September 20, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☐ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☐ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☐ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☒ Other **Sections 1(d)-(f) of the Occupational Diseases Act**

FINDINGS

On **December 19, 2014**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, John Restivo ***did not*** sustain an accident or occupational disease that arose out of and in the course of employment.

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

John Restivo's current condition of ill-being ***is not*** causally related to the accident or exposure.

In the year preceding the injury, John Restivo earned **$67,463.76;** his average weekly wage was **$1,297.38**.

On the date of accident, John Restivo was **62** years of age, ***married*** with **0** dependent children.

Petitioner claimed no medical.

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

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

ORDER

Petitioner failed to prove that Mr. Restivo developed an occupational lung disease as a result of exposures arising out of and in the course 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

November 13, 2018
Date

NOV 16 2018

Vera Restivo as Representative of John Restivo v. Mach Mining, LLC,
15 WC 13605

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Arbitrator finds:

Without objection from Respondent, at the time of arbitration, Vera Restivo was substituted as Petitioner in this matter as representative of her husband John Restivo. Vera Restivo resides in Mulkeytown, Illinois. She was married to John Restivo for 47 ½ years. She testified that Mr. Restivo passed away on May 10, 2018. He was 65 years old at that time.

Medical records of Dr. David Knowles were admitted into evidence. Mr. Restivo was seen by Dr. Knowles on November 16, 2011, for an abnormal PSA. On that date Mr. Restivo denied shortness of breath and productive cough. Physical examination of his respiratory system revealed breath sounds were clear bilaterally and his respiratory effort/rhythm showed no retraction and normal rate. (Respondent's Exhibit No. 5, pp. 92-94).

Mr. Restivo underwent biopsies of his prostate on December 14, 2011. In a report dated December 14, 2011, adenocarcinoma of the prostate was confirmed. (Respondent's Exhibit No. 5, p. 81). He was treated for the prostate cancer with prostatectomy. (Respondent's Exhibit No. 5, p. 66).

Mr. Restivo continued to deny a productive cough or shortness of breath when seen by Dr. Knowles on December 14, 2011, February 22, 2012, March 22, 2012, June 11, 2012, and September 12, 2012. (Respondent's Exhibit No. 5, pp. 43-45, 54-56, 65-67, 72-74, 77-78, 86-88).

Medical records of West Frankfort Family Practice were admitted into evidence. Mr. Restivo was seen by Dr. Andrew Yochum, on October 29, 2012, to establish care. His review of systems respiratory was negative. He was noted to be a former smoker. Physical examination of the lungs showed they were clear to auscultation with normal respiratory efforts. (Respondent's Exhibit No. 7, pp. 54-57).

Petitioner returned to West Frankfort Family Practice on February 4, 2013 and, again, his review of systems was negative on February 4, 2013. On that date pulse oximetry was 94%. Physical examination of the lungs showed they were clear to auscultation with normal respiratory effort. (Respondent's Exhibit No. 7, pp. 42-45). Mr. Restivo was seen at Southern Illinois GI Specialist on February 15, 2013. It was noted that he was "current someday smoker." On review of systems respiratory Mr. Restivo

denied cough, dyspnea or shortness of breath with exercise. Auscultation of the chest showed normal breath sounds with no rales, wheezes or rhonchi. (Respondent's Exhibit No. 7, pp. 39-41).

Mr. Restivo was seen by Dr. Knowles on April 1, 2013. His review of systems respiratory remained negative. Mr. Restivo denied shortness of breath. He had clear breath sounds on examination. Dr. Knowles noted Mr. Restivo continued to be free of his prostate cancer. His social history indicated that Mr. Restivo was a former smoker having smoked for 20 years, 20 years prior. (Respondent's Exhibit No. 5, pp. 36-38). Mr. Restivo again denied shortness of breath and had clear breath sounds bilaterally on July 16, 2013. (Respondent's Exhibit No. 5, pp. 24-26). Mr. Restivo was seen on October 2, 2013. His review of systems respiratory showed no cough or difficulty breathing. On physical examination he had clear breath sounds. (Respondent's Exhibit No. 5, pp. 18-20).

Mr. Restivo's last day in the mine was December 19, 2014. (AX 1)

Mr. Restivo saw Dr. Knowles again on June 19, 2014 and he denied shortness of breath or difficulty breathing, (Respondent's Exhibit No. 5, pp. 13-15)

Mr. Restivo followed up at Southern Illinois GI on several occasions. The review of his respiratory system continued to be negative and physical examination of the lungs remained clear to auscultation with normal respiratory effort on May 30, 2013, November 21, 2013, April 28, 2014, February 26, 2015, August 6, 2015, September 14, 2015 and December 17, 2015. (Respondent's Exhibit No. 7, pp. 3-5, 7-9, 11-13, 16-18, 23-26, 30-33, 34-37). Mr. Restivo was also seen by Dr. Knowles on January 21, 2015 and August 6, 2015 and during these visits examination of his chest revealed clear breath sounds. (Respondent's Exhibit No. 5, pp. 3- 5, 8-10)

On April 10, 2015 John Restivo signed his Application for Adjustment of Claim in this matter. (AX 2)

On June 7, 2015, Dr. Henry K. Smith, board certified radiologist and B-reader, interpreted a chest x-ray of Mr. Restivo dated May 22, 2015. Dr. Smith interpreted the chest x-ray as positive for pneumoconiosis, profusion 1/0 with P/S opacities in the bilateral mid to lower lung zones. (Petitioner's Exhibit No. 2)

On December 1, 2015, and at the request of his attorneys, Mr. Restivo was examined by Dr. Glennon Paul. A written report issued in which Dr. Paul concluded that Mr. Restivo had simple coal workers' pneumoconiosis. His pulmonary function studies were normal. It was Dr. Paul's understanding that Mr. Restivo had worked as a coal miner from 1973 through 2014 and was laid off for five years during that time. He worked

underground the entire time, usually at the face, but he spent six months roof bolting. Dr. Paul wrote, "He gets shortness of breath with some exertion but it is hard to tell whether the shortness of breath is from exertion or from his orthopedic problems from his legs. He takes no medicine for it." Mr. Restivo was retired at the time of the exam. He had a past history of prostate cancer and his prostate had been removed. He also has arthritis in his left shoulder and knees. (Ex. 2 to PX 1)

Additional Medical Treatment

Mr. Restivo was seen at SIH on July 21, 2016. His review of systems respiratory was negative. He reported that his knees were worn out. On examination his lungs were clear to auscultation, and he had normal respiratory effort. (Respondent's Exhibit No. 10, pp. 44-47).

On April 26, 2016, and at the request of Respondent's attorney, Dr. Christopher Meyer, board certified radiologist and B-reader, interpreted a May 22, 2015 chest x-ray of Mr. Restivo. Dr. Meyer found no radiographic evidence of coal workers' pneumoconiosis. He noted that, with the exception of a single calcified granuloma, Mr. Restivo's lungs were clear. (Respondent's Exhibit 3)

Deposition of Dr. Christopher Meyer

The deposition of Dr. Meyer was taken on August 12, 2106. Dr. Meyer has been board certified in radiology since 1992. (Respondent's Exhibit No. 1, p. 8). Dr. Meyer has been a B-reader since 1999. (Respondent's Exhibit No. 1, pp. 20-21). Dr. Meyer was asked to take the B-reading exam by Dr. Jerome Wiot who was part of the original committee that designed the training program which is called the B-reader Program. (Respondent's Exhibit No. 1, pp. 21-22). Dr. Meyer has recently been asked to have a more active academic role in the B-reader program. Dr. Meyer is on the American College of Radiology Pneumoconiosis Task Force which is engaged in redesigning the course, the exam and submitting cases for the B-reader training module and exam. Dr. Meyer testified that the faculty for the B-reader program is typically experienced senior level B-readers. (Respondent's Exhibit No. 1, pp. 33-34). Dr. Meyer testified that radiologists have a 10% higher pass rate on the B-reading exam than other specialties. In Dr. Meyer's opinion, radiologists have a better sense of what the variation of normal is. Dr. Meyer testified that one of the most important parts of the B-reader training and examination is making a distinction between the 0/1 and 1/0 film. (Respondent's Exhibit No. 1, pp. 35-36).

Dr. Meyer testified that the B-reader looks at the lungs to decide whether there are any small nodular opacities or any linear opacities and based on the size and appearance of those small opacities, they are given a letter score. (Respondent's Exhibit No. 1, pp. 23).

Dr. Meyer testified that specific occupational lung diseases are described by specific opacity types. Coal workers' pneumoconiosis is characteristically described as small round opacities. Diseases that cause pulmonary fibrosis, like asbestosis, will be described by small linear opacities. (Respondent's Exhibit No. 1, p. 29). The distribution of the opacities is also described because different pneumoconioses are seen in different regions of the lung. Coal workers' pneumoconiosis is typically an upper zone predominant process. The last component of the interpretation is the extent of lung involvement or the so-called profusion. (Respondent's Exhibit No. 1, p. 24). Dr. Meyer testified that the profusion is basically trying to define the density of the small opacities in the lung. (Respondent's Exhibit No. 1, p. 31).

Dr. Cristopher Meyer reviewed a PA and lateral chest radiograph of Mr. Restivo dated May 22, 2015, from Central Illinois Allergy and Respiratory. Dr. Meyer initially reviewed copy films. He subsequently reviewed the same examination but the original film and not the copy exam. (Respondent's Exhibit No. 1, p. 41). Dr. Meyer testified the copy films were quality 3 due to severe overexposure. (Respondent's Exhibit No. 1, pp. 41-42). Dr. Meyer testified that the original examination was quality 1. (Respondent's Exhibit No. 1, p. 42; Respondent's Exhibit No. 3). Dr. Meyer testified that he saw a calcified granuloma in the right lower lobe of the lung. He testified that there were no small opacities. He testified that with the exception of a single calcified granuloma, the lungs were clear. He testified that there were no findings of coal workers' pneumoconiosis. (Respondent's Exhibit No. 1, p. 42).

Additional Medical Treatment

On September 13, 2016, and at the request of Respondent's attorneys, Dr. Castle reviewed a chest x-ray dated May 22, 2015, from Central Illinois Allergy and Respiratory Services. He found no evidence of coal workers' pneumoconiosis but he did note evidence of granulomatous disease. (Respondent's Exhibit No. 2, deposition exhibit).

Deposition of Dr. Paul

The deposition of Dr. Paul was taken on March 14, 2017. Dr. Paul testified that he saw Mr. Restivo on December 1, 2015, at the request of Mr. Restivo's attorney. (Petitioner's Exhibit No. 1, Deposition Exhibit No. 2). Dr. Paul testified that he was the Director of St. John's Respiratory Therapy and Clinical Assistant Professor of Medicine at the SIU Medical School. (Petitioner's Exhibit No. 1, p. 6). Dr. Paul further testified that he was the Senior Physician at the Central Illinois Allergy and Respiratory Clinic. Those physicians specialize in Allergy and Pulmonary Disease and they take care of patients with respiratory diseases, critical care, allergic diseases and some internal medicine problems. (Petitioner's Exhibit No. 1, p. 7). Dr. Paul is semi-retired and does work comp examinations. Dr. Paul supervises a DUI Clinic's medical treatment program.

(Petitioner's Exhibit No. 1, pp. 43-44). Dr. Paul is board certified in asthma, allergy and immunology. (Petitioner's Exhibit No. 1, p. 9). Dr. Paul testified that at the time he did his fellowship in 1970 to 1972 there were not any pulmonary fellowships developed. He testified that it was strictly in allergy, asthma and respiratory disease. (Petitioner's Exhibit No. 1, pp. 9-10). Dr. Paul is not an A-reader or a B-reader of films. He has never been board certified in pulmonary disease. (Petitioner's Exhibit No. 1, p. 43). Dr. Paul has seen a hundred or more individuals at the request of Petitioner's counsel. (Petitioner's Exhibit No. 1, p. 38).

Dr. Paul testified that Mr. Restivo reported working 37 ½ years in the coal mines with all of those years being underground. Mr. Restivo reported shortness of breath with some exertion, but it was hard for him to tell whether that was because of his orthopedic problems related to his legs or from his lungs. (Petitioner's Exhibit No. 1, p. 11). Mr. Restivo did not report to Dr. Paul that he was taking any pulmonary medication. Mr. Restivo reported that he smoked an occasional cigarette when he was younger, but he never smoked more than two cigarettes a day. Dr. Paul did not consider Mr. Restivo's smoking history to be significant in terms of his pulmonary health. Dr. Paul's methacholine testing was negative. Mr. Restivo's spirometry was within the range of normal. Dr. Paul testified that Mr. Restivo's diffusing capacity was slightly below normal. (Petitioner's Exhibit No. 1, p. 12). Dr. Paul testified that given all the data that he had concerning Mr. Restivo, it was his opinion that Mr. Restivo had coal workers' pneumoconiosis caused by inhalation of coal dust. Dr. Paul testified that in light of the diagnosis of coal workers' pneumoconiosis, Mr. Restivo could not have any further exposure to the environment of a coal mine without endangering his health. (Petitioner's Exhibit No. 1, p. 14).

Dr. Paul testified that in order to have pneumoconiosis, one must have, in addition to coal mine dust deposited in his lungs, a tissue reaction to it. That tissue reaction is called scarring or fibrosis. Dr. Paul testified that by definition if one has coal workers' pneumoconiosis, he would have some impairment in the function of his lung at the site of the scarring whether it can be measured by spirometry or not. (Petitioner's Exhibit No. 1, pp. 17-18). Dr. Paul testified that it is possible for one to have injury or disease in his lung despite having normal pulmonary function test results. (Petitioner's Exhibit No. 1, p. 18). Dr. Paul testified that a person could have radiographically significant coal workers' pneumoconiosis and normal pulmonary function testing, normal blood gases and normal physical examination of the chest. (Petitioner's Exhibit No. 1, p. 21). Dr. Paul testified that a person could have coal workers' pneumoconiosis and have a normal chest x-ray. He testified that coal workers' pneumoconiosis can be found on pathology and autopsy and not show up on the chest x-ray. (Petitioner's Exhibit No. 1, p. 35). Dr. Paul testified that a negative x-ray can never rule out the existence of coal workers' pneumoconiosis. (Petitioner's Exhibit No. 1, p. 36).

Dr. Paul testified that he did not get a history from Mr. Restivo that he had ever taken breathing medication. He testified that the past medical history that he got from Mr. Restivo did not include respiratory disease. (Petitioner's Exhibit No. 1, p. 39). Dr. Paul did not review medical records regarding Mr. Restivo. Dr. Paul testified that Mr. Restivo did not tell him that he left coal mining when he did on the advice of a physician or that he was unable to do the duties of his last job in the coal mine. Dr. Paul testified that the spirometry performed on Mr. Restivo did not reveal an obstruction. With regard to the lung volumes, there was no evidence of restriction. (Petitioner's Exhibit No. 1, p. 40). Dr. Paul did not know what the American Thoracic Society standards were for inhalation time of the tracer gas in diffusion capacity testing. He did not know the hold time for the tracer gas. He testified that the technicians who performed the testing under his direction would know that information. (Petitioner's Exhibit No. 1, p. 41). Dr. Paul testified that if an impairment in Mr. Restivo's diffusion capacity was due to scarring of the lung from his inhalation of dust in the coal mine that would be permanent. (Petitioner's Exhibit No. 1, p. 42.)

Dr. Paul did not know the date of the chest x-ray that he reviewed. Dr. Paul noted that with regard to what lung zones were involved, he recorded that changes were throughout both lung fields. By this he meant it involved the entire chest x-ray. (Petitioner's Exhibit No. 1, pp. 42-43). Dr. Paul testified that he does not describe the opacity types because if there are opacities and somebody was a coal miner, the opacities have to be due to coal dust. Dr. Paul testified that he does not measure profusion. (Petitioner's Exhibit No. 1, p. 43).

Additional Medical Treatment

Mr. Restivo was seen at SIH on May 25, 2017, with complaints of dizziness and fatigue after working outside in the heat and drinking less water than normal. On examination his lungs were clear to auscultation with normal respiratory effort. He was counseled regarding the importance of being hydrated. (Respondent's Exhibit No. 10, pp. 30-33). On May 30, 2017, and June 2, 2017, Mr. Restivo's lungs were clear to auscultation with normal respiratory effort. On those dates he reported the weakness and dizziness had gone away after he increased his water intake. (Respondent's Exhibit No. 10, pp. 22-29). Mr. Restivo had normal respiratory effort and normal breath sounds on June 13, 2017. (Respondent's Exhibit No. 10, pp. 2-4). When seen on July 13, 2017, he reported no shortness of breath. He reported that his knees were shot and that he was going to consider surgery on same after he was eligible for Medicare. His review of systems respiratory was negative for chest tightness, shortness of breath and wheezing. On examination his respiratory effort was normal as were his breath sounds. (Respondent's Exhibit No. 10, pp. 4-5).

Deposition of Dr. James Castle

Dr. Castle was deposed on August 4, 2017. He testified that, at the request of Respondent's counsel, Dr. James R. Castle reviewed medical records and a chest x-ray regarding Mr. Restivo. (Respondent's Exhibit No. 2, p. 21). Dr. Castle is a pulmonologist and is board certified in internal medicine and the subspecialty of pulmonary disease. (Respondent's Exhibit No. 2, p. 4). Board certification in pulmonary disease was first established in 1941. (Respondent's Exhibit No. 2, p. 40). Dr. Castle practiced in Roanoke, Virginia for 30 years. His practice was limited to pulmonary disease and chest disease, which encompassed critical care medicine. (Respondent's Exhibit No. 2, p. 7). Dr. Castle's practice included patients with occupational lung disease. He had some patients in his practice who had coal workers' pneumoconiosis. (Respondent's Exhibit No. 2, p. 8). Dr. Castle was first certified as a B-reader in 1985. He was continuously certified as a B-reader until his certification expired on June 30, 2017. (Respondent's Exhibit NO. 2, pp. 13-14).

Dr. Castle reviewed a chest x-ray dated May 22, 2015, from Central Illinois Allergy and Respiratory Services. Dr. Castle testified that there were no parenchymal abnormalities consistent with pneumoconiosis on that chest x-ray. He did note evidence of granulomatous disease. (Respondent's Exhibit No. 2, p. 30). Dr. Castle testified that for a proper reading of a chest x-ray for pneumoconiosis one must first determine the quality of the film and then determine whether or not there are any parenchymal abnormalities consistent with the disease. If there are, the reader categorizes those abnormalities based on their size and shape. The reader then determines in what area of the lung the opacities are located. (Respondent's Exhibit No. 2, pp. 30-31). Dr. Castle testified that the most important part of the interpretation is determining the profusion. This is done by comparing the film to the ILO standard films and determining the exact profusion and noting that on the 12-point scale. (Respondent's Exhibit No. 2, p. 31). Dr. Castle testified that it is very unlikely for simple coal workers' pneumoconiosis to progress once the exposure ceases. (Respondent's Exhibit No. 2, p. 31). Dr. Castle testified that there was not any pathologic evidence of pneumoconiosis in the medical records that he reviewed. (Respondent's Exhibit No. 2, p. 30).

Dr. Castle testified that there is no such thing as radiographically apparent pulmonary impairment. The American Thoracic Society has indicated that the only way to determine pulmonary impairment is by doing valid physiologic studies. Dr. Castle testified that he agrees with the position taken by the American Thoracic Society that an older worker with a mild pneumoconiosis may be at low risk for working in currently permissible exposure levels until he reaches retirement age. Dr. Castle testified that there is no clinical significance to subradiographic pneumoconiosis in that it means that there has been a limited or inadequate amount of dust retention to cause radiographic changes and there would be no impairment related to that. (Respondent's Exhibit No. 2, pp. 31-

32). Dr. Castle testified that he disagreed with Dr. Paul's testimony that anybody that has coal dust in his lungs has pneumoconiosis. He testified that it would be fair to say that anyone that has a significant history of coal mining probably has some coal dust in his lungs. He testified that only a minority of coal miners who have had a significant exposure to coal dust develop pneumoconiosis. (Respondent's Exhibit No. 2, pp. 32-33). Dr. Castle disagreed with Dr. Paul's testimony that if a coal miner has opacities in his lungs it has to be the result of coal dust. Dr. Castle testified that an opacity may be due to a number of other things like granulomatous disease, which can cause a similar appearance. He testified that the opacities of coal workers' pneumoconiosis are consistent with things such as tuberculosis, sarcoidosis or a number of infectious problems. (Respondent's Exhibit No. 2, p. 34). Dr. Castle testified that Mr. Restivo's diffusion capacity measured on March 24, 2016, at Methodist Hospital was 108%. He testified that this indicates there would not be any significant clinical scarring of the lung. (Respondent's Exhibit No. 2, p. 32).

Dr. Castle testified that based upon a thorough review of all the data, he concluded that Mr. Restivo did not suffer from any pulmonary disease or impairment occurring as a result of his occupational exposure to coal mine dust. (Respondent's Exhibit No. 2, p. 36). He testified that Mr. Restivo worked in or around the underground mining industry for a sufficient enough time to develop coal workers' pneumoconiosis if he were a susceptible host. Dr. Castle testified that another risk factor for the development of pulmonary disease was that of tobacco abuse. He testified that the tobacco use history in Mr. Restivo's record is too vague for him to accurately determine Mr. Restivo's tobacco smoking history. He testified that another risk factor for the development of pulmonary symptoms and disease is that of obesity. Mr. Restivo had an elevated BMI greater than 30 or 31 on most occasions. (Respondent's Exhibit No. 2, pp. 36-37). Dr. Castle noted that Dr. Henry Smith reviewed the same x-ray and described minimal changes consistent with pneumoconiosis in the middle and lower lung zones. Dr. Smith classified the film as 1/0 which meant he also considered that the film may be negative. Dr. Castle testified that having lesions present in the middle and lower lung zones was somewhat atypical to coal workers' pneumoconiosis. (Respondent's Exhibit No. 2, p. 38).

Dr. Castle testified that the physiologic study obtained by Dr. Paul was a valid study and was entirely normal showing no evidence of any functional abnormalities. Mr. Restivo had no evidence of obstruction or restriction. The diffusing capacity from Methodist Hospital was also entirely normal. Dr. Castle opined that Mr. Restivo did not have any functional respiratory impairment whatsoever from any cause including coal workers' pneumoconiosis. (Respondent's Exhibit No. 2, p. 39). Dr. Castle testified that he is familiar with the *AMA Guides to the Evaluation of Permanent Impairment Sixth Edition*. When he applied the results from the valid objective testing on Mr. Restivo to Table 5-4 of the *Guides*, Mr. Restivo fell in Class 0 impairment. Dr. Castle testified that Mr. Restivo was capable of heavy manual labor from a ventilatory standpoint. (Respondent's Exhibit No. 2, pp. 39-40).

Dr. Castle testified that Mr. Restivo could have coal worker's pneumoconiosis notwithstanding a negative chest x-ray. He testified that coal workers' pneumoconiosis can be a latent and progressive disease. He testified that pneumoconiosis could be seen on a chest x-ray even in the year after the miner leaves the coal mine presuming that it was present at the time he left the coal mine. (Respondent's Exhibit No. 2, p. 42). Dr.Castle testified that no matter what he saw on Mr. Restivo's chest x-ray, it would not rule out the possibility that Mr. Restivo could have pneumoconiosis that could be found pathologically or at autopsy. (Respondent's Exhibit No. 2, p. 47). Dr. Castle testified that recent studies have shown that as many as 50% of long term coal miners have pathological coal workers' pneumoconiosis that was not appreciated by a radiographic study during their life. (Respondent's Exhibit No. 2, p. 48). Dr. Castle testified that coal workers' pneumoconiosis is basically an x-ray diagnosis except for the caveat about pathology. (Respondent's Exhibit No. 2, p. 51). Dr. Castle testified that coal workers' pneumoconiosis is basically trapped coal dust in a part of the lung which ends up wrapped in scar tissue and can be accompanied by emphysema around it. Dr. Castle testified that the tissue affected by the scarring and emphysema cannot perform the function of normal healthy lung tissue. He testified that by definition, if a person has coal workers' pneumoconiosis, he would have an impairment in the function of his lungs at the site of the scarring. (Respondent's Exhibit No. 2, pp. 52-53)

Additional Medical Treatment

Mr. Restivo continued to treat at SIH. His review of systems respiratory remained negative for cough and shortness of breath, and his pulmonary examination was normal on November 9, 2017 and, again, on February 15, 2018. (Respondent's Exhibit No. 10, pp. 6-10). Mr. Restivo was seen on April 5, 2018, for pre-op clearance for his bilateral total knee replacements. His review of systems respiratory was negative for cough, shortness of breath and wheezing. There were no abnormalities on physical examination of the chest. (Respondent's Exhibit No. 10, pp. 11-13).

Medical records of Memorial Hospital of Carbondale were admitted into evidence. Mr. Restivo was admitted to Memorial Hospital on May 3, 2018. On that date he reported chest pain that started approximately one and a half weeks earlier. He had been having chest pain daily with radiation to his elbows bilaterally. Following the appointment with his orthopedic physician and rehab at Herrin Hospital, he reported to the Herrin Hospital ER for chest pain. STEMI was called at Herrin ER with acute anterior wall MI and Mr. Restivo was transferred to Memorial Hospital for emergent cardiac cath. (Respondent's Exhibit No. 9, p. 13). On examination his lungs were clear to auscultation bilaterally and his respiratory effort was normal. (Respondent's Exhibit No. 9, p. 16). His review of systems respiratory was negative for shortness of breath and cough. (Respondent's Exhibit No. 9, p. 15). During a cardiac catheterization an occlusion was found and a stent

was placed. Following the initial catheterization he had chest pain which resulted in another cardiac catheterization with patent stent findings. (Respondent's Exhibit No. 9, p. 19). On May 7, 2018, Mr. Restivo was talking with his son when he suddenly was unable to talk and when he was able to speak his speech was slurred. Code stroke was called. Mr. Restivo underwent a CT of the brain on May 7. Same revealed questionable chronic lacunar infarction of the left basal ganglia. He had no intracranial hemorrhage or mass. (Respondent's Exhibit No. 9, p. 119). The discharge note indicated that on May 7, 2018, Mr. Restivo was found to have right cerebrellar and right temporal ischemia. On May 8, 2018, code blue was called due to sustained VT. He received CPR and multiple shocks. He was intubated and transferred to ICU. Mr. Restivo was ultimately transferred to Barnes-Jewish Hospital via helicopter. (Respondent's Exhibit No. 9, p. 32).

Medical records of Barnes-Jewish Hospital were admitted into evidence. Mr. Restivo was admitted to Barnes-Jewish Hospital on May 9, 2018, as a transfer from an outside hospital for "cardiogenic shock following VT/VF arrest." (Respondent's Exhibit No. 6, p. 45). According to the History and Physical, on May 8, Mr. Restivo went into VT/FV arrest and was reportedly coded for 1.5 hours. During the code, he received CPR, multiple rounds of EPI and was shocked eight times. He was intubated during the code. Following cardiac arrest, Mr. Restivo was persistently hypotensive. He was transferred to Barnes-Jewish Hospital via helicopter for further management. (Respondent's Exhibit No. 6, p. 45). Mr. Restivo's hemodynamics initially improved, however, overnight on May 9, he had worsening hypotension and worsening hypoxemia. On the morning of May 10, he had recurrent episodes of VT/SVT requiring shocks. Cardiology was again consulted and they felt that Mr. Restivo was not a candidate for escalation of care. Mr. Restivo was made DNR/do not reintubate. He was transitioned to comfort care and passed away on May 10, 2018. The preliminary cause of death was listed as cardiogenic shock. Secondary diagnoses included acute hypoxemic respiratory failure, acute kidney injury, anemia, bacteremia, cardiac arrhythmia, cerebral vascular accident, coronary artery disease, ischemic cardiomyopathy and ventricular tachycardia. (Respondent's Exhibit No. 6, p. 3).

Mr. Restivo's case went to arbitration on September 20, 2018. Mrs. Restivo, Petitioner, was the sole witness testifying at the hearing.

Mrs. Restivo testified that her husband worked in the mines for 30 years. She testified that he started in the mines in 1970. He worked at Old Ben Coal Company beginning in 1973. He worked for Freeman from 1976 to 1978. He worked at Old Ben from 1978 to 1983. He worked for Specialty Mine Services from 1983 to 1985 and at Arch Mine from 1985 to 1996. Mr. Restivo worked for American Coal from 1996 to 2002. He worked at Alliance from 2003 to 2006. Mr. Restivo worked at Mach Mining from November 2006 to June 2011. He returned to Mach Mining from September 2011 to December 19, 2014. Mrs. Restivo testified that this was her husband's last day of coal

mine employment because he retired. She testified that he was employed with Respondent on that date. Mrs. Restivo testified that during his coal mining career her husband was a shuttle car operator and miner operator which meant he ran a machine that cut the coal out of the face of the mine.

Mrs. Restivo testified that her husband's primary care physician was Dr. Yochum. Mrs. Restivo testified that when her husband came home from work his clothes were dusty and dirty. She testified that it was difficult to wash his clothes. Sometimes she had to wash the washer after she washed his clothes because of the dust.

Mrs. Restivo testified that she observed her husband having difficulty breathing. She testified that he did not have the stamina to do a lot of things that he used to do. She testified that they had built their house themselves, but he did not have the capacity to do that anymore. She testified that he used to hunt and fish a lot but he had just about quit both of those activities because he was afraid to be out by himself with his breathing. She testified that he had slowed down a bunch with regard to playing with the grandkids.

Mrs. Restivo testified that Mr. Restivo smoked in his 20s. She testified that he had quit in the early 1970s. She testified that when he smoked he probably smoked a pack a week. She testified that more recently he might have smoked once or twice a year with a grandson. She testified that her husband had prostate cancer which had resolved. She testified that he also had high blood pressure.

Mrs. Restivo testified that after he retired, her husband did not work again. He signed up for Social Security at the time of his retirement. She testified that her husband also had significant problems with his knees. She testified that they were a problem for him at the time of his retirement. She testified that he needed them replaced. She testified that his knees cut short a lot of his activity as well. She testified that he put off getting his knee replacement until he received Medicare. He had both knees replaced on April 18, 2018. She testified that soon after that surgery he had a significant deterioration in his health. She testified that he had a heart attack and suffered renal failure and was put on dialysis, and then he had a stroke. She testified that they sent him to St. Louis after he had the stroke and that is where he passed away.

The Arbitrator concludes:

1. Mr. Restivo failed to prove by a preponderance of the evidence that he sustained an occupational disease arising out of and in the course of his employment. In so concluding, the Arbitrator finds the B-readings by Drs. Meyer and Castle to be more persuasive. In particular the Arbitrator finds the testimony of Dr. Meyer to be insightful, informative and persuasive. His background and experience in

radiology, B-reading and coal workers' pneumoconiosis is impressive and beyond that of Drs. Smith and Paul. Dr. Meyer testified to the training received in the B-reading course. Dr. Paul does not have that training. Drs. Meyer and Castle are both B-readers and have been recertified as same numerous time. Coal workers' pneumoconiosis is a diagnosis made by chest x-ray interpretation absent pathologic evidence. Three B-readers interpreted the 2015 chest x-ray. Two of them found it to be negative for coal workers' pneumoconiosis. Dr. Meyer testified that coal workers' pneumoconiosis is generally an upper lung zone predominant process. Petitioner offered no evidence to contradict this opinion. Dr. Smith noted opacities only in the middle and lower lung zones bilaterally. His interpretation is not consistent with the general progression of coal workers' pneumoconiosis. Dr. Paul testified that all of Mr. Restivo's lungs were involved. Dr. Meyer explained that pneumoconiosis is typically an upper lung zone process. Additionally, while miners with significant years of mining may have some coal dust in their lungs, not all of them have a tissue reaction to the coal dust and develop coal workers' pneumoconiosis. All of the experts agree that CWP is diagnosed either through x-rays or pathological exam/autopsy. No pathological exam/autopsy was undertaken in this case. Mr. Restivo's primary cause of death was cardiogenic shock.

2. The Arbitrator notes that over the years Mr. Restivo's medical records did not include complaints of coughing or shortness of breath. Mr. Restivo did complain to Dr. Paul of dyspnea on exertion but did not complain of cough with sputum. The Arbitrator gives more weight to the medical entries than Mr. Restivo's complaints to Dr. Paul as the latter may have been motivated to support his claim.

3. The Arbitrator also notes that the date of accident/exposure therein was Mr. Restivo's date of retirement from the mine. His retirement was not associated with any specific breathing problems.

4. Petitioner failed to prove by a preponderance of the evidence that Mr. Restivo's condition of ill-being was causally connected to his employment.

5. Petitioner failed to prove by a preponderance of the evidence that Mr. Restivo suffered a timely disablement under Section 1(f) of the Occupational Diseases Act.

6. Petitioner's claim for benefits is denied and no benefits are awarded.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

TERRI LITTLE.

Petitioner,

vs. NO: 13 WC 30627

MEMORIAL HOSPITAL OF CARBONDALE,

Respondent.

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DECISION AND OPINION ON REVIEW

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

The Commission affirms and adopts the Decision of the Arbitrator, in part, except the Commission vacates the Arbitrator's award of 3.5% loss of use of a person as a whole pursuant to Section 8(d)2 for the cervical spine and vacates the award of 3.5% loss of use of a person as a whole pursuant to Section 8(d)2 for the lumbar spine.

The Commission agrees with the Arbitrator's finding that the Petitioner's cervical spine injury was a minor temporary aggravation of a pre-existing condition, and that shortly thereafter she returned to her baseline pre-existing condition by November 19, 2013, and that any future treatment for the cervical spine is not related to the July 12, 2013, accident.

The Commission further finds that Petitioner's lumbar spine injury was also a temporary aggravation of a pre-existing condition, and that shortly thereafter she returned to her baseline preexisting condition by November 19, 2013, and that any future treatment for the lumbar spine is not related to the July 12, 2013, accident.

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Findings of Fact and Conclusions of Law

There is no dispute that Petitioner had both pre-existing cervical and lumbar pain complaints, treatment and in the case of her cervical spine, a pre-accident surgical recommendation.

> It has long been recognized that, in preexisting condition cases, recovery will depend on the employee's ability to show that a work-related accidental injury aggravated or accelerated the pre-existing disease such that the employee's current condition of ill-being can be said to have been causally connected to the work-related injury and not simply the result of a normal degenerative process of the pre-existing condition. *Caterpillar Tractor Co. v. Industrial Comm'n*, 92 Ill. 2d 30, 36-37, 65 Ill. Dec. 6, 440 N.E.2d 861 (1982); *Caradco Window & Door v. Industrial Comm'n*, 86 Ill. 2d 92, 99, 56 Ill. Dec. 1, 427 N.E.2d 81 (1981); *Azzarelli Construction Co. v. Industrial Comm'n*, 84 Ill. 2d 262, 266, 49 Ill. Dec. 702, 418 N.E.2d 722 (1981); *Fitrro v. Industrial Comm'n*, 377 Ill. 532, 537, 37 N.E.2d 161 (1941).
>
> Whether a claimant's disability is attributable solely to a degenerative process of the pre-existing condition or to an aggravation or acceleration of a pre-existing condition because of an accident is a factual determination to be decided by the Industrial Commission. *Roberts v. Industrial Comm'n*, 93 Ill. 2d 532, 538, 67 Ill. Dec. 836, 445 N.E.2d 316 (1983); *Caterpillar Tractor Co. v. Industrial Comm'n*, 92 Ill. 2d at 36-37; *Caradco Window & Door v. Industrial Comm'n*, 86 Ill. 2d 92, 99, 56 Ill. Dec. 1, 427 N.E.2d 81 (1981)... "[T]o the extent that the medical testimony might be construed as conflicting, it is well established that resolution of such conflicts falls within the province of the Commission, and its findings will not be reversed unless contrary to the manifest weight of the evidence." *Caterpillar Tractor Co. v. Industrial Comm'n*, 92 Ill. 2d at 37. *Sisbro, Inc. v. Indus. Comm'n (Rodriguez)*, 207 Ill. 2d 193, 204-206, 797 N.E.2d 665, 672-673, 2003 Ill. LEXIS 776, *15-18, 278 Ill. Dec. 70, 77-78

Cervical Spine

The Commission agrees with the Arbitrator that the Petitioner sustained a minor temporary aggravation of her pre-existing cervical condition, however, the Commission finds that Petitioner returned to her baseline condition and she failed to prove her current condition warrants an award of permanent partial disability. The Commission relies upon the Petitioner's testimony that in June 2012, eleven months before the date of accident, her primary care physician, Dr. Kevin Oestmann, referred her to surgeon Dr. Jon Taveau. (T, pp. 37-39) Dr. Taveau examined Petitioner and noted a history of onset of neck pain two years ago. He noted symptoms of constant pain in her neck, both shoulders, both sides of her upper back and radiating pain into both arms and to all her fingers. (RX9, p. 46) The frequency of pain was constant. The pain in 2012 was described as aching, piercing, sharp and tingling and aggravated by the following activities: bending, coughing, driving, exertion, flexion, lifting, lying down, pushing, rotation, sneezing, straining, turning head,

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twisting and working. Associated symptoms include decreased mobility, difficulty sleeping, muscle spasm, tenderness, tingling and weakness. She had severe neck pain, arm pain, numbness, tingling and Lhermitte's symptom with cervical range of motion. (RX9, p. 46) Petitioner's physical exam revealed positive Spurling sign, positive limited range of motion especially with rotation left and her recent MRI of her cervical spine showed a disc osteophyte complex at C6-7. Dr. Taveau recommended either a Prestige or ACDF. He ordered a repeat EMG with NCV and MRI, flexion extension views, prior to her follow-up appointment. Petitioner did not want to proceed with surgery at that time. (RX9, p. 48)

A cervical MRI was repeated on October 10, 2012. Compared to the October 5, 2011 exam, the minor anterolisthesis of C4 on C5 was new and the facet arthropathy on the left at C4-C5 and on the right at C5-C6 worsened. (RX9, p. 44) On November 7, 2012, Dr. Taveau's history documents a disk osteophyte complex at C6-7 and instability and a disk osteophyte complex at C4-5. Petitioner continued to report severe neck pain, arm pain, numbness, tingling and Lhermitte's symptom with cervical range of motion. She reported having been symptomatic for two years. (RX9, p. 40)

On November 16, 2012, the Petitioner underwent an EMG/NCS where the history described left-sided neck pain, and left upper extremity radiating and shooting pain with tingling and numbness involving her hand. (RX9, p. 57) At the follow-up appointment on November 20, 2012, Dr. Taveau stated that the recent imaging of the cervical spine revealed large disk osteophyte complexes at C4-C5 and C6-7 with anterior subluxation of C4-5, 2 mm. Flexion extension views revealed worsening of her C4-5 subluxation to 4 mm with flexion. (RX9, p. 42)

After the work-related accident of July 12, 2013, Petitioner provided a history in the emergency room at Memorial Hospital in Carbondale. She complained of pain radiating down her right lower extremity and tenderness in her neck, back and left upper extremity. Petitioner ultimately was referred back to Dr. Taveau. The first consult, on August 19, 2013, notes that an established patient returned with recent injury at work. She reported she still has severe neck pain, arm pain, numbness, tingling and Lhermitte's symptom with cervical range of motion. The Commission agrees with the Arbitrator that the symptoms described by Dr. Taveau on June 27, 2012, and at all of his office visits preceding the work accident mirrored the pain complaints Petitioner described after the accident.

Petitioner underwent a section 12 evaluation with Dr. Andrew Zelby, a neurosurgeon, at Respondent's request on June 3, 2015. (RX1, p. 4) Petitioner reported a history of a "little" neck pain in 2012, and that she claimed that neck pain and her pre-accident low back pain were much less severe than following her work accident. (RX1, pp. 8-9) Dr. Zelby testified that he reviewed Dr. Taveau's records and on June 27, 2012, Dr. Taveau documented Petitioner's complaints of neck pain and tingling which radiated to both shoulders and down both arms to the thumbs and index fingers and down the upper back. At that time, Dr. Taveau recommended either a disc arthroplasty or an anterior cervical discectomy and fusion. (RX1, pp. 19-20) Dr. Taveau referred Petitioner for another cervical spine MRI that she underwent on October 10, 2012. *Id.* Petitioner underwent a cervical-spine MRI on August 9, 2013, after her work-related accident, which revealed no interval change from the October 10, 2012, MRI scan. (RX1, pp. 20-21) Furthermore, Dr. Zelby testified that, "The objective physical findings in my exam did not correlate to any of

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the pathology seen on any of Ms. Little's cervical scans either before or after the accident." (RX1, p. 21) Dr. Zelby did not find any evidence of any aggravation of any pre-existing degenerative condition in Petitioner's cervical spine. (RX1, p. 22)

Dr. Zelby found that Petitioner's reported pain of 8 constantly on a scale of 1/10 was inconsistent with his observations of her movements and at rest. (RX1, p. 10) Petitioner exhibited multiple Waddell findings, "a symptom amplification, inconsistency" after Petitioner reported decreased sensation in the entire upper left extremity, the entire left foreleg, and findings on vibratory sensation performed with a tuning fork were also non-anatomic. (RX1, pp. 14-15) Dr. Zelby noted that Petitioner's inconsistent behavioral responses, the Waddell signs, were positive for pain on simulation and non-anatomic sensory changes. (RX1, pp. 15-16)

Dr. Jeffrey Jones, Petitioner's neurosurgeon, testified on behalf of Petitioner. Dr. Jones testified he had no record of Petitioner being symptomatic with regard to either her neck or her lumbar spine prior to the work accident. He thought "clinically, before the accident she really didn't have severe problems and after the accident she did." (PX19, pp. 18-19) Dr. Jones provided an equivocal opinion that the incident on July 12, 2013, "probably" aggravated the underlying condition and caused her to become symptomatic in her cervical and lumbar spines. He testified, "But we don't really have any films of her before the incident that I know of anyway, so it's hard to say whether the slip was there or not. But surely, the symptoms were much more severe after it so it's at least an exacerbation of what she had." (PX1, pp. 19-20) Dr. Jones testified that Petitioner did really well after her shoulder surgery and he noted Petitioner's neck was no longer an issue. (PX19, p. 34)

The Commission finds Dr. Jones's causation opinion is not credible and is entitled to little weight. He did not review the pre-accident treating records for her cervical condition. *See, e.g.*, *Sunny Hill of Will County v. Ill. Workers' Comp. Comm'n*, 2014 IL App (3d) 130028WC, 14 N.E.3d 16, 383 Ill. Dec. 184 (Expert opinions must be supported by facts and are only as valid as the facts underlying them.)

The Commission finds that Dr. Zelby's causation opinion is more persuasive than Dr. Jones' opinion regarding Petitioner's cervical spine condition because Dr. Jones was not aware of Petitioner's prior extensive pre-existing treatment or diagnostic tests, either pre-dating or immediately post-dating the accident.

Therefore, the Commission finds that the Petitioner suffered a minor temporary aggravation of her pre-existing cervical spine condition and that her cervical spine condition was at baseline by November 19, 2013, with no evidence of permanent disability from the work accident of July 12, 2013. Therefore, the Commission vacates the Arbitrator's award of permanent partial disability for Petitioner's cervical spine condition.

Lumbar Spine

The Commission takes note of Petitioner's pre-accident lumbar back complaints. The Respondent requested a utilization review report of both prospective and retrospective medical treatments provided for Petitioner's cervical, thoracic and lumbar spine and left shoulder

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conditions that was authored by Dr. Michael Treister. (RX7) Dr. Treister testified on December 21, 2015, regarding his records review and the report he authored. (RX6) According to Dr. Treister, Petitioner saw her primary care physician, Dr. Oestmann on October 17, 2012, nine months prior to the work incident and at that time she was diagnosed with chronic back pain, arthralgias (joint aches) along with cervical disc degeneration. Dr. Oestmann noted that she was taking Aleve for symptom relief. (RX7, p. 6) On October 19, 2012, Petitioner went to Memorial Hospital of Carbondale for x-rays of her lumbosacral and thoracic spines. The diagnosis for the diagnostics states: "a patient history of backache." The radiologist documented facet arthropathy in the lumbar films at L4-L5 and L5-S1. Dr. Treister explained "Facet arthropathy is the fingerprint of degenerative disc disease." (RX7, p. 6)

Dr. Treister reviewed both the thoracic and lumbar spine x-rays on CD and opined the lumbar x-ray showed clear evidence of mild L1-L2 disc space narrowing and the thoracic spine showed extensive anterior osteophyte formation throughout the thoracic spine with a couple of lower levels more involved than most of the others. Dr. Treister noted that Petitioner did not undergo the thoracic spine MRI as had been ordered by Dr. Taveau after the November 7, 2012, office visit. (RX7, p. 7)

Dr. Treister opined that Dr. Oestmann's documentation of Petitioner's complaints of tenderness in the thoracic and lumbar spine and widespread tenderness should be considered a Waddell sign noting that there was no documentation of any focal spinal tenderness, muscle spasm or motion restrictions. (RX7) Dr. Treister further noted that Petitioner misrepresented her history to a number of different physicians. (RX6, p. 59) The Commission finds it significant and is persuaded by Dr. Treister's comments regarding Petitioner's veracity: "Based upon my review of these records I wouldn't believe a word that this patient said." This opinion comports with both Dr. Zelby's and Dr. Hayward's findings that Petitioner had multiple positive Waddell signs on exam, as noted below. (PX8; RX8)

Petitioner underwent a section 12 evaluation with Dr. Andrew Zelby, a neurosurgeon, at Respondent's request on June 3, 2015. (RX1, p. 4) Petitioner reported that her pre-accident low back pain was much less severe than following her work accident. (RX1, pp. 8-9) Dr. Zelby found that Petitioner's reported pain of 8 constantly on a scale of 1/10 was inconsistent with his observations of her movements and at rest. (RX1, p. 10) Petitioner exhibited multiple Waddell findings, "a symptom amplification, inconsistency" after Petitioner reported decreased sensation in the entire upper left extremity, the entire left foreleg, and findings on vibratory sensation performed with a tuning fork were also non-anatomic. (RX1, pp. 14-15)

Dr. Zelby opined that Petitioner had a normal lumbar spine exam and a normal neurologic exam. He testified that she does have some degeneration and some disc protrusions, but nonetheless she was neurologically normal. (RX1, pp. 20-21)

Dr. Zelby testified continued treatment of her lumbar spine is not reasonable or necessary. He further opined that she does have a small paracentral right disc protrusion at L1-2 but she has no symptoms or findings on exam suggestive of an L2 radiculopathy. She did have symptoms that questionably followed an L4 dermatomal distribution but the small far lateral disc at L3-4 on the left would result in an L3 radiculopathy not an L4 radiculopathy. They are not causing any

SOINCC0003

symptoms or any neurologic abnormalities and represent no clinical problems. (RX1, p. 24) Even with an EMG/NCV positive for findings at L1 and L2, that finding has little meaning in terms of guiding the care and treatment of the patient. ...[T]hat would not be an indication for lumbar surgical intervention for the same reason. (RX1, p. 50)

Further, the Commission finds Dr. Hayward's records provide evidence of a lack of correlation between Petitioner's post-accident symptoms and her diagnostic findings. On November 19, 2013, Dr. Hayward reviewed Petitioner's MRI report and noted "MRI of the lumbar spine does not demonstrate a reason for her symptoms." (PX8, 11/19/13, p. 2)

Likewise, on December 16, 2013, Dr. Hayward noted, "She does not have any lumbar radicular findings." (PX8, 12/16/13, p. 1) Dr. Hayward referred her to physical therapy but documented that he "did not see anything on the patient's MRI or diagnostic studies to recommend/suggest any surgical treatment of the lumbar spine." (PX8, 1/10/14 OV, p. 2)

Notably, after Petitioner returned to Dr. Hayward's office and complained physical therapy was making her low back pain worse, PA-C Davidson discharged her stating: "At this time, there is nothing that we can offer the patient. She is released from our care." (PX8, 1/28/14 OV, p. 1)

Thereafter, an addendum authored by Dr. Hayward, dated February 18, 2014, was added to the January 28, 2014, office note. The addendum stated:

> I have just been informed by her physical therapist, Brandy, that during her functional testing, the patient had multiple inconsistencies as well as 3/5 Waddell's. The patient has been released from my care. She was referred to Dr. Riew. The therapist also mentioned that the patient said that I wanted to operate on her. No surgery has been offered to her by myself. I do not contemplate any surgery in the future. WC has denied the referral to Dr. Riew. Considering the above, my referral will be canceled. The patient is released from my care. *Id.*

Petitioner did not seek any additional lumbar back treatment until she consulted another orthopedic surgeon, Dr. Jeffrey Jones in 2015. Dr. Jones referred Petitioner to pain management. Petitioner sought pain management treatment with Dr. Brent Newell from October 1, 2015, through July 7, 2016. (PX14)

The Commission notes Dr. Newell's causation opinion but does not find it persuasive. Dr. Newell suspects most of the findings pre-date her accident but have been aggravated. However he notes the difficulty in assessing causation as he first saw her two years after the accident. Regardless, he notes that "she relates this is at least more likely than not an aggravation of some of these preexisting degenerative changes." (PX14) The Commission finds that Dr. Newell's causation opinion was based on a factually incomplete history and is not persuasive.

On March 29, 2016, Dr. Newell also documented a normal physical and neurological exam. On May 24, 2016, Petitioner returned to Dr. Newell, and he reviewed the lumbar spine MRI she underwent as a result of a visit to the emergency room and found that Petitioner had a synovial cyst at L3-L4 that was the possible source of her pain. (PX14) The Arbitrator noted, and the

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Commission agrees, that the Petitioner's spondylolisthesis at L3-4, diagnosed by Dr. Jones, occurred two years after the work accident and that the intervening objective diagnostic tests were devoid of evidence that Petitioner had spondylolisthesis at L3-4, or any other level, despite other degenerative findings. Even assuming the presence of that condition, the Commission finds that none of Petitioner's subjective complaints or objective physical or neurological exams correlate to L3-L4 spondylolisthesis or any other degenerative condition of her lumbar spine.

The Commission further agrees with the Arbitrator's finding that the surveillance videos from August 28, 2013 and September 5, 2013, are relevant because it shows no evidence of a limp or significant lumbar back problem based on scenes of Petitioner walking and lifting a large gas can into her car after filling it at a pump, contrary to Petitioner's complaints to Dr. Criste and Dr. Cantrell around the same time. Based on the surveillance videos as well as the credibility issues raised by Petitioner's treating physician as well as Dr. Zelby and Dr. Treister, the Commission finds Petitioner lacks credibility.

The Commission relies upon the findings and opinions of Dr. Treister, Dr. Zelby and Dr. Hayward where Petitioner exhibited either self-limiting behaviors, Waddell findings or symptom magnification in its determination that Petitioner's current condition is not causally related to the accident of July 12, 2013. The Commission agrees with the Arbitrator, that the inconsistencies make it difficult to find any ongoing symptoms can be validly connected to the July 12, 2013, accident.

Therefore, the Commission finds that the Petitioner suffered a temporary aggravation of her pre-existing lumbar back condition and that her lumbar back condition was at baseline by November 19, 2013, with no evidence of permanent disability from the accident of July 12, 2013. Therefore, the Commission vacates the Arbitrator's award of permanency for Petitioner's lumbar back condition.

Finally, the Commission corrects scrivener's errors in the Arbitrator's decision. At page 17, last paragraph, second to the last sentence, striking the "d" off the word "continued" wherein it will read "...and to continue light exercise..." not [continued]. Also, on page 32, second paragraph from the bottom, strike the apostrophe and the letter "s" ('s) off the first word, wherein it will read "Petitioner" [not Petitioner's].

At page 28, third paragraph, the second sentence, wherein it should read "Petitioner underwent a lumbar x-ray [not "MRI"] on 10/19/12 which indicated degenerative findings at L1/2 and some facet arthropathy in the lower spine."

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 5, 2019, is hereby modified for the reasons stated herein, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the permanent partial disability award of 3.5% loss of the person as whole under Section 8(d)2 for the cervical spine

SOIMCC0003

condition is vacated because the Petitioner sustained a temporary aggravation of her pre-existing cervical condition on July 12, 2013 and that her cervical condition was not causally related to the July 12, 2013, accident after November 19, 2013.

IT IS FURTHER ORDERED BY THE COMMISSION that the permanent partial disability award of 3.5% loss of the person as whole under Section 8(d)2 for the lumbar spine condition is vacated because the Petitioner sustained a temporary aggravation of her pre-existing lumbar condition on July 12, 2013, and that lumbar condition was not causally related to the July 12, 2013, accident after November 19, 2013.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $268.23 per week, until Petitioner reaches age 67 or five years from the date of the final award, whichever is later, because the injuries sustained to the left shoulder caused a loss of earnings, as provided in Section 8(d)1 of the Act. The Commission notes that the parties stipulated that weekly benefits were paid by Respondent through the Arbitration hearing date. Respondent shall pay Petitioner compensation that has accrued from November 19, 2013 through December 14, 2017 and shall pay the remainder of the award, if any, in weekly payments.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay reasonable and necessary medical services contained in Petitioner's Exhibit 1, as provided in Sections 8(a) and 8.2 of the Act, with the following exceptions. The Petitioner is not entitled to medical expenses related to treatment of the cervical spine or lumbar spine after November 19, 2013. The Petitioner is not entitled to the expenses related to Dr. Oestmann's treatment of Petitioner on August 5, 2014 and May 5, 2015.

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: JAN 3 - 2020
KAD/bsd
O11/5/19
42

Kathryn A. Doerries

Maria E. Portela

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20IWCC0007

DISSENT

I respectfully dissent from the opinion of the majority and would affirm and adopt the Decision of the Arbitrator. After considering the totality of the evidence, I believe the Arbitrator appropriately determined that Petitioner sustained a 3.5% loss of use of the whole person as result of injuries to the cervical spine and a 3.5% loss of use of the whole person as a result of injuries sustained to the lumbar spine, in addition to a wage differential award for left shoulder injuries sustained due to the July 12, 2013, work incident.

While the majority agrees with the Arbitrator's conclusion that Petitioner is entitled to a wage differential award pursuant to Section 8(d)1 of the Act due to her left shoulder injury, the majority has also seen fit to reverse the Arbitrator's combined award of 7% loss of use of whole person for injuries to Petitioner's cervical and lumbar spine sustained as a result of the work incident. The Arbitrator wrote a thorough and well-reasoned Decision and carefully weighed all the evidence. There is no question that Petitioner had preexisting cervical and lumbar spine conditions. However, I agree with the Arbitrator's conclusion that Petitioner sustained minor aggravations of her preexisting cervical and lumbar spine conditions. The totality of the evidence supports a finding that those minor aggravations resulted in a small level of permanent partial disability regarding her cervical and lumbar spine. I view the evidence differently than the majority and do not believe the evidence supports a finding that Petitioner sustained no level of permanent disability as a result of the proven injuries to her cervical and lumbar spine. The Arbitrator's award of 3.5% loss of use of the whole person for each of Petitioner's cervical and lumbar injuries pursuant to Section 8(d)2 is appropriate given the credible evidence.

For the forgoing reasons, I would affirm and adopt the Arbitrator's Decision and find that in addition to the awarded wage differential for Petitioner's left shoulder condition, Petitioner sustained a combined 7% loss of use of the whole person (3.5% each for the cervical and lumbar spine injuries) due to the July 12, 2013, work incident.

Thomas J. Tyrrell

SOIMCC0003

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

LITTLE, TERRI
Employee/Petitioner

Case# **13WC030627**

MEMORIAL HOSPITAL OF CARBONDALE
Employer/Respondent

20IWCC0007

On 3/5/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.46% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0696 RICHRICH & COOKSEY PC
THOMAS C RICH
6 EXECUTIVE DR SUITE 3
FAIRVIEW HTS, IL 62208

0693 FEIRICH MAGER GREEN RYAN
D BRIAN SMITH
2001 W MAIN ST PO BOX 1570
CARBONDALE, IL 62903

700000W10S

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

TERRI LITTLE
Employee/Petitioner

v.

MEMORIAL HOSPITAL OF CARBONDALE
Employer/Respondent

Case # **13** WC **30627**

Consolidated cases: _____

20IWCC0007

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Paul Cellini**, Arbitrator of the Commission, in the city of **Herrin**, on **December 14, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

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

20IWCC0007

FINDINGS

On **July 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 left shoulder condition of ill-being ***is*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**52,964.12**; the average weekly wage was $**999.31**.

On the date of accident, Petitioner was **50** 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 $**ALL PAID** for TTD, $ for TPD, $**N/A** for maintenance, and $**N/A** for other benefits, for a total credit of $**ALL PAID**.

Respondent is entitled to a credit for all payments made by Respondent under Section 8(j) of the Act.

ORDER

The Arbitrator finds that the Petitioner's left shoulder condition is causally related to the July 12, 2013 accident.

The Arbitrator finds that the Petitioner's cervical condition was causally related to the July 12, 2013 accident on a temporary basis, and that the cervical condition was no longer causally related to the July 12, 2013 accident after November 19, 2013.

The Arbitrator finds that the Petitioner's lumbar condition was causally related to the July 12, 2013 accident on a temporary basis, and that the lumbar condition was no longer causally related to the July 12, 2013 accident after November 19, 2013.

Respondent shall pay reasonable and necessary medical services contained in Petitioner's Exhibit 1, as provided in Sections 8(a) and 8.2 of the Act, with the following exceptions. The Petitioner is not entitled to medical expenses related to treatment of the cervical spine or lumbar spine after November 19, 2013. The Petitioner is not entitled to the expenses related to Dr. Oestmann's treatment of Petitioner on 8/5/14 and 5/5/15.

Respondent shall be given a credit for all awarded medical benefits that have been paid prior to hearing, via workers' compensation or Section 8(j), 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 **$599.59 per week** for **17.5 weeks**, because the injuries sustained to the cervical spine caused the **3.5% loss of the person as a whole**, as provided in Section 8(d)2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of **$599.59 per week** for **17.5 weeks**, because the injuries sustained to the lumbar spine caused the **3.5% loss of the person as a whole**, as provided in Section 8(d)2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits, commencing December 14, 2017, of $268.23 per week, until Petitioner reaches age 67 or five years from the date of the final award, whichever is later, because the injuries sustained to the left shoulder caused a loss of earnings, as provided in Section 8(d)1 of the Act. The Arbitrator notes that while the Petitioner's entitlement to such benefits prior to the hearing date, the parties stipulated that weekly benefits have been paid by Respondent through the hearing date.

Respondent shall pay Petitioner compensation that has accrued from **November 19, 2013** through **December 14, 2017**, 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

March 4, 2019
Date

MAR 5 - 2019

STATEMENT OF FACTS

An employee since 2001, the Petitioner testified that she worked for Respondent as an x-ray technician until 7/12/13. She currently works at the front desk for Respondent, performing registration, answering phones, burning CDs and relieving other co-workers during lunch or absences.

On 7/12/13, Petitioner was pushing a dual CR monitor that was on wheels, describing it as about the same approximate size as a small apartment refrigerator. In order to avoid colliding with a nurse, she testified: ". . . I yanked it with my left arm as hard as I could and pushed it away from her with my right arm. And then it was headed towards the glass door, so I really pulled it, and I had my right leg to stop it from rolling, and the thing yanked me, and it pulled up my (left) arm and down my side."

The parties stipulated prior to hearing that the Petitioner sustained a compensable left shoulder injury on 7/12/13, but the Respondent disputes any causal connection between the accident and the Petitioner's claimed cervical and lumbar conditions.

Petitioner acknowledged that she previously hurt her right shoulder in 2007, but testified she was only off work for three days as a result. She denied having any prior workers' compensation claims related to her neck or back. Petitioner testified she has reviewed her medical records and physician depositions and agreed they accurately reflected what she reported to her providers.

Following the 7/12/13 incident, Petitioner testified she had left scapular pain and burning as well as pain in the left neck and down the left arm. The Memorial Hospital ER records reflect Petitioner was pushing a monitor, twisted and hurt her left posterior shoulder and right lower back with pain radiating down the right leg with tingling. X-rays were obtained of the cervical spine (no fracture, diffuse degenerative disc and facet disease with mild C4/5 spondylolisthesis), lumbar spine (no fracture, mild spondylosis) and left shoulder (normal). A history of chronic neck pain was noted. She was diagnosed with lumbar radiculopathy, cervical strain and left shoulder injury. (Px3). There is a separate note from 7/15/13 which noted, as to the cervical strain, "intermittent radiculopathic symptoms to left more than right upper extremity, most is pre-existing." Intermittent right leg radiculopathy to the toes was also noted and Petitioner was restricted to light duty. Norflex, Naproxen and Norco were prescribed. (Px3; Px4).

Various pre-accident records of Petitioner were submitted into evidence by Respondent. Petitioner underwent a breast augmentation procedure in 2011. On 6/27/12, Dr. Taveau, DO, noted Petitioner complained of a two-year history of neck pain that had worsened. Her pain was constant in the bilateral neck, upper back, shoulders and arms with radiation into the arms, hands and bilateral thumbs and index fingers. The left arm was the worst, and she also noted numbness in the bilateral arms. Numerous activities would aggravate her symptoms. Dr. Taveau indicated Petitioner also had Lhermittes symptom with cervical range of motion. He noted MRI showed a large C6/7 disc/osteophyte complex and that EMG/NCV showed no evidence of radiculopathy. Dr. Taveau recommended either a fusion or disc replacement at C6/7, but that Petitioner did not want to have surgery at that time. He ordered EMG/NCV, MRI and flexion/extension x-rays. (Rx9).

The x-rays on 10/10/12 showed minimal anterior subluxations of C4 on C5 and C5 on C6, most likely chronic. There was moderate degenerative disc disease at C6/7 with disc space narrowing and severe bilateral foraminal stenosis. Cervical MRI from the same date reflected loss of lordosis, minimal degenerative C4 over C5 anterolisthesis, mild C4/5 and moderate C6/7 central canal stenosis and multilevel hypertrophic facet arthropathy (most marked at left C4/5 and right C5/6). Foraminal stenosis was indicated at C2/3 (mild left due to hypertrophy), C4/5 (severe left and minimal right due to hypertrophy), C6/7 (severe left greater than right due to osteophytes and hypertrophy). Petitioner followed up with Dr. Taveau on 11/7/12, noting in addition to the already noted complaints she reported thoracic pain between her shoulder blades. He noted that the updated MRI showed disc-osteophyte complexes at C4/5 and C6/7, along with the subluxed levels. He wanted to obtain the EMG as well as thoracic MRI. The 11/16/12 EMG/NCV testing reflected a left C6/7 radiculopathy, mild bilateral carpal tunnel (left worse than right) and mild left ulnar neuropathy at the elbow. The history portion indicated Petitioner complained of left neck pain radiating and shooting into the left arm as well as tingling and numbness in the left hand. It is unclear what EMG/NCV Dr. Taveau was indicating was negative for radiculopathy. (Rx9).

On 7/22/13, Nurse Practitioner Kommer at occupational health noted diagnoses of cervical strain with bilateral radiculopathy, left greater than right, and thoracolumbar strain with radiculopathy into the right leg, and she was held off work. Spinal CT scans were prescribed along with Vicodin, Soma and Medrol dosepak. Norflex and Norco were discontinued. (Px3; Rx11). The 7/22/13 cervical CT scan showed multilevel degenerative changes, worst at C6/7 and with C4 over C5 grade 1 anterolisthesis, minimal C5 over C6 anterolisthesis and minimal C6 over C7 retrolisthesis. Foraminal narrowing was noted at C2/3 (moderate bilateral), C4/5 (mild right, severe left), C6/7 (moderate/severe right, mild/moderate left) and C6/7 (severe bilateral), as well as mild central

stenosis at C6/7. This was noted to have been compared to 10/10/12 films, but the comparative findings were not noted. (Px4; Rx11). 7/22/13 lumbar films showed no evidence of disc protrusion or extrusion, no significant canal or foraminal stenosis, and mild to moderate right facet arthropathy at L2/3. (Px4; Rx11). Thoracic films from the same date showed multilevel degenerative disc disease without neural compromise. (Px4; Rx11).

An 8/9/13 cervical MRI reflected: 1) slight anterolisthesis of C4 on C5 and C5 on C6, 2) multilevel degenerative spondylosis (mild C4/5 and mild/moderate C6/7 central canal stenosis), 3) multilevel foraminal stenosis (worst at C4/5, C5/6 and C6/7), and 4) multilevel hypertrophic facet arthropathy. 8/9/13 lumbar films showed: 1) right L1/2 disc herniation with no central stenosis, 2) left L34 herniation with moderate left L3 foraminal stenosis, 3) mild right L1/2 and minimal left L2/3 and L5/S1 foraminal stenosis, and 4) multilevel facet hypertrophy. Thoracic MRI from 8/9/13 reflected disc herniations at T3/4, T4/5 and T8/9 with minor cord deformity, a T9/10 disc bulge with minor cord deformity and no central canal stenosis. There also was lower thoracic facet hypertrophy. (Px4).

The Arbitrator notes that while the 8/9/13 MRIs were noted to have been ordered by Dr. Taveau, there is no record in evidence that the Arbitrator saw indicating Petitioner saw Dr. Taveau prior to 8/19/13. On 8/19/13, Petitioner saw Dr. Taveau with complaints of severe neck pain, arm pain, numbness, tingling and Lhermittes symptoms with cervical range of motion. The history notes she hurt her cervical, thoracic and lumbar spine "again" on 7/12/13. Numbness and tingling was reported in the bilateral legs. Following exam, Dr. Taveau diagnosed cervical osteophytes, disc displacement, radiculitis and strain. Also diagnosed was lumbar disc displacement and thoracic and lumbar degenerative disc disease. (Px5).

Petitioner also saw her primary provider, Dr. Oestmann, with complaints of severe pain and numbness in her left upper extremity and right lower extremity since the 7/12/13 accident. After obtaining and reviewing the MRIs of Petitioner's cervical, thoracic, and lumbar spine, he prescribed pain medication and muscle relaxers "since none of her other physicians are concerned about her pain." He advised Petitioner to return if her symptoms persisted or worsened, or if she developed new symptoms. He also recommended pain management, but this was not authorized by Respondent. Petitioner again reported persistent neck and back symptoms to Dr. Oestmann on 8/20/13 and was referred to Dr. Hayward. Petitioner returned relatively regularly for follow-up and refills of her medication and updates of her work restrictions. (Px7).

Following review of the MRI films, Dr. Taveau noted worsening at C4/5 and C6/7 but doesn't indicate what prior films he was comparing them to. He also stated Petitioner "has not yet" completed her "repeat" EMG/NCV. (Px5; Rx9). Lumbar x-ray from 8/19/13 was unchanged versus 7/12/13 films. (Px4; Rx9).

On 8/21/13, Dr. Taveau noted Petitioner was treating with multiple providers and was being evaluated for possible surgery, and he indicated he would manage her medications if she proceeded with surgery, but that her medications otherwise should be managed through her primary provider or pain management. (Px5).

Petitioner underwent a lower extremity EMG/NCV on 8/27/13, and Dr. Alam indicated the results were consistent with right high lumbar radiculopathy, probably L1/2, as well as left L3 nerve root irritability with no frank radiculopathy. Upper extremity EMG/NCV from 8/28/13 was read by Dr. Alam as showing left C4 and C7 radiculopathies, mild bilateral carpal tunnel syndrome and no evidence of ulnar neuropathy. (Px6).

Surveillance video was obtained by Respondent on 8/28/13 which followed Petitioner for a period of time after she left Dr. Alam's office. The Arbitrator notes that the video depicts the Petitioner walking, bending for a couple of minutes to fill what appears to be a 5-gallon gas can and getting in and out of her car. While there was no overly significant physical activity depicted, the Arbitrator would note that the Petitioner was not limping at

any time and did not appear to be having any difficulty with her activities. The Arbitrator further notes that only five minutes of video was obtained on 8/28/13, and according to the investigator's report was not seen at all on 8/27/13 or 8/30/13. (Rx12; Rx14).

On 9/6/13, Dr. Taveau noted that Petitioner had a worsening of her lumbar and thoracic symptoms after her work injury. He was recommending C4/5 and C6/7 fusion surgery as well as L1/2 laminectomy/discectomy, but that Petitioner "does not wish to proceed with any surgery." She was referred to pain management with Dr. Juergens and was advised to follow up as needed. (Px5; Rx9).

Petitioner saw Dr. Criste at the same facility as Dr. Taveau on 9/6/13. She reported neck pain radiating into the low back, with her only relief being medication. She also reported moderate to severe low back pain since her accident that radiates to the right foot. He prescribed physical therapy (4 weeks for the lumbar spine), continued use of a TENS unit and a possible L1/2 epidural in the future based on EMG and MRI findings, which Petitioner declined. (Px3; Rx9). There is a handwritten note on the therapy order which states: "9/6/13. Dr. Taveau said this would not be good for me right now because of my pain level." (Px3). The Arbitrator notes that multiple reports in evidence show handwritten notes on them, which appear to have been written by Petitioner, which constitute statements by Petitioner that were not necessarily testified to.

Further surveillance was obtained on the Petitioner on 9/6/13, this time for a total of about a minute. She was seen entering and exiting a restaurant. When walking she did not display a limp. No physical activity was seen beyond walking and exiting and entering her vehicle. The report of the investigator notes she was also seen driving through a bank drive-thru. (Rx13; Rx15).

Petitioner was examined by physical medicine and rehabilitation specialist Dr. Cantrell at the Respondent's request on 10/10/13. She reported an onset of symptoms on 7/12/13 while pushing an x-ray monitor, abruptly stopping its roll by pulling it with her right arm and pushing it with her left. Petitioner reported this caused mid-thoracic spine pain that went into the bilateral lumbar spine and into the right leg, along with left neck pain and associated left arm numbness. The report indicated that "because of the fact she had a prior history of a work-related injury to her neck and left shoulder, for which she had seen Dr. Taveau, she was directed to Dr. Taveau for an evaluation." Petitioner reported that Dr. Taveau told her if she wasn't going to have neck surgery, he had nothing more to offer her, and that Dr. Alam's EMG findings correlated with her cervical MRI abnormalities. She indicated she found Dr. Criste to be "rude and felt that he blew her off regarding treatment recommendations." On exam of her cervical spine, Petitioner had moderate limitations in active movement of her neck in left rotation, and mild limitations to the right, with full neck flexion and extension. She had mild limitations in bilateral side bending. She had relief of her neck complaints at the end range of extension. She had full range of motion of the shoulders and no weakness of the upper extremities. Neurologic exam was essentially normal. Dr. Cantrell noted that Petitioner was holding her head in a bent position to the right during the exam, and later during the exam was holding her head bent to the left. She walked with a limp favoring the right side with complained of the right knee and hip. Petitioner indicated a shaky sensation in her back with full extension and that her right arm is tremulous at times. (Rx2).

Following his exam and review of medical records, both pre and post-accident, diagnostic testing results and surveillance video from August and September 2013, Dr. Cantrell opined there was nothing indicating the Petitioner needed to be off work for her subjective complaints and that she was capable of working in at least a light to medium duty capacity. He noted the Petitioner lifting a gas can in the video and "the obvious discrepancy between her demonstrated capabilities on the video surveillance compared to that which she has described being capable of doing and the obvious discrepancy between her limp favoring her right lower extremity on today's examination in contrast to the absence of any obvious antalgia on two separate dates of

video surveillance does not support the need for an off-work status. . . particularly this far out from her injury." He opined that she could work with a 40-pound restriction and allowing her to alternate sitting and standing every two hours, on a temporary basis. (Rx2).

A 12/11/13 cervical x-ray showed segmental instability at C4/5 and C5/6 with flexion/extension, and grade 1 anterolisthesis of C5 on C6 at neutral, along with diffuse degenerative disc disease. (Px4).

Petitioner saw Dr. Hayward, DO, on 11/19/13. He took a history of persistent cervical pain, mid back pain, lower back pain with radicular right foot and posterior thigh pain and bilateral toe paresthesias, and left shoulder pain with radicular left upper extremity numbness. Petitioner reported being injured at work when she had to stop suddenly to avoid a collision between the monitor she was pushing and a fellow employee. Dr. Hayward noted the Petitioner's MRI and EMG/NCV results and indicated the Petitioner's arm symptoms didn't correlate with C4 radiculopathy, but could represent C5 radiculopathy, though they were "in an incomplete dermatomal distribution." The diagnoses were cervical and lumbosacral spondylosis without myelopathy. He continued Petitioner's restrictions and recommended an MRI of Petitioner's left shoulder and flexion/extension films of the cervical spine to rule out instability. Barring indication of injury in these studies, he indicated that a determination of maximum medical improvement (MMI) and a functional capacity evaluation (FCE) would be appropriate. He also noted that Petitioner was working with a 10-pound work restriction but complained of turning her head as a cashier, and that she did not feel she could tolerate physical therapy. Petitioner returned on 12/16/13 with persistent complaints of left arm and bicep pain, shoulder pain made worse with movement of the head and neck, and pain throughout her mid and low back. Dr. Hayward found no lumbar radicular findings on exam. Following review of cervical MRI and EMG/NCV testing, it appears he was recommending an anterior cervical fusion, but wanted Petitioner to see Dr. Riew for a second opinion. He recommended therapy and pain management for the thoracic/lumbar spine, noting he saw nothing surgical on MRI or other diagnostic studies, and that Petitioner "would like to continue conservative care." Dr. Hayward's assistant on 1/28/14 noted the referral to Dr. Riew was not authorized by Respondent since Heyward himself was already a second opinion. Dr. Hayward indicated he had nothing further he could offer to Petitioner and released her from his care. Since physical therapy was making Petitioner's low back pain worse, however, the assistant recommended that she cease physical therapy. However, an addendum by Dr. Hayward on 2/18/14 notes: "I have just been informed by her physical therapist, Brandy, that during her functional testing, the patient had multiple inconsistencies as well as 3/5 Waddell's. The patient has been released from my care. She was referred to Dr. Riew. The therapist also mentioned that the patient said that I wanted to operate on her. No surgery has been offered to her by myself. I do not contemplate any surgery in the future. WC has denied the referral to Dr. Riew. Considering the above, my referral will be canceled. The patient is released from my care." (Px8; Rx8).

Petitioner underwent therapy at Occupational Performance Rehab from 1/21/14 to 2/18/14 for the low back and radiculitis on referral from Dr. Hayward. She was noted to have a mild antalgic gait favoring the right leg. The notes reflect improvement, particularly in terms of radicular symptoms into the legs. On 2/11/14, Petitioner reported an increase in pain, indicating it may have been due to vacuuming. On 2/18/14, Petitioner reported she didn't feel her back was any better and that two doctors wanted to operate, but this wasn't approved, and that Dr. Hayward felt her low back was not bad enough for surgery yet. She also reported not doing her home exercises as she had been advised, noting she is sometimes exhausted after work. She continued to indicate she had less pain and radiating numbness in the right leg, but that her back and neck were the same or worse. She was discharged due to a lack of progress. The therapist documented Petitioner was unable to perform any of her job duties based on the exam, but also documented several limiting factors during the objective functional tests including client anxiety, increased pain, mechanical changes, and self-limiting behaviors. Petitioner's job was noted to be in the medium demand category. A final discharge report was issued on 3/4/14, with that report

stating: "PT was discontinued per request by MD." Petitioner had only partially achieved two out of six noted goals. (Px8; Px9; Rx10).

Petitioner agreed Dr. Hayward released her in February 2014 and that she thereafter didn't see a neck surgeon until she saw Dr. Riew in January 2015.

On 6/3/14, Dr. Oestmann ordered full spinal MRIs. (Px7). 7/15/14 cervical films revealed that Petitioner's degenerative findings, including those at C4/5 and C6/7, were stable when compared to Petitioner's previous cervical MRI of 8/9/13. The lumbar MRI revealed a stable disc bulge/protrusion at L1/2 when compared to the prior lumbar MRI of 8/9/13, with increasing marrow edema along the right pedicle of L3, new marrow edema and stress-related changes involving the left L3/4 facet joint, and multilevel facet joint arthropathy seen within the lower lumbar spine, most severe at left L3/4. (Px4).

Petitioner also had a new MRI of her thoracic spine and left shoulder MRI on 9/24/14, indicated to have been ordered by Dr. Oestmann. The thoracic MRI again showed disc herniations at T3/4 and T8/9 with right ventral cord deformity, unchanged versus 8/9/13 films, and the left shoulder MRI demonstrated: 1) marked rotator cuff tendinosis with a partial tear of the insertional fibers of the supraspinatus representing greater than 50% of the tendon thickness as well as small partial tears along the infraspinatus and subscapularis without a full thickness tear or tendon retraction; 2) mild fluid within the subacromial/subdeltoid bursa; 3) intrasubstance degenerative fraying involving the posterosuperior glenoid labrum with a small linear filling defect within the joint adjacent to the posterosuperior labrum, and a small flap/fragment related to an underlying labral tear was not excluded; 4) hypertrophic degenerative changes of the AC joint with joint-centered marrow edema suggesting stress reaction or contusion. (Px4).

Petitioner did see Dr. Riew, using her regular health insurance, on 1/13/15 with complaints of neck and arm pain with numbness (in the forearm into the middle three fingers) and weakness, which she reported having since 7/12/13 and with worsening since. Her neck pain was 75% and her arm pain 25%, much more significantly in the left arm than the right. Per the completion of an intake form by Petitioner that he reviewed with her, the doctor noted no relevant past medical history. Exam noted loss of sensation in various places on the left upper extremity. During exam Petitioner did report "she had some degenerative neck problems prior to the injury but was not known to have herniated discs at that time." Dr. Riew reviewed cervical x-ray (10/2012), MRIs (8/9/13 & 7/15/14) and CT scan (7/22/13). He diagnosed cervical spondylosis with radicular symptoms that he believed were mainly arising from the C4 to C7 levels with possible contribution from C3/4. He referred Petitioner to the Pain Center, prescribing physical therapy, which Petitioner indicated she had not undergone for the neck, and diagnostic and therapeutic left nerve blocks at C4/5 and C6/7. Dr. Riew indicated he would not recommend surgery for neck pain and would only consider it to address the left arm and hand and right small finger numbness. The Arbitrator notes that where the intake form asks how long her pain had been present, Petitioner responded "July 12, 2013." The Arbitrator also notes that the Petitioner's pain drawing indicates leg symptoms only from the knees down to the feet. (Px10).

Petitioner only saw Dr. Riew once, agreeing that his only specific recommendations were nerve blocks and physical therapy, but she testified both he and Dr. Jones told her to wait on any surgery as long as she could.

Petitioner initially saw Dr. Lee on 11/19/14 on referral from Dr. Oestmann for left shoulder pain. Petitioner reported yanking the rolling monitor with her left arm, pushing it with the right "in a twisting motion injuring complete spine and left shoulder." She reported numbness and tingling down the arm into the palm with occasional numbness in all fingers but the pinky. She also complained of numbness down the bilateral legs. Following exam and review of Petitioner's left shoulder, cervical and lumbar MRIs, Dr. Lee diagnosed

radiculitis/radiculopathy, neck pain, partial rotator cuff tear and shoulder pain, noting the case was complicated by multiple areas of symptoms since onset, though her upper extremity symptoms appeared more cervical in origin. The left subacromial space was injected. (Px11).

Petitioner was examined at the Respondent's request on 6/3/15 by neurosurgeon Dr. Zelby. She provided a consistent history of the accident. Petitioner stated that she felt pain instantly in her neck on her left side, going through her left shoulder, and down the front of her left arm to the elbow, with numbness on the back of the left forearm into the back of her hands and fingers. Petitioner also described a sharp, stabbing pain in her lower thoracic, upper lumbar area with a feeling like heat and burning radiating down the spinal axis on to the outside of the right hip and right thigh, with tingling down the outside of the right foreleg to the little toe more than the middle toe. Petitioner also reported more severe pain along the left side of the low back into the outside of the left hip and down the front of the left thigh and foreleg to the foot, with numbness in the bottoms of both feet. Petitioner told Dr. Zelby she had the same, constant subjective symptoms since the work accident, and rated her pain as 8/10 and constant. Petitioner reported to Dr. Zelby a pre-accident history of "a little" neck pain in 2012, but that her neck pain was much less severe than it was following her work accident. She stated she was told in 2012 that she had only degenerative disc disease in her neck. Petitioner also reported a pre-accident history of low back pain which, again, was less severe than following her work accident. She had undergone prior bilateral carpal tunnel surgery. (Rx2).

Dr. Zelby indicated Petitioner stated her job as an x-ray tech was a heavy physical job. She was working under restrictions performing clerical work. Exam noted diminished sensation in the entire left arm, foreleg and bilateral feet. Some Waddell signs were noted. Following his review of Petitioner's pre and post-accident records, Dr. Zelby diagnosed cervical and lumbosacral spondylosis. He noted Petitioner's complaints of a "constellation of symptoms" and that, other than obviously non-anatomic sensory changes, her examination was normal. While Petitioner reported modest pre-accident complaints, Dr. Zelby indicated that her complaints and objective findings did not change before and after the accident, including objective MRI films. He noted that cervical surgery was recommended to Petitioner prior to the accident, and that the current recommendation for C4/5 and C6/7 surgery was "an inherently poor surgical construct." Referencing recommended L1/2 surgery, Dr. Zelby opined that cervical and lumbar surgery were being recommended based on the MRI films and that the recommended levels did not correlate with Petitioner's symptoms. This suggested that the work accident had nothing to do with the MRI abnormalities. Dr. Zelby opined that Petitioner suffered a cervical strain in the context of a preexisting and already symptomatic cervical condition, and this did not aggravate, accelerate or alter this the preexisting condition. He further opined that there was no evidence to support her inability to return to work by October or November of 2013, and any treatment after that time would not be related to the accident. Dr. Zelby stated: "A medical basis for her reported degree of infirmity is elusive and is difficult to even relate her ongoing subjective complaints to a manifestation of her underlying degenerative condition. He determined she had reached MMI as to any work-related condition by October/November 2013. (Rx2).

Petitioner did not return to Dr. Lee until 6/26/15. She reported the injection helped about 75% for two to four months before starting to wear off, and that her anterior shoulder pain had returned. She had a catching sensation with a certain movement. Given her response to the injection, Dr. Lee believed the shoulder pain could be due to biceps tendonitis, as there was fluid there per MRI. A second injection was performed, noting if she still had anterior pain at the next visit, the biceps would be injected. Surgery was also discussed. On 7/24/15, Petitioner reported the last injection was very painful and after three days felt like a "toothache" pain. The biceps was injected and Petitioner felt some improvement soon after. On 8/21/15, Petitioner reported significant improvement with the injection. It was noted she was taking medications for her neck and back and was working modified duty. At that point, Dr. Lee recommended one more biceps injection and, if that didn't

help, arthroscopic surgery "while continuing to sort out plans with work comp for neck and back." Petitioner was released to return as needed and advised to contact Lee if she wanted the injection and/or surgery. (Px11).

The Respondent forwarded additional medical records to Dr. Cantrell and he issued an updated report on 9/14/15. These included the records of Dr. Hayward, Dr. Oestmann, Dr. Lee, Dr. Riew and Dr. Zelby, as well as various diagnostic testing. Referencing his prior report and opinion regarding Petitioner's ability to work, Dr. Cantrell stated that he supported Dr. Zelby's conclusion that Petitioner was capable of returning to her full work duties by November 2013, given there were no clinical neurological deficits, the presence of non-anatomic sensory symptoms, and non-physiologic pain behaviors "as noted on several occasions in the medical records following my examination of (Petitioner)." (Rx5).

Cervical MRI performed on 9/15/15 reportedly showed; 1) severe neuroforaminal stenosis at left C4/5 and C6/7, moderate/severe at right C6/7 ("these findings are grossly unchanged" versus 10/10/12 films); 2) mild progression of degenerative changes at other levels; 3) mild/moderate canal stenosis at C6/7, mild at C4/5, unchanged; 4) mild grade 1 anterolisthesis of C4 over C5 and C6 over C7, unchanged; 5) loss of lordosis suggesting muscle spasm; and, 6) unchanged left thyroid lobe nodule. (Px12). Lumbar films from the same date showed: 1) moderate left neuroforaminal stenosis at L3/4, grossly unchanged from 8/9/13 and 7/15/14; 2) mild/moderate neuroforaminal stenosis at right L1/2 and left L5/S1, slightly progressed; 3) mild canal stenosis at L3/4, slightly progressed; and, 4) loss of lordosis suggestive of muscle spasm. (Px12).

On 9/16/15, Petitioner saw orthopedic surgeon Dr. Jones for the first time for her low back. She reported constant, chronic low back pain aggravated by daily activities and radiation to the left thigh. She also reported neck pain into the left arm. Dr. Jones noted MRIs showed multilevel degeneration in the cervical and lumbar spine. Mild lumbar spondylosis was noted with C5/6 anterolisthesis and C6/7 disc-osteophyte complex with positive EMG at C4 and C7. Dr. Jones stated: "(Petitioner) was involved in a workplace accident while pushing an x-ray machine and has had neck and back pain since that time and reports that she did not have any neck or back pain prior to this incident." He also noted her left shoulder issue as well and that she was going to have surgery. He recommended surgery only at C6/7 based on her arm pain, but that other levels might need to be addressed in the future. Noting her neck pain improved with shoulder injection, Dr. Jones recommended addressing the shoulder first. As to the lumbar spine, again noting multilevel problems, he identified L3/4 spondylolisthesis as the "most striking" and that this was consistent with *some* of her leg pain. He did not believe the slight anterolisthesis at L2/3 was significant enough to address. He noted significant L3/4 facet arthropathy and foraminal stenosis and no relief with "multiple rounds" of physical therapy. He recommended facet injections with Dr. Newell, noting L3/4 fusion would be considered if that failed. (Px13).

Asked if she failed to tell Dr. Jones about her prior cervical treatment, Petitioner testified this was not correct. When confronted with an intake form she completed which asked what cervical diagnostic testing she had undergone, Petitioner acknowledged she only listed her post-accident testing ("I thought he was only talking about the accident.") and testified that she did tell him about pre-accident testing verbally. (Px8).

On 9/18/15, Respondent requested a retrospective and prospective Utilization Review with orthopedic surgeon Dr. Treister regarding the reasonableness and necessity of treatment and treatment recommendations, not causation. Dr. Treister reviewed Petitioner's cervical MRIs and x-rays from prior and subsequent to her work accident. He testified that, over the course of eight (8) years prior to her work accident, Petitioner's scans showed significant cervical changes, including severe collapse of the C6/7 disc space and severe left-sided neural foraminal stenosis. His review of Petitioner's 7/12/13 cervical x-rays indicated mild anterolisthesis at C4/5 and C5/6, as well as moderate osteophyte formation and near complete disc space collapse at C6/7 and opined that these findings were virtually identical to those seen on Petitioner's pre-accident diagnostic scans. In

his review of Petitioner's 7/22/13 cervical CT scan and 8/19/13 cervical MRI, Dr. Treister saw no evidence of any changes in Petitioner's cervical spine pathology versus her prior diagnostic studies in 2012. Dr. Treister indicated Petitioner's 8/19/13 cervical MRI showed very light anterolisthesis of C4 on C5, and C5 on C6 with multiple levels of degenerative disc disease and severe foraminal stenosis at C6/7, worse on the left. He noted that the radiologist who interpreted this study noted the findings were identical to Petitioner's pre-accident cervical MRI. (Rx7).

As to the lumbar spine, Dr. Treister reviewed Petitioner's 10/19/12 lumbar and thoracic x-rays and observed some mild L1/2 disc space narrowing with minimal facet arthropathy at the base of the lumbar spine. He found thoracic films to be striking in that there was extensive anterior osteophyte formation throughout the thoracic spine. His review of 7/12/13 lumbar x-rays reflected minimal lumbar osteophytes and mild disc space narrowing at L1/2 that was virtually identical to that seen on 10/19/12. Dr. Treister's review of the 7/22/13 lumbar CT scan indicated degenerative disc disease at L1/2 and nothing very significant below that level. He indicated the 8/19/13 lumbar MRI also didn't show any changes, but in addition to the L1/2 degeneration there was a likely L3/4 disc bulge with moderate spinal canal stenosis. He saw no acute disc herniation at L1/2. Dr. Treister's stated that his review of the 7/15/14 lumbar MRI showed basically identical findings as the 8/9/13 films, with a degenerative L1/2 disc bulge and mild disc bulging at L3/4. (Rx7).

Dr. Treister also reviewed and commented on various medical records. As to the initial ER records from Memorial Hospital, he indicated they contained no documentation of any positive neurological findings, and no focal, post-traumatic physical findings, such as muscle spasm, swelling, focal tenderness, or motion restriction. The 7/22/13 WorkCare notes documented physical exam findings of widespread tenderness of the neck and right lower extremity. The doctor said that such widespread findings are generally considered Waddell findings, meaning the findings were more likely functional or hysterical and not objective. No focal findings were documented. The WorkCare note also documented 4 out of 5 strength without any localization. Dr. Treister opined this was likely another Waddell finding, as diffuse weakness does not indicate pathology at any single injured level. No positive neurological findings were documented. (Rx7).

Dr. Treister reviewed Dr. Taveau's records and noted that while his 8/19/13 note documented some unusual pain and numbness in Petitioner's lower extremities, there were no objective physical findings establishing any acute post-traumatic pathology and no radiological findings or objective physical exam findings establishing an acute injury on 7/12/13. The motor and sensory neurological exam findings were normal. Dr. Treister also noted Petitioner's prior cervical treatment with Dr. Taveau. Dr. Treister noted Dr. Criste's 9/6/13 report states that Petitioner's pain "begins in the neck and radiates to the lower back," which Dr. Treister stated was not a description of lumbar disc generated discomfort, but rather was a diffuse, non-localizing complaint. He also noted that Petitioner's description of constant, sharp, burning, and aching symptoms were the same words Petitioner used to describe her symptoms prior to the work accident. Dr. Criste's note contained no detailed anatomic location of Petitioner's complaints, and his physical exam did not document any focal tenderness or spasm. Instead, Petitioner again described widespread tenderness, which Dr. Treister stated was a Waddell finding, in the face of a normal neurological exam. Dr. Treister noted the 9/26/13 examination at Trinity Neuroscience Institute (Dr. Criste and Dr. Taveau) was normal with no reference to any focal tenderness, muscle spasm, or motion limitation with the exception of: a positive Spurling test (without any specific description of the findings); and a positive limited range of motion (with no specific measurements or pain description). There was also "significant pain with any range of motion cervical, thoracic and lumbar," which Dr. Treister stated should also be considered a Waddell sign. (Rx7).

In reviewing the records of primary care provider Dr. Oestmann, Dr. Treister noted that on 8/20/13 the Petitioner reported diffuse tenderness over the cervical spine and left trapezius muscle, which Dr. Treister noted

were the same symptoms documented by Dr. Oestmann prior to 7/12/13. Dr. Oestmann also documented diffuse tenderness in the thoracic and lumbar spines, which Dr. Treister again indicated was widespread tenderness that should be considered a Waddell sign. There was no documentation of any focal spinal tenderness, muscle spasm, or motion restriction. (Rx7).

Dr. Treister noted 8/28/13 EMG/NCV testing with Dr. Alam found evidence of left-sided C4 and C7 radiculopathy. Dr. Treister opined that the C7 radiculopathy was not surprising given Petitioner's C6/7 advanced spondylosis, but that the C4 findings were somewhat suspect, as there were no subjective complaints of objective findings consistent with a C4 radiculopathy. Dr. Treister also opined the EMG/NCV study was not reasonable and necessary. (Rx7).

Dr. Treister's review of Dr. Cantrell's record of 10/10/13 noted multiple documented Waddell findings, including diffuse tenderness on palpation, and Petitioner keeping her head tilted to the left and then shifting to tilting to the right. Dr. Treister stated Petitioner's subjective complaints on that date were not substantiated by the documented objective findings. In his review of the records of Dr. Riew, Dr. Treister noted a very impressive and thorough consultation on 1/13/15. He did not believe physical therapy would have given Petitioner more than a day's relief from her cervical symptoms, given the very severe, preexisting deterioration at C6/7. He agreed that a nerve block at C6/7 would have been a reasonable diagnostic test, but such a block would not be reasonable at C4/5 since Petitioner had no subjective complaints or objective findings that would correlate to C4/5. He opined that Dr. Riew's documentation of pain over the left side of the neck and the entire cervical spine would be considered a Waddell finding. (Rx7).

Following his documentary review, Dr. Treister opined that the evidence he reviewed showed no substantive change in the Petitioner's spinal pathology between a year or two prior to the accident date to present, and little change in her subjective complaints or the medical objective findings over that time. He opined that her preexisting degeneration would be reasonably expected to progress over time, but that "there is little doubt" that no significant time-related deterioration had occurred from 7/12/13 to present: "Had there been some degree of aggravation to any of her degenerative disc disease in the cervical, thoracic or lumbar on 7/12/13, then by this point in time we would have anticipated some localized radiological acceleration: there has been none." Dr. Treister noted that Petitioner had subjective left-sided C7 radiculopathy and substantial C6/7 spinal canal stenosis which was persistent and had been gradually worsening for over two years according to the records. While Dr. Treister opined the 2012 recommendation by Dr. Taveau's pre-7/12/13 surgical recommendation was reasonable, and that when it was not performed ongoing persistent symptoms would be expected because the preexisting mechanical problems had not been alleviated. Dr. Treister believed Petitioner has a congenital predisposition to disc deterioration and was surprised this was not mentioned by Dr. Riew, whose facility is at the forefront of such issues, but that Petitioner didn't provide Dr. Riew with an accurate history of her preexisting condition. Dr. Treister opined that Petitioner suffered nothing more than strains on the accident date with no permanent injury or aggravation. He further opined that Petitioner's 7/12/13 treatment at Memorial Hospital, as well as the treatment of Dr. Oestmann, Dr. Taveau, and Dr. Criste (including medication) through 9/6/13 (when she was examined by Dr. Criste) was reasonable and necessary, and that any treatment after that date was not reasonable and necessary treatment to cure the effects of the work accident, but rather would have addressed the preexisting condition. He noted that Petitioner "dismissed" the therapy recommended by Criste at that time. Dr. Treister also noted that Dr. Taveau's 9/6/13 letter to Dr. Oestmann failed to reference his pre-accident surgical recommendation, which "does not appear to represent an honorable portrayal of the patient's medical condition." He also specifically opined that the 7/22/13 CT scans and 8/9/13 MRI scans were not necessary per ODG guidelines, but that the MRIs, while not reasonable in light of the CT scans, would have been reasonable otherwise as a "useful and convenient patient status baseline" given the Petitioner's long history of prior neuromuscular complaints. Dr. Treister also questioned how the mechanism of injury, involving

low kinetic energy, could have impacted all three areas of the spine, and that "physicians should be doubtful when more than one spinal area is claimed as injured by a patient, even in a high kinetic energy dissipating accident." He noted that Petitioner's severe pre-existing pathology at C6/7 may have explained this, but that such severe pain preexisted the accident date. (Rx7).

Dr. Treister was subsequently deposed by the parties on 12/21/15. He testified that he performed spine surgeries for about 32 years, but that in the last 15 to 20 years he did not. He reviewed a 1/29/03 cervical MRI that both he and the radiologist agreed showed obvious degenerative disc disease at C6/7. 9/19/11 cervical x-rays showed moderate to severe disc space narrowing at C6/7 with severe left neuroforaminal stenosis. These films showed a significant progression of deterioration at C6/7 over the time between with severe or significant disc space collapse. Additionally, the x-ray showed evidence of anterolisthesis of C5 on C6. There was then a 10/5/11 cervical MRI and after a lot of follow-up care, Dr. Taveau on 6/27/12 gave the Petitioner a choice of recommended surgeries at C6/7, that being decompression and fusion or decompression and disc replacement, either of which Dr. Treister indicated would have been reasonable at that time. He noted he has both performed both of these surgeries as well as had undergone both himself. Petitioner's 11/16/12 EMG/NCV with Dr. Alam showed mild bilateral carpal tunnel and ulnar neuropathy at the left elbow. Dr. Treister testified that while it did not show evidence of radiculopathy, "when you have really longstanding crushing of a nerve it can be very misleading on an EMG. So I would say it didn't support it or didn't go against it, but it didn't show anything about the radiculopathy. (Rx6).

Dr. Treister reviewed post-accident cervical x-ray (7/13/13), CT scan (7/22/13) and MRI (8/19/13) and saw no evidence of anatomical change in pathology versus the 2011 and 2012 diagnostic testing. On 9/26/13, Dr. Taveau recommended C4/5 and C6/7 discectomy and fusion surgery. While there was some C4/5 degenerative changes, Dr. Treister indicated surgery at that level was not reasonable given no objective evidence of a C5 radiculopathy. He didn't understand why Taveau was recommending C4/5 involvement. As to Dr. Riew's 1/13/15 evaluation of Petitioner, Dr. Treister testified that while therapy, as he recommended, could have given her temporary relief, it wouldn't do anything for the severe, longstanding C6/7 deterioration. A C6/7 nerve block would have been a reasonable diagnostic test, but "I don't think it relates to the work injury." There was no need for a C4/5 nerve block given no objective findings there and no subjective complaints relative to that level. (Rx6).

Petitioner had lumbar and thoracic x-rays on 10/19/12. Lumbar films showed narrowing of the L1/2 disc space and minimal arthropathy at L4 to S1. The 7/12/13 lumbar x-ray showed basically the same findings. The subsequent lumbar CT scan showed degenerative disc disease at L1/2 – Dr. Treister noted that while the radiologist indicated this as at L2/3, but Treister reviewed the films and it was actually L1/2. Again, the changes were mild. Based on Dr. Treister's review of the records and scans, Dr. Taveau's recommendation of L1/2 laminectomy surgery was not reasonable given no subjective complaint of radiculopathy from that level, no objective findings to support it, no evidence of disc herniation and no conservative treatment to that point: "Its an off-the-wall recommendation. It has no basis in fact." Dr. Treister notes that the 7/15/14 lumbar MRI showed some small bulges at L1/2 and L3/4, but that the films were essentially the same as on 8/9/13. He opined that Petitioner needed no further lumbar treatment. There were some significant degenerative changes in the thoracic spine that were clearly longstanding, noting he believed there was evidence of this in chest x-rays from many years prior to the accident. Petitioner really had no complaints referable to the thoracic spine, and there's no evidence that it was injured or aggravated by the work accident. Dr. Treister further opined that Petitioner's left shoulder findings indicated generally age-appropriate degenerative changes, Petitioner's complaints were diffuse and not focal, again indicating Waddell-type findings. He opined that left shoulder surgery was not reasonable and necessary. (Rx6).

On cross-examination, the doctor agreed that he stopped performing surgeries and ended his practice in July 2014, and that he had not performed a spine surgery in 2008. He did not specialize in spinal surgery. He did not examine the Petitioner himself. He could not say whether he reviewed every medical record of the Petitioner. He agreed he believed the Petitioner was dishonest with her doctors where she failed to disclose her pre-accident medical history but agreed that he had no direct knowledge of what Petitioner said to her doctors other than what those doctors recorded. He also assumed that there were likely a lot of pre-accident records that reflected similar complaints as Petitioner had post-accident. Asked if he agreed Petitioner's treatment was reasonable and necessary setting aside the issue of causation, Dr. Treister testified "some of the treatment that's recommended is totally bogus", noting there was no indication for a lumbar laminectomy. The C6/7 fusion/disc replacement recommended prior to the accident was reasonable, but post-accident "the patient has so many functional complaints I don't know whether you would find a surgeon willing to entertain surgery at this time." He agreed that the last note he had of cervical complaints prior to the accident date was November 2012, though Dr. Oestmann on 5/21/13 noted diagnoses that included "arthralgias, cervical disc degeneration, pineal cyst and cervical spondylosis." Dr. Treister agreed that people can have asymptomatic spinal degeneration per MRI/x-ray, and in fact "more often than not that's the case." Asked if Petitioner would be in the best position to determine how her symptoms may have changed since the accident, Dr. Treister testified: "Based upon my review of these records I wouldn't believe a word that this patient said." He testified this was based on her misrepresentation of her history to a number of different physicians, noting her physicians would have been dishonest if she reported her preexisting condition and they failed to indicate it in their records. He referenced multiple records as reflecting functional findings, widespread tenderness, global anesthesia and weakness, all of which are non-objective findings and were documented as Waddell findings. He couldn't find objective findings that correlated with recommendations. (Rx6).

On 10/1/15, Dr. Newell documented complaints of radiating pain to the left thigh and buttock and documented an essentially normal neurological exam on this date. He performed bilateral facet joint injections at L3/4 on 10/20/15. (Px14; Px15). Petitioner returned on 11/1/15 indicating she was nervous about physical therapy causing more pain. She reported a 40% improvement in her symptoms following the L3/4 facet injection. (Px14).

Petitioner returned to Dr. Lee on 11/9/15, noting injections for her back had not improved her shoulder pain. She said she was advised to get the shoulder surgery before back surgery but did not indicate who told her this. Surgery was planned but was not approved pending a Section 12 evaluation on behalf of Respondent. Another biceps injection was performed on 12/7/15. (Px11).

On 11/20/15, Petitioner returned to Dr. Jones, who again noted he wanted to hold off on neck treatment until the completion of left shoulder treatment given the significant improvement of her neck and left upper extremity symptoms following a left shoulder injection. Regarding her low back, Petitioner reported the L3/4 facet injections greatly helped her pain, but that the pain increased again with physical therapy. While he noted that surgery might still be needed for the L3/4 spondylolisthesis, he wanted to wait until the shoulder treatment was completed unless she developed any significant weakness in the upper part of her leg or in dorsiflexion of her foot. He noted spondylolisthesis, however, tends to get worse over time. He indicated she could work modified duty and indicated restrictions on lifting (5-10 pounds), repeated bend/stoop/squatting and no prolonged sitting. (Px13).

On 11/30/15, Petitioner returned to Dr. Newell. His review of Petitioner's imaging studies reflected arthritic changes in her neck and lower back as well as a lumbar spondylolisthesis. Petitioner noted relief with the facet injections but that her pain again flared either because of therapy or because it wore off. Dr. Newell suspected most of these conditions preexisted Petitioner's injury but were aggravated. She reported numbness in both feet

since the accident. He commented that it was very difficult for him to evaluate causation in this case, his treatment being two years following the accident. Dr. Newell noted Petitioner's pain was "multifaceted" and recommended a second L3/4 injection, which Petitioner declined. He indicated her myofascial pain could be helped with significant postural changes. He also recommended continued physical therapy despite Petitioner's complaints that she felt it aggravated her pain and was fearful of therapy aggravating her pain. (Px14).

Petitioner was examined pursuant to Section 12 of the Act on 12/17/15 by orthopedic surgeon Dr. Emanuel for the left shoulder. He noted a "long and complicated history" and that he discussed this with Petitioner for 45 minutes. At the time of the accident, Petitioner reported instantaneous left arm pain, "basically a pop in her shoulder radiating up to her neck." She also reported right hip pain and a knifelike pain in the midportion of her back that was burning and radiating to the lower lumbar spine, and that within an hour her left leg was numb with tingling in her toes. Petitioner reported a history of cervical disc disease going back to 2012, and that she had a prior left shoulder injury at work in 2007, noting she returned to work after a week but continued to have off and on shoulder pain "but nothing to the degree she is currently experiencing." Petitioner reported that she had good relief with four injections to the shoulder with Dr. Lee, but that the relief has lasted for shorter periods with each one. She indicated she felt relief of the pain radiating into her neck. Current complaints included shooting pains from the shoulder to the neck, feeling like "rubber bands rolling underneath each other" in her shoulder when reaching overhead and even just with turning magazine pages, and paresthesias in the left arm and numbness in the hand. Following his examination, review of Petitioner's medical records and review of surveillance video, Dr. Emanuel diagnosed left AC joint arthritis, and opined that the work accident substantially aggravated this condition. This was in part based on the mechanism of injury and the Petitioner's report to him of a pop in the shoulder. He did not believe the mechanism of injury would have caused a rotator cuff or glenoid labrum tear. Dr. Emanuel also did not believe Petitioner showed signs of biceps tendonitis. The surveillance video did not change his opinions. He recommended subacromial decompression, distal clavicle resection and debridement of the rotator cuff. He indicated he also believed the Petitioner could have continued to work full duty as to the shoulder injury only, as he deferred any spinal opinions to spine specialists. (Rx17).

Petitioner again returned to Dr. Newell on 12/30/15, and at that time he noted multiple positive Waddell signs on exam, including moderate pain behavior, light touch pain, distraction difference on straight leg raise testing and non-anatomic pain. He again recommended diagnostic nerve blocks and that she attend therapy to learn postural correction. (Px14).

On 1/8/16, Dr. Newell performed diagnostic medial branch blocks at left L2, L3 and L4, noting the possibility of a radiofrequency ablation procedure in the future. Petitioner reported immediate 30% pain relief, and she was asked to keep a pain diary over the following 24 hours. On 1/26/16, Petitioner returned to Dr. Newell reporting no benefit from injections and that she had a lot of side effects including headache and with her vision. The doctor indicated she did not have enough benefit to consider radiofrequency ablation and given this and the side effects, he was "not too interested" in pursuing further injections. He once again recommended physical therapy given his belief that there was a muscular component to her problem with a lot of "dysfunctional movement." He believed it would be difficult to get her back to a pain free level given she was exhibiting chronic pain. (Px14).

Left shoulder surgery was performed on 2/11/16 by Dr. Lee. His operative report was not located in the record of evidence. The Arbitrator notes that Dr. Emanuel's review of the report indicates Dr. Lee performed repairs of subscapularis and supraspinatus tendon tears, debridement of the rotator cuff, biceps tenodesis and subacromial decompression. (Rx17). Post-surgery, Petitioner continued to follow up with Dr. Lee and underwent physical therapy while being held off work. Light duty restrictions were issued as to the shoulder on 4/1/16. (Px11).

On 2/26/16, Petitioner returned to Dr. Jones for a re-check. Petitioner reported she was doing fairly well and did not think she needed surgery. (Px13). On 3/29/16, Dr. Newell documented a normal physical and neurological exam. He noted her left-sided lower extremity symptoms could be related to L3/4 changes on the left but did not believe her right-sided lower extremity symptoms were related to Petitioner's 2015 lumbar MRI findings. Dr. Newell discussed Petitioner undergoing cognitive behavioral treatment and a comprehensive pain management program to address her subjective pain complaints. (Px14).

On 4/15/16, Petitioner returned to Dr. Jones. She described chronic, worsening, constant, severe symptoms in her low back, and radiating to the ankle on the left. He released Petitioner from his care on this date, advising her to return if her leg pain increased. (Px13).

On 5/24/16, Petitioner returned to Dr. Newell, and noted she had been to the ER due to severe pain in her left lower leg. He noted Petitioner's lumbar MRI taken that date revealed a new synovial cyst at L3/4 that was the possible source of her pain. He noted her work status was sedentary and she could return with occasional walking and standing, occasional lifting up to 10 pounds and no overhead work. (Px14).

It appears Petitioner last saw Dr. Newell on 7/7/16. In a note to Dr. Oestmann, he stated that Petitioner made some progress, but it was slow, and he didn't think she needed further injections given her poor response. Barring any other surgical recommendations, he believed Petitioner had reached MMI and recommended Petitioner work on weight loss and home exercise, and that she obtain an FCE to determine restrictions. (Px14).

On 7/27/16, Dr. Lee noted Petitioner was working light duty and has occasional biceps pain with activity, such as typing at work or pulling a door shut with backwards motion. Physical therapy "has stopped due to limitations with her back." (Px11).

On 4/6/16, Petitioner went to Southern Illinois Hospital stating she awoke that morning with bad sciatica and pain shooting down her left leg. She denied any new trauma. She noted a 4-day history of right big toe numbness. She reported that the way she had to lay in bed due to shoulder surgery resulted in her back being worse. Despite significant injections of morphine and Decadron, Petitioner complained of pain with no improvement. A consult with Dr. Jones resulted in her admission and recommendation of new MRI to see if anything changed. Following the 4/6/16 lumbar MRI, Dr. Jones indicated no changes were seen and he recommended discharging Petitioner with a Medrol dosepak with a plan to schedule elective L3/4 fusion surgery. (Px15).

Petitioner testified that the surgery with Dr. Lee helped her condition, and that post-surgical therapy helped "for a while." She testified that on one occasion in therapy when additional exercises were added to her routine, including wall push-ups and bands, something popped in her left arm, resulting in increased pain with neck pain and a "knot" in her biceps. At that point, Dr. Lee terminated therapy.

Petitioner was reexamined by Dr. Emanuel pursuant to Section 12 of the Act on 8/25/16. Petitioner reported she did well after surgery until being in therapy two months later and performing an exercise behind her back when she felt pop with immediate anterior and posterior shoulder pain. She reported improvement in her neck pain with the shoulder surgery. He noted that Petitioner's therapy and recommended work hardening were limited or discontinued due to her low back problems. Following exam and review of additional updated medical and noting that Dr. Lee did not perform the AC joint debridement he had recommended, Dr. Emanuel opined that Petitioner should undergo AC joint cartilage debridement and revision distal clavicle resection. He recommended work restrictions pending same. (Rx17).

On 10/26/16, Petitioner complained of biceps pain and that she had pain sleeping on her shoulder. She noted having had a Section 12 exam on 8/29/16. Dr. Lee indicated she had AC joint pain that day on exam, and that Dr. Emanuel had recommended a distal clavicle resection for this. However, given the Petitioner's neck and back condition possibly requiring surgery, Dr. Lee "agreed with her" that the shoulder could wait until the other issued were addressed. Dr. Lee also stated: "The painful tightness in her biceps is not specific enough to determine etiology nor treatment. Although it occurred during therapy, there does not appear to be enough asymmetry compared to the other side to suspect excess shortening." She was continued on light duty and was to return after her neck and back were addressed, noting if she had spine surgery that left her restricted from heavy lifting, another shoulder surgery might be unnecessary. (Px11).

Petitioner saw Dr. Alam on 10/27/16 and 11/28/16 on referral from Dr. Oestmann based on a history of paresthesias in her fingers, toes and feet. He more specifically noted complaints of numbness and tingling in the bilateral middle and ring fingers and in the bilateral middle and first toes with occasional numbness on the tops and sides of the feet. She had previously undergone bilateral carpal tunnel surgeries ten years ago. Neurologic exam was normal. While he stated that prior EMGs showed bilateral carpal tunnel and left ulnar neuropathy, the most recent EMG report specifically stated that there were no findings of ulnar neuropathy. Petitioner reported shoulder surgery helped her left arm pain, and that bilateral carpal tunnel releases helped the paresthesias, but that "her symptoms have come back", including other fingers. Dr. Alam stated that 11/4/16 EMG/NCVs reflected right L5 and left L3 radiculopathies, left C4/5 nerve root irritability without frank radiculopathy and mild bilateral sensory carpal tunnel. Petitioner was noted to be taking Gabapentin, Hydrocodone and Flexeril as needed, and she was advised to follow up in three months. (Px6).

Petitioner returned to Dr. Lee on 12/16/16, noting ongoing shoulder problems and a knot at the biceps and that she wanted to discuss surgery. Dr. Lee noted that some of the Petitioner's complaints could be neck related, that he didn't believe there was a surgical remedy for the biceps knot, and that the clavicle resection could help with her catching pain but not all of her symptoms. Petitioner wanted to proceed despite the risks even if there was only a 50% chance of improving her pain. Light duty was continued. (Px11).

Petitioner underwent the second left shoulder surgery with Dr. Lee on 2/23/17 for left AC joint inflammation, consisting of diagnostic arthroscopy and open distal clavicle resection. His report notes the arthroscopy noted intact rotator cuff repairs involving the subscapularis and supraspinatus tendons. There were no significant or unusual adhesions. (Px11; Px16). She attended therapy at Joyner for a short time post-operatively. The records from this facility note consistent complaints of increased pain after treatments and Petitioner terminated therapy as of 5/8/17, indicating this was per her doctor's orders. (Px17).

Following the second left shoulder surgery, Petitioner testified to only "some" improvement. She testified that because she knew the protocol from after the first surgery, Dr. Lee advised her to perform a home therapy program, which she did, and prescribed Toradol and Percocet. Petitioner continued to follow up with Dr. Lee until her release at MMI on 6/9/17. Petitioner was continued off work and advised to work on range of motion at home. While his 3/8/17 note continued Petitioner off work, on 4/5/17 Petitioner noted her pain had improved, including her bicep, but that she had triceps burning and pain with keyboarding. She denied numbness and tingling. She was advised to discontinue the use of a sling other than as needed and was released to light duty. On 5/5/17, Petitioner reported "therapy is tearing her up." Petitioner continued to report she had "herniated discs" in her neck and back. She was advised to stop formal therapy and to continued light exercises at home that didn't involve her neck. Light duty was continued and she was offered Toradol if needed. (Px11).

A lumbar MRI was performed on 5/11/17 that was compared to the 4/6/16 films, noting no significant changes with ongoing increased signal at the left L3 and L4 pedicles that could be stress reaction or reactive edema, and the L3/4 synovial cyst was no longer evident. (Px15).

Updated 5/13/17 cervical MRI showed continued stable mild cervical spondylosis and degenerative disc disease primarily in the lower cervical spine with mild central canal stenosis at C4/5 and C6/7, persistent mild degenerative anterolisthesis at C4/5 and C5/6, and mild right and mild/moderate left C2/3 foraminal stenosis, moderate/severe left and mild right C4/5 foraminal stenosis, mild/moderate right C5/6 foraminal stenosis and severe left and moderate right C6/7 foraminal stenosis. (Px4).

On 6/9/17 Petitioner reported the Toradol helped her pain, and she was also taking Norco and Flexeril. Dr. Lee noted the true limitations of the shoulder could not be determined given the neck and back problems also limit her abilities to lift outstretched and overhead. She was to see her primary provider for medications, and she was released to return as needed with ongoing restrictions on the shoulder: no overhead or outstretched lifting or work, keyboarding as tolerated, and lifting/pushing/pulling up to 5 pounds but only close to her body. (Px11).

On 7/13/17, Dr. Emanuel reviewed the Petitioner's second shoulder operative report and noted the prior surgical tendon repairs remained intact but he biceps tenodesis failed, leaving Petitioner with essentially a biceps tenotomy, for which he did not recommend further surgery. He noted Dr. Lee wanted Petitioner to obtain an FCE to determine any permanent restrictions, but that she was not cleared for this due to her back condition. Dr. Emanuel opined that Petitioner had reached MMI for the left shoulder. He opined Petitioner should be restricted from lifting over 25 pounds from floor to waist, 15 pounds from waist to shoulder and 5 pounds above shoulder height. He also recommended no repetitive shoulder height or above reaching, pushing, pulling or lifting. On 8/23/27, Dr. Emanuel provided an AMA impairment rating based on the Sixth Edition of 9% of the left upper extremity, or 5% of the body as a whole. (Px17). Dr. Emanuel testified on 10/2/17 consistently with his reports. (Rx16).

Petitioner returned to Dr. Alam on 9/12/17, noting she had undergone a second shoulder surgery but that her arm and fingers still go numb, mainly the left three middle fingers, as well as the right middle finger. Petitioner indicated she was seeing Dr. Jones for cervical radiculopathy, but that it was unclear if her ongoing numbness was due to the neck or carpal tunnel/ulnar neuropathy, so repeat EMG/NCV studies were ordered. (Px6).

The 9/15/17 EMG/NCV report indicated the study was consistent with mild/moderate bilateral carpal tunnel, left greater than right, mild left ulnar neuropathy at the elbow and C5/6 nerve root irritability without frank radiculopathy. At Petitioner's 10/11/17 follow up with Dr. Alam, he advised her to follow up with an orthopedic surgeon for evaluation of carpal tunnel and ulnar neuropathy, and prescribed elbow and wrist braces. Per the last report of Dr. Alam in evidence from 12/12/17, he noted Petitioner had been seen by an ortho and was prescribed braces. (Px6).

Petitioner testified she earned $25.18 per hour as an x-ray tech for Respondent, and that x-ray technicians there continue to earn this wage. She currently earns $15.18 and continues to receive ongoing wage differential benefits.

Petitioner testified she had immediate neck and back pain after the accident and reported this to her physicians. She has been prescribed medication and therapy for her neck and low back. She's had a brace and injections for the low back, but the neck has not been injected. Her medications have included hydrocodone, acetaminophen, gabapentin and Zanaflex. Petitioner acknowledged that she became addicted to hydrocodone and has been trying to wean herself off it, indicating she has reduced her use from 6 to 8 per day to 1 to 3 per day.

Petitioner testified her left shoulder remains weak with pain and burning. Her left bicep will burn, hurt and cramp up. The top of her shoulder is numb, and her fingers and feet will go numb. She has good range of motion but has pain with putting her arm behind her back. Petitioner testified she is a musician who plays multiple instruments, and that her injuries limit her ability to play, particularly the fiddle. It also hampers her ability to do side work as a freelance graphic artist. She is awakened at times when sleeping in certain positions.

As to her neck, Petitioner testified she has pain between the neck and shoulder area, and typically has shoulder and neck pain together, sometimes under her jaw. Her low back pain is worse on the left than the right and she feels a knot from the left bra line to her left waist. She feels tingling on the left side and stabbing pain with prolonged walking or standing. She testified: "It feels like there's little bugs that crawl up and down my back on that left side." Her back always aches between the shoulder blades, sometimes with sharp pain like a knife, and at times gets so severe that she has to stop what she's doing to change positions.

On cross-examination, Petitioner agreed that Respondent authorized both left shoulder surgeries and paid her TTD benefits while off work for that left shoulder condition. Petitioner admitted she had cervical problems prior to her 7/13/13 accident, and did not dispute reporting to Dr. Oestmann, her primary provider, on 8/23/11 that she had numbness in fingers. She did not disagree with any of the indications in Oestmann's records of her complaints of neck and back pain. She agreed that Dr. Oestmann in June 2012 referred her to surgeon Dr. Taveau for her neck, and that at that time she complained of constant pain in her neck, both shoulders and both sides of her upper back with radiating pain into both arms and all of her fingers. She was referred for a cervical MRI in October 2012.

Petitioner agreed that subsequent to the work accident she saw both Dr. Taveau and Dr. Criste, and both assessed her with a potential lumbar problem at L1/2. She did not dispute the accuracy of any of her subjective complaints in their records. Petitioner agreed she also saw surgeon Dr. Hayward in Cape Girardeau in July 2013, and agreed she had no reason to dispute anything in his records.

As to her October 2013 visit with Dr. Cantrell, Petitioner agreed she was limping at the time. Respondent's counsel indicated she did not appear to be limping at the time of the hearing, and Petitioner testified she still limps but "I try to hide it." Dr. Cantrell indicated in his report that the Petitioner initially had her head tilted to the right side then switched it to the left side halfway through the exam. Noting she had it tilted to the right at hearing, the Petitioner testified: "I shift a lot. I'm sort of wiggly. Even sitting here, I feel like I am a wiggle worm, but I change positions often."

Petitioner reviewed the surveillance videos taken of her on 8/28/13 and 9/5/13, prior to her seeing Dr. Cantrell, and she agreed they don't show her limping. She testified that she doesn't limp "non-stop", and that it depends on her pain level. She agreed, however, that she told Cantrell in that she had been favoring her right leg since July 2013.

Petitioner agreed the first treatment she sought for her low back following Dr. Heyward's February 2014 release was when she saw Dr. Jones in September 2015. She testified she knew Dr. Jones from working with him at the Respondent hospital. She agreed she trusted him, and that she had reviewed his records and deposition prior to the hearing. She understood he testified he never saw her prior back or neck scans. She testified she didn't catch that he testified he never saw her post-accident scans but indicated he should have had access to her 9/15 MRI at Cedar Court MRI.

Advised that Dr. Jones indicated that Petitioner reported she had no pre-accident neck or back pain when she first saw him on 9/18/15, Petitioner denied that this was accurate: "We talked about that I had some bulging discs before but never herniated disc." She disputed it if he indicated he had no knowledge of her pre-accident neck or back conditions.

Petitioner agreed that her current job is within her work restrictions. She testified that a recent raise is what got her up to $15.18 per hour. She agreed that the documentation of her wages in Rx18 is accurate. The portions where she earned $0 in February and March of 2017 represented the periods she was receiving TTD.

On redirect exam, Petitioner testified she knew both Dr. Taveau and Dr. Jones from working with them at the Respondent's hospital facility and that Dr. Taveau was aware that she had neck and back problems prior to the accident date. She wasn't sure if Dr. Jones did or not.

Orthopedic surgeon Dr. Lee testified by way of deposition on 11/23/15, and he indicated his practice is mainly focused on the upper extremities. When Petitioner presented to him on 11/19/14 on referral from Dr. Oestmann, examination of the left shoulder reflected pain over the tuberosity where the rotator cuff attaches, pain along the biceps over the front of the shoulder, good range of motion and strength, and pain with positions like crossing her arm in front of her body and raising the arm. She did not report any pre-accident shoulder problems. He reviewed MRI reports of her entire spine and left shoulder, noting he likely only reviewed the films themselves for the left shoulder. He believed her examination was consistent with a partial rotator cuff tear, and he felt it was more likely than not related to the accident. He also diagnosed cervical radiculopathy. Petitioner indicated she was going to have an evaluation with a spine surgeon, after which she was to follow up with Dr. Lee "accordingly." On 6/25/15, Petitioner reported approximately 75% relief with injection that had lasted for two to four months. Most of the pain returned to the front of her shoulder, and he testified that the injections to the biceps provided more relief than those to the rotator cuff. His diagnosis at that point included biceps tendonitis. At her 11/9/15 follow up, Petitioner continued to have localized pain over the biceps in front of the shoulder. Dr. Lee was not aware of any intervening accidents since he first saw her. At that point he recommended surgery to perform biceps tenodesis and exploration and possible repair of the rotator cuff. He testified that he did not believe he had ever issued work restrictions for Petitioner. He received and reviewed the surveillance videos taken of Petitioner. (Px18).

On cross, Dr. Lee testified he had not reviewed any of Petitioner's records from prior to her first visit with him other than the noted MRIs, so the history of Petitioner's complaints came directly from her. He agreed she reported complaints of symptoms down her left arm into the fingers and in the bilateral legs, and she reported no prior treatment. He wasn't sure if this referred to only to shoulder treatment or regarding all of the symptoms she reported. He agreed Petitioner's shoulder MRI referenced a 2007 shoulder injury, and that his copy has some "scribbling" that states "wrong/false" and some attempted clarification, but he couldn't say who wrote it, agreeing it could have been Petitioner who brought it to him. There was no way to tell from the MRI if there were any acute findings, particularly given the MRI was taken over a year after the accident. There was degeneration, especially with the labrum. He agreed he didn't initially diagnose a biceps tear and that he did think some of her symptoms were related to radiculopathy, but noted she initially had some biceps symptoms and he diagnosed it the second time because the problem was still present. He has never reviewed any of Petitioner's records regarding cervical treatment. (Px18).

Dr. Lee agreed Petitioner first reported a catching sensation in the shoulder on 6/15/15 but opined this would be related to the accident if its related to the partial cuff tear. He agreed he didn't initially recommend treatment for the shoulder on 11/19/14 because she was to have a cervical evaluation. As to why he then didn't think it was important to see how that treatment went before operating on the shoulder, he testified Petitioner's most recent

focus has been on the low back, and her back surgeon said to treat the shoulder first – "she didn't say she needed neck surgery beforehand." If the Petitioner actually had a cervical treatment recommendation in January 2015, it could make him reconsider shoulder surgery depending on the condition. No cervical surgeon had indicated he should go first with the shoulder per Petitioner. As to the video surveillance, Dr. Lee testified that he did not believe that Petitioner's lifting of a gas can was contraindicated, because Petitioner was not engaged in any outstretched lifting or lifting to any significant height. She moved the can a short distance to the back seat of her car and did not perform any twisting movements. (Px18).

Family practitioner Dr. Oestmann testified on 3/15/16. His first post-accident visit with Petitioner was on 8/20/13, at which time she reported complaints of pain in her back, neck, thoracic spine, lumbar spine and left shoulder. She also complained of some right foot numbness. He testified that Petitioner came to him distressed because her pain was not resolved despite being seen by three other doctors (Dr. Taveau, Dr. Alam and Respondent's examiner). Dr. Oestmann changed Petitioner's medication to Relafen, Tylenol with codeine, and Soma, and advised her to take Prilosec to protect gastrointestinal tract from the medication. Dr. Oestmann opined that Petitioner's neck symptoms were related to the accident. Her condition since 8/20/13 has been "one of chronic discomfort, waxing and waning a little bit of how severe the symptoms were. Sometimes more neck or – symptoms, sometimes more back symptoms and shoulder symptoms." Some medications have worked for a period of time before they don't work anymore, or they cause a side effect and she stops taking them, and he has referred her for pain management. He testified that if all of the Petitioner's symptoms resolve with shoulder surgery, that would likely indicate the shoulder was the problem, but that he would defer any opinions regarding the shoulder to Dr. Lee or any other orthopedic shoulder surgeon involved. On cross-examination, Dr. Oestmann agreed Petitioner had a prior cervical issue where an MRI was ordered, and she was referred to Dr. Taveau in 2012. He agreed Dr. Taveau indicated the MRI showed a C6/7 disc-osteophyte complex. Dr. Taveau on 11/20/12 also indicated that Petitioner had degenerative disc disease in the cervical spine with disc displacement and radiculitis, and he recommended cervical surgery. Dr. Oestmann agreed he didn't really perform a neurologic examination on Petitioner either before or after the accident date but did note a positive straight leg raise on 8/20/13. He agreed a lot of his notes indicated tenderness in the cervical, lumbar and thoracic spine, but that he didn't really make any focal physical findings regarding these complaints. Dr. Oestmann testified that Petitioner's 8/5/14 and 5/5/15 visits were unrelated to the accident. (Px19).

Neurosurgeon Dr. Jones was deposed by the parties on 7/19/16. He first saw Petitioner on 9/18/15. Petitioner reported shoulder, neck and back pain following an injury at work. The history noted symptoms that had been chronic and nontraumatic, and Dr. Jones testified that some of her symptoms had been longstanding "but they've gotten a lot worse after that incident at the hospital." Petitioner reported pushing a fluoroscopy unit, she had to jerk it back to avoid hitting someone and "I guess it was a twisting-type injury." She had neck and radicular pain that matched with MRI findings at C6/7. She had degenerative changes through the cervical spine. She had a slight C4 over C5 anterolisthesis, which is frequently degenerative, but the radicular arm pain appeared related to C6/7. Dr. Jones didn't review any outside records other than the MRIs. There were no significant findings on examination: "It was mostly pain-type symptoms that we were dealing with." In the low back, MRI showed L3 over L4 spondylolisthesis with a synovial cyst at the same level, "all of which can cause problems for her in the future." (Px20).

Because neck problems and shoulder problems can have overlapping symptoms, because Petitioner had significant improvement with a shoulder injection, and because Petitioner had already been set up for shoulder surgery when she first saw Dr. Jones, he recommended she have the shoulder surgery first to then evaluate if there were remaining symptoms from the neck. Some of her degenerative changes were likely preexisting the accident date, but Dr. Jones had no record of her being symptomatic prior to the accident. Petitioner completed an intake form that asked if she had similar prior symptoms "and she stated that it's not like this. She probably

had the same, you know, minimal back and neck pain that we have, you know, as we get older, but this was clearly worse." (Px20).

Dr. Jones diagnosed radicular symptoms likely coming from C6/7, which he wanted to clarify by getting the shoulder addressed first, and L3/4 spondylolisthesis that "may need to be addressed in the future" with a fusion depending on how she does clinically. He recommended L3/4 injections, for both diagnostic and therapeutic purposes. (Px20).

On 11/20/15, he testified that Petitioner reported significant improvement with injections and a reduction in pain medication, but that she worsened again with therapy. She reported that she did very well following her left shoulder surgery. He last saw Petitioner on 4/15/16, and she'd had severe left leg pain to where she was seen in the ER, but she had significant improvement with steroids. He believed it would be best for Petitioner to delay surgery for as long as possible, until she had leg pain too severe to live with, and she was released from care. With regard to causal connection, Dr. Jones testified that it was hard to say whether Petitioner's cervical and lumbar conditions were related to the work accident without having pre and post-accident films to compare anatomically. However, based on the Petitioner's report that she had no prior significant symptoms and treatment and much more severe symptoms after the accident, the accident probably aggravated, or at least exacerbated, her underlying cervical and lumbar conditions "unless she's got a history of seeing doctors for neck and back pain." (Px20).

On cross exam, Dr. Jones testified that he reviewed Petitioner's 2015 cervical and lumbar MRIs from Cedar Court Imaging; however, he did not review any of Petitioner's prior, multiple diagnostic scans from either before or after the work injury. He agreed his initial 9/18/15 examination of Petitioner did not indicate any significant abnormalities that would lead to possible surgery, and that his diagnoses were based on Petitioner's subjective complaints. Agreeing his 9/18/15 report notes Petitioner reported no prior neck or back pain, Dr. Jones testified that whether this mattered to his causation opinion "depends on how much she was having, because I would be really surprised if she didn't have some neck or back pain in her life, because when you look at her MRI, all of that stuff on her MRI wasn't from that accident. So she had – I mean, she had some degenerative arthritic changes beforehand, so I would expect that she has kind of neck and back pain like me. That is, I have neck and back pain, and its something, you know, when you get up in the morning, it's hard to move around, and then after the day goes by, you feel better or as the more you move. So, yes, I don't think it would change the fact that it got much worse after surgery; however, it depends what she was complaining of before and if she had films of it before." He then went on to testify that if Petitioner had "multiple MRIs and it's shown that she had the leg pain beforehand, then you could argue that, well, maybe all this stuff preexisted the accident. The problem is if she just had minor pain, I would expect her to have that based on her MRIs, because there's no way all of that degenerative stuff was there just after the accident." (Px20).

Dr. Jones further testified that the L3/4 spondylolisthesis is "tricky" in terms of causation, since the initial post-accident films were not obtained until two years after the accident "so we don't know if that slip occurred because of the incident two years before." He testified that his thinking on causation would be the same with the cervical spine, but "It's a little different with the cervical because there is no instability in the neck other than some at C4/5, but it appeared her arm symptoms were coming from C6/7, though her neck pain still could have been from C4/5." Again, he reiterated that Petitioner reported that her spinal condition became much worse after the work accident. The cervical anterolisthesis and the lumbar spondylolisthesis could be degenerative. He also reiterated that there is no way to tell if there were any anatomical changes in the cervical or lumbar spine due to the accident, "so we're basically going off of just subjective complaints." There is no way to say how the spine may have changed between the accident date and the 2015 MRIs while she was undergoing conservative treatment. (Px20).

As to the cervical condition, Dr. Jones testified that Petitioner did really well after her shoulder surgery, and regardless of that most radicular symptoms like Petitioner had, about 80%, go away on their own. He testified that she had reached MMI as to the neck. Petitioner's main issue at her last visit was her lumbar spine, and he testified it was fair to say that there were no objective physical or neurological findings on exam which would correlate to L3/4. Again, he is not recommending lumbar surgery unless her leg pain becomes intolerable or she develops leg weakness, though he believed it would probably be needed at some point in the future, though he remained hopeful she would never need it. He testified that he knows the Petitioner from her being an x-ray tech for many years at the hospital. (Px20).

Dr. Zelby, a neurosurgeon who examined Petitioner at the Respondent's request on 6/3/15, testified via deposition on 9/28/15. Petitioner reported to Dr. Zelby a pre-accident history of a little neck pain in 2012, but that her neck pain was much less severe than it was following her work accident. She stated she was told in 2012 that she had only degenerative disc disease in her neck. Petitioner also reported a pre-accident history of low back pain which, again, was less severe than following her work accident. Petitioner stated that, following her work accident, she felt pain instantly in her neck on her left side, going through her left shoulder, and down the front of her left arm to the elbow, with numbness on the back of the left forearm into the back of her hands and fingers. Petitioner also described a sharp, stabbing pain in her lower thoracic, upper lumbar area with a feeling like heat and burning radiating down the spinal axis on to the outside of the right hip and right thigh, with tingling down the outside of the right foreleg to the little toe. Petitioner further described more severe pain along the left side of the low back into the outside of the left hip and down the front of the left thigh and foreleg to the foot, with numbness in the bottoms of both feet. Petitioner told Dr. Zelby she had continued to have the same complaints, and her symptoms were constant and at an 8 out of 10 level. He testified that she did not appear to be at this pain level to observation. (Rx1).

Dr. Zelby testified that Petitioner's reported persistence and severity of her symptoms was inconsistent with the objective medical findings, as well as with the natural history of her objective medical condition, irrespective of cause. He testified that Petitioner's indicated diminished sensation was non-anatomic and it was not possible for her to have such sensory deficits be related to the spine or nervous system. Other non-anatomic findings made by Dr, Zelby, Waddell signs of symptoms magnification, were non-anatomic diminished vibratory sensation and positive pain on simulation. He testified to the cervical findings in Petitioner's two pre-accident MRIs and Dr. Taveau's 10/10/12 cervical surgical recommendation, and that this was not consistent with Petitioner's stated history of mild cervical problems. Dr. Zelby testified that there were no interval changes between the pre-accident October 2010 cervical MRI and post-accident 8/9/13 cervical MRI, which was even noted by the radiologist. (Rx1).

Dr. Zelby testified that Petitioner had no objective physical findings that would correlate with her cervical MRI findings. Her lumbar examination was normal, and while she did have some degeneration and disc protrusions, she was neurologically normal. He opined there was no evidence that Petitioner's preexisting degenerative spine conditions (cervical, thoracic and lumbar) were aggravated by the accident. Noting Dr. Riew recommended therapy and nerve blocks for the lumbar spine, Dr. Zelby testified he disagreed with Dr. Taveau's cervical surgery recommendation. In support of his opinion, Dr. Zelby testified again that there was no correlation between the subjective complaints and her cervical MRI findings, and that suggesting a discectomy at two separate non-contiguous levels is a poor biomechanical surgical construct. The lack of any real correlation between the symptoms and the MRI findings does not provide a reasonable expectation that surgery would provide relief to Petitioner. As to the low back, she has a small L1/2 right paracentral disc protrusion but no symptoms relatable to L2 radiculopathy. She had symptoms that questionably followed an L4 pattern, but the small disc she had at left L3/4 would impact L3, not L4. (Rx1).

Based on his review of everything and examination of Petitioner, Dr. Zelby opined that Petitioner sustained no more than a cervical strain in the context of her preexisting degenerative condition. There is no medical evidence supporting that the preexisting condition was aggravated, accelerated or altered by the July 2013 accident. Plus, she had the noted inconsistencies between her complaints and exam and diagnostic findings. He opined she would have been at MMI by October or November of 2013, and there was no basis to conclude she couldn't have returned to her regular work at that time. (Rx1).

On cross examination, Dr. Zelby testified he believed he was he was qualified to opine as to the Petitioner's physical condition and work ability more than a year-and-a-half prior to his exam, even though his opinion conflicted with the opinions of other contemporaneous physicians, based on his review of their records and his exam. During cross-examination, Petitioner's attorney sought to ask questions regarding the intake questionnaire completed by Petitioner, but Dr. Zelby indicated all he keeps is his electronic record and that he shredded it. Dr. Zelby agreed that while he found no evidence of atrophy, Dr. Riew noted findings of atrophy in Petitioner's left upper arm. He testified he had no opinion as to whether the Petitioner sustained a shoulder injury from the accident and he paid no attention to any diagnostic testing of the shoulder. He acknowledged that Dr. Riew also noted pain over the left aspect of Petitioner's neck with pain at the base of her skull into her left shoulder. He had no knowledge of whether Petitioner had undergone any left nerve root blocks or what the results of such blocks may have been. Dr. Zelby testified that he himself does not perform nerve blocks "because I think that the information provided is confusing at best and useless at worst." He testified that, based on his review of Petitioner's cervical MRI reports, she had some progression of problems from 2003 to 2011, little if any progression from 2011 to 2012, and no progression from 2012 to 2013. As to whether a doctor can determine if a pathology is acute or not via diagnostic films, he testified: "Sometimes you can. Sometimes you can't" Asked if Petitioner's treatment prior to his exam had been reasonable, Dr. Zelby again referenced that Petitioner had pre and post-accident cervical treatment, and that there "is such a disconnect between her objective findings and her subjective complaints" that any treatment is questionable as necessary, but he reiterated that any treatment after November 2013 would be unrelated to the accident. Asked again, Dr. Zelby opined that post-accident an MRI and four or so weeks of physical therapy would have been reasonable as a consequence of the work injury. As to the 9/6/13 cervical x-ray, he was asked if he agreed with the report indicating an acute L1/2 disc herniation, and Dr. Zelby testified: "I reviewed that MRI." He testified that he agreed there was a disc protrusion at that level and that it could have been acute, but that Petitioner had no symptoms suggestive of an L2 radiculopathy. As to Dr. Taveau's 9/6/13 report, he testified the report only states that Petitioner reported having L1 and L2 radiculopathy and questioned her expertise to make such determination. Dr. Zelby acknowledged he did not review Petitioner's lower extremity EMG prior to his report and did not know why it was not provided to him. It was noted that Taveau's 9/6/13 report also indicated that EMG/NCV confirmed an L1/2 radiculopathy in addition to C4 and C7 radiculopathy. (Rx1).

Physical medicine and rehabilitation physician Dr. Cantrell testified via deposition on 12/15/15. His expertise is in evaluating and treating musculoskeletal conditions and injuries. He testified his initial 10/10/13 report was prepared based solely on a request for his opinion on Petitioner's ability to work. Petitioner told him she had subjective complaints of pain complaints in her right lower extremity that was causing her to limp as well as symptoms in her axial spine. On physical exam of her cervical spine, Petitioner had limitation of neck rotation, moderate to the left and mild to the right while flexion and extension was full. She had mild limitations in bilateral side bending. She had relief of her neck complaints at the end range of extension. Dr. Cantrell noted that Petitioner was holding her head bent to the right initially during the exam, and then later had it bent to the left, and testified this was unusual if it was an involuntary muscle spasm or contraction. The left shoulder had normal range of motion and good strength. On physical exam of the lumbar spine, Dr. Cantrell noted negative bilateral straight leg testing and normal neurologic exam in the upper and lower extremities. Petitioner

ambulated with a limp favoring her right lower extremity, noting she had right hip and knee pain with walking. She noted she had a shaking sensation at the end range of back extension, and that she had occasional tremor feeling in the right arm. (Rx3).

Dr. Cantrell reviewed the two surveillance videos from 8/28/13 and 9/6/13 and testified Petitioner was ambulating without any obvious antalgia, entering and exiting vehicles without any obvious pain behaviors, bending freely at the waist while filling a portable gas tank, and lifting the gas tank and placing it into her vehicle. He testified that several of these behaviors were inconsistent with how the Petitioner presented at his office on 10/10/13. (Rx3).

Consistent with his report, Dr. Cantrell opined that Petitioner was capable of working with a 40-pound lifting restriction and the ability to alternate sitting and standing every two hours when he saw her on 10/10/13. These restrictions were not permanent. Because the Petitioner had previously been placed on fairly restrictive restrictions before he saw her, he didn't want her to return immediately to full duty in case of deconditioning. Dr. Cantrell reviewed updated medical records on or about 9/14/15 and opined at that time that Petitioner could return to her regular work duties. This was based on Dr. Zelby's findings a month after Cantrell had seen Petitioner, including normal neurologic exam and the presence of non-physiologic pain behaviors that had been noted several times in her medical records, and the passage of time (Rx3).

On cross examination, Dr. Cantrell agreed that he had not reviewed any of Petitioner's records subsequent to Dr. Zelby's June 2015 report, and he was not aware that Dr. Lee had subsequently prescribed left shoulder surgery. He had no opinion as to causation and no opinion regarding whether such surgery would be reasonable or not. (Rx3).

Px21 is the Petitioner's Motion to Strike the Respondent's expert opinion, that of Dr. Zelby. (Px21). This was significantly based on Dr. Zelby's indication that he shredded an intake form the Petitioner completed, as well as his refusal to answer questions. As to the former concern, the Arbitrator notes that Dr. Zelby summarized in his report what the Petitioner indicated in the intake form, and that under the circumstances of this case, this does not appear to be much different than the doctor indicating what he may have verbally heard from a patient. The Arbitrator finds that this objection would go to the weight of the evidence as opposed to the admissibility. As to the latter concern, the Arbitrator notes for the record that a review of Dr. Zelby's cross examination does reflect a level of contentiousness in his responses from early on in that testimony without any instigation, however the Arbitrator again finds that this issue goes to the weight of the opinions of Dr. Zelby as opposed to the admissibility of his opinions. The Arbitrator denies the Petitioner's Motion to Strike (Px21).

CONCLUSIONS OF LAW

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

The parties stipulated that the Petitioner's left shoulder condition is causally related to the 7/12/13 accident. This is supported by the opinions of Dr. Lee and Dr. Emanuel.

It has long been recognized that, in preexisting condition cases, recovery will depend on the employee's ability to show that a work-related accidental injury aggravated or accelerated the preexisting disease such that the employee's current condition of ill-being can be said to have been causally connected to the work-related injury and not simply the result of a normal degenerative process of the preexisting condition Whether a claimant's

disability is attributable solely to a degenerative process of the preexisting condition or to an aggravation or acceleration of a preexisting condition because of an accident is a factual determination to be decided by the Commission. *Sisbro, Inc.v. Industrial Comm'n.*, 207 Ill. 2d 193 (2003).

With regard to the Petitioner's claimed cervical injury, the Arbitrator finds that the Petitioner sustained a minor temporary aggravation of a preexisting condition, and that she shortly thereafter returned to her baseline preexisting condition. Any future treatment for the cervical spine is not related to the 7/12/13 accident.

Petitioner was initially diagnosed with a cervical strain. Petitioner had an undisputed history of cervical and radicular complaints and treatment going back to 2011, when she underwent cervical MRIs that showed multilevel degenerative changes, most significantly at C6-7. In 2012 she reported a two-year history of symptoms, meaning they go back to 2010.

Petitioner's preexisting cervical condition was referenced by both Dr. Oestmann and Dr. Taveau. On 6/27/12, a year prior to the accident, Petitioner reported a two-year history of worsening constant neck pain that was also in the upper back, shoulders and arms with radiation into the arms, hands and bilateral thumbs and index fingers, along with numbness in the arms. The left arm was the worst. She had seen Dr. Taveau, a neurosurgeon, on 7/27/12 with complaints of constant neck pain that was aching, piercing, sharp, and tingling. Her pain was located all over her upper body: in the bilateral anterior neck, lateral neck, posterior neck, shoulders, arms, upper back, scapulars, and interscapulars. She also reported radiation of pain to her bilateral upper arms, elbows, forearms, wrists, hands, thumbs, and index fingers. He documented that the symptoms were aggravated by a wide variety of activities, including bending, coughing, driving, exertion, flexion, lifting, lying down, pushing, rotation, sneezing, straining, turning her head, twisting, and working.

On 11/7/12, Dr. Taveau noted complaints of severe neck pain, arm pain, numbness, tingling, and Lhermittes symptoms with cervical range of motion. At her post-accident visit with Dr. Taveau on 8/19/13, he recorded virtually identical subjective complaints and exam findings. While he documented a "worsening" of Petitioner's preexisting thoracic and lumbar symptoms, but not the cervical symptoms. 10/10/12 cervical MRI testing showed a large C6/7 disc/osteophyte complex with severe bilateral foraminal stenosis. Dr. Taveau in late 2012 recommended either a fusion or disc replacement at that level and specifically noted that Petitioner did not want to have surgery at that time. 10/10/12 x-rays showed minimal but present subluxations at both C4/5 and C5/6 that were noted to be chronic at that time. The cervical MRI also showed degenerative C4 over C5 anterolisthesis, mild C4/5 and moderate C6/7 central canal stenosis and multilevel hypertrophic facet arthropathy that was worst from C4 to C6. Foraminal stenosis was indicated at C2/3, C4/5 and C6/7 that was mainly all due to degeneration/hypertrophy. On 11/7/12, Petitioner complained to Dr. Taveau of thoracic pain between her shoulder blades. Dr. Taveau noted the MRI showed disc-osteophyte complexes at C4/5 and C6/7 along with the subluxed levels. 11/16/12 EMG/NCV indicated a left C6/7 radiculopathy, mild bilateral carpal tunnel (left worse than right) and mild left ulnar neuropathy at the elbow, and a history of left neck pain radiating and shooting into the left arm with tingling and numbness in the left hand was noted. A cervical MRI report from 9/15/15 noted findings that were grossly unchanged versus 10/10/12 pre-accident films.

Petitioner's subjective cervical and radicular complaints do not appear reliable based on the evidence. As noted, the records do not support any significant worsening of her cervical condition after 7/12/13 versus what she was complaining of in 2012. At that time, in fact, she was complaining of bilateral symptoms and reported to Dr. Taveau on 6/27/12 that her two-year history of neck pain had been worsening at that time. Again, there was really no difference between Petitioner's initial complaints to Dr. Taveau after the accident and what she was reporting in 2012. Petitioner undisputedly had degenerative findings on her pre- and post-accident x-rays and MRI studies. Dr. Taveau, Dr. Jones, Dr. Riew, Dr. Zelby, Dr. Treister, and the interpreting radiologists, all

believed Petitioner's most significant findings were at C4/5 and C6/7, the same levels indicated prior to the accident at issue here. Petitioner's subjective complaints, however, were widespread.

Several of Petitioner's own treating physicians, as well as Respondent's examining physicians, documented instances of Waddell findings and/or symptom magnification during Petitioner's treatment. The WorkCare records from 7/22/13 note sensory deficit with light touch on neurological exam. On 8/19/13, Dr. Taveau documented "significant" pain with any range of motion in her cervical, thoracic, and lumbar spine. On 2/18/14, Petitioner underwent therapy at Occupational Performance and Rehab, and the records document multiple instances of self-limiting behaviors. When Dr. Hayward learned of this from the therapist, he discharged Petitioner from his care. In 2015, Dr. Newell documented multiple Waddell findings during his physical examination and his ultimate recommendation on 3/28/16 was that Petitioner pursue pain management and cognitive behavioral therapy. Dr. Hayward also noted Petitioner's arm complaints were "in an incomplete dermatomal distribution."

Dr. Zelby, Respondent's Section 12 examiner, also documented evidence of symptom magnification on 6/3/15. He noted that her widespread complaints did not follow any known pattern that would relate them to being caused by a spinal problem. This included loss of sensation to her entire left upper extremity, her entire left foreleg and the entire aspects of both feet. Dr. Zelby testified that no condition of a person's spine or nervous system would produce such sensory deficits.

The surveillance video in this case, while minimal in terms of the amount of time Petitioner was actually filmed, was nevertheless telling and cannot be ignored. The reason the Arbitrator finds the video relevant is that the Petitioner shows no evidence of a limp or significant back problems, based on scenes of her walking and lifting a large gas can into her car after filling it at a pump, versus the complaints she was making to her doctors around this same time. These 8/28/13 and 9/5/13 videos were taken within days of Dr. Criste's 9/6/13 exam, where Petitioner complained of a gait disturbance, and just before her exam with Dr. Cantrell on 10/10/13, where he observed Petitioner walking with a limp and she told him that she had been limping since the accident date. Petitioner agreed the videos do not show her limping but testified that she doesn't limp "non-stop" and that it depends on her pain level. In the arbitrator's view, this explanation is self-serving and simply not believable in the context of all of the evidence in this case.

There also are too many instances in this case where the Petitioner was not truly forthcoming about her preexisting complaints and conditions. This includes her history statements to Dr. Hayward, Dr. Riew and Dr. Jones. Petitioner admitted she failed to tell Dr. Riew that she had multiple MRIs and x-rays prior to her work accident. Dr. Riew's report notes Petitioner indicated no relevant prior medical history, but that she had some preexisting degenerative neck problems prior to the injury but no herniated discs. On 9/16/15, Dr. Jones stated: "(Petitioner) was involved in a workplace accident while pushing an x-ray machine and has had neck and back pain since that time and reports that *she did not have any neck or back pain prior to this incident.*" (emphasis added). Again, the Petitioner's explanation for this was not believable in the Arbitrator's view. Dr. Jones's causation opinion is therefore flawed. First, Dr. Jones admitted he had not reviewed any of Petitioner's prior medical records, including pre-and post-accident records. He further admitted he never reviewed any of Petitioner's multiple cervical MRIs, CT scans, and x-rays from both before and after her accident. He did not even know Petitioner had undergone *any* such scans until mere days before his initial evaluation in September of 2015. Dr. Jones admitted that his causation opinion was based solely on Petitioner's subjective complaints. Dr. Jones conceded that if Petitioner had films and visits to a neurosurgeon prior to her accident, her cervical condition might have preexisted the work accident.

The Arbitrator finds that any aggravation of the Petitioner's cervical spine was temporary and involved identical symptoms as she had prior to the accident. The Arbitrator, giving the Petitioner some benefit of the doubt, finds that any causal relationship of the Petitioner's cervical spine to the 7/12/13 accident ended as of 11/19/13. This is consistent with being shortly after surveillance was obtained on Petitioner which impacted her credibility, the testimony of Dr. Zelby indicating that Petitioner at worst would have been at MMI as to her cervical sprain by November 2013, and with Dr. Hayward's 11/19/13 report wherein he indicated that Petitioner's cervical symptoms were in "an incomplete dermatomal distribution" with arm symptoms that did not correlate to the MRI findings. Further, this is also consistent with Dr. Treister's opinion that any treatment after 9/6/13 was not reasonable and necessary, irrespective of cause.

The Arbitrator incorporates the above findings with regard to the lumbar spine as well in terms of the surveillance video and findings of symptoms magnification.

Both the records of Dr. Oestmann and Dr. Taveau indicate the Petitioner had low back pain prior to the 7/12/13 accident. The Petitioner acknowledged this as well in her testimony. Petitioner underwent a lumbar MRI on 10/19/12 which indicated degenerative findings at L1/2 and some facet arthropathy in the lower spine.

Dr. Hayward noted he saw nothing surgical regarding Petitioner's lumbar spine. Dr. Newell suspected most of the conditions preexisted Petitioner's injury but were aggravated. However, he noted that it was very difficult for him to evaluate causation in this case, his treatment being two years following the accident. Dr. Newell noted Petitioner's pain was "multifaceted." He indicated her myofascial pain could be helped with significant postural changes and physical therapy, which Petitioner declined, indicating concern that it would aggravate her pain. Dr. Newell on 12/30/15 noted multiple positive Waddell signs on exam. On 1/26/16, Newell indicated his belief that there was a muscular component to her problem with a lot of "dysfunctional movement". On 3/29/16, Dr. Newell documented a normal physical and neurological exam. He noted her left-sided lower extremity symptoms could be related to L3/4 changes on the left but did not believe her right-sided lower extremity symptoms were related to Petitioner's 2015 lumbar MRI findings. Petitioner declined an injection at that level. Dr. Newell even discussed Petitioner undergoing cognitive behavioral treatment, along with a comprehensive pain management program, which supports that he believed there was a nonorganic involvement in her complaints.

On 4/6/16, Petitioner went to Southern Illinois Hospital stating she awoke that morning with bad sciatica and pain shooting down her left leg, but a 4-day history of right big toe numbness, and despite being given doses of morphine and Decadron, Petitioner still complained of pain with no improvement.

During the pendency of treatment, the Petitioner's complaints went from the right leg to the left leg. A pain drawing she completed for Dr. Riew indicated her leg symptoms were only in the legs from the knees down. Other records reflect complaints of pain going down the thighs. There are records which note complaints of numbness in the bilateral feet. On 11/19/14, Petitioner complained to Dr. Lee of bilateral leg numbness. The notations of some of the doctors in this case regarding widespread complaints and symptoms that did not fit anatomical patterns is credible given these types of complaints.

Petitioner reported prior neck symptoms to Dr. Austin on 7/15/13 but reported nothing regarding prior low back complaints. An intake form completed for Dr. Hayward documents no prior lumbar symptoms. Dr. Jones' reports indicate a history of no low back pain prior to the accident.

The Arbitrator has already referenced the issues that exist in this case in terms of the findings of Waddell signs/non-anatomic complaints and her activities in the surveillance videos versus her complaints in the same time period.

The most significant finding on Petitioner's initial lumbar scans was of a paracentral disc bulge or herniation at L1/2, and a lower extremity EMG/NCV revealed a possible radiculopathy at that level. However, Dr. Hayward opined in late 2013 that none of Petitioner's low back or alleged radicular symptoms were explained by any lumbar MRI finding, and he did not recommend surgery. It was not until 2015, more than two years after the accident, that Dr. Jones assessed an L3/4 spondylolisthesis based on a September 2015 MRI. However, following the 2013 accident, Petitioner underwent a lumbar x-ray, a lumbar CT scan, a lumbar MRI, and a lumbar flexion extension x-ray, and there was no indication of an L3/4 spondylolisthesis on any of these scans. In fact, the radiologists specifically noted in their respective reports that no spondylolisthesis was present on either the 2013 MRI or the 2013 flexion extension x-ray. Dr. Jones acknowledged that he had not reviewed Petitioner's prior lumbar MRIs, CT scans, or x-rays. Dr. Jones also noted multilevel lumbar problems, and that the "most striking" finding of L3/4 spondylolisthesis was consistent with *some* of her leg pain, and he did not believe the slight anterolisthesis at L2/3 was significant enough to address. He noted Petitioner indicated she's had "multiple rounds" of physical therapy with no relief, but the Arbitrator found no evidence of such multiple rounds in the medical records.

Dr. Taveau, Dr. Hayward, Dr. Zelby, and Dr. Treister (who performed utilization review) all reviewed these scans, and none identified any potentially symptomatic condition at L3/4, let alone a symptomatic degenerative spondylolisthesis. Dr. Hayward specifically commented that the 2013 lumbar flexion extension x-ray demonstrated no movement in the lumbar spine, i.e., that no spondylolisthesis was present. This was consistent with the radiologist's impression of that scan that no spondylolisthesis was present on that scan.

From the time she was discharged by Dr. Hayward in January of 2014 until she saw Dr. Jones in September of 2015, Petitioner was not seen by any surgeon. During that time, Dr. Oestmann ordered a repeat lumbar MRI in July of 2014, which showed no spondylolisthesis at L3/4 or any other level.

Two things are clear from the foregoing: Petitioner's L3-4 spondylolisthesis developed approximately two years after her work accident, and even assuming the presence of any such condition, none of Petitioner's subjective complaints or objective physical or neurological exams correlate to that, or any other, degenerative condition of Petitioner's lumbar spine.

Dr. Zelby essentially testified that the Petitioner's subjective complaints were excessive when compared to her clinical and diagnostic findings, and that her widespread complaints failed to pinpoint any specific area of relevant pathology. While Dr. Zelby's testimony was confrontational on cross exam, which does impact his persuasiveness, the Arbitrator cannot ignore his findings given the consistency with the findings of other providers in this case.

Dr. Treister review of 7/12/13 lumbar x-rays reflected minimal lumbar osteophytes and mild disc space narrowing at L1/2 that was virtually identical to that seen on 10/19/12. Dr. Treister's review of the 7/22/13 lumbar CT scan indicated degenerative disc disease at L1/2 and nothing very significant below that level. While Dr. Treister was addressing the reasonableness of treatment, he testified as to how causation was intertwined in this, and his report is an exhaustive review of the vast majority of the medical records that existed up to his exam. This put the doctor in an excellent position to see all of the existing medical evidence in this case at one time in offering his opinions.

Incorporating the findings of the Arbitrator regarding the cervical spine as well, the Arbitrator finds that the Petitioner's causally related lumbar condition ended as of 11/19/13.

The Arbitrator finds that the Petitioner in this case reached maximum medical improvement regarding the left shoulder as of 6/9/17 based upon the release of Dr. Lee following the second left shoulder surgery, at which point she was released with permanent restrictions.

The Arbitrator notes that none of the physicians involved in this case has referenced the thoracic spine as being involved with Petitioner's subjective complaints in any way. As such, there is no evidence that the thoracic spine was injured on 7/12/13.

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

The Petitioner submitted her claimed medical expenses as Petitioner's Exhibit 1.

The Arbitrator initially notes that Dr. Oestmann testified that Petitioner's 8/5/14 and 5/5/15 visits were unrelated to the accident. As such, any billing related to these dates of treatment is denied based on a lack of causal relationship.

The Arbitrator finds that the billing that is related to the treatment of Petitioner's left shoulder condition is the responsibility of the Respondent and this billing is awarded pursuant to Section 8(a) of the Act, subject to the fee schedule limitations of Section 8.2 of the Act.

The Arbitrator finds that any causal relationship of the Petitioner's cervical condition ended as of 11/19/13. The expenses for any treatment Petitioner received prior to and including that date which relates to the cervical spine is awarded. Any cervical treatment and expenses that were incurred after that date are denied.

The Arbitrator finds that any causal relationship of the Petitioner's lumbar condition ended as of 11/19/13. The expenses for any treatment Petitioner received prior to and including that date which relates to the lumbar spine is awarded. Any lumbar treatment and expenses that were incurred after that date are denied.

The Respondent is entitled to credit for any and all awarded medical expenses that were paid prior to the hearing date via either workers' compensation insurance coverage through the Respondent or any group health insurance coverage through the Respondent, and Respondent shall hold the Petitioner harmless from any and all claims or liabilities that may be made against him by reason of having received such payments only to the extent of such credit, pursuant to Section 8(j) 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 (AMA) "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 AMA permanent partial impairment rating or report was submitted into evidence by either party with regard to the Petitioner's cervical or lumbar spine injuries. While an AMA permanent partial impairment rating was submitted by Respondent with regard to the Petitioner's left shoulder injury, the Arbitrator has determined that §8.1b is not applicable this injury, as noted below. This factor carries no weight in the permanency determination regarding the Petitioner's spine.

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 an x-ray technician at the time of the accident and that he is not able to return to work in his prior capacity as a result of said injury. However, the evidence supports that this incapacity is due to her left shoulder condition, not her cervical and lumbar conditions. This factor carries no significant weight in the permanency determination regarding the Petitioner's spine.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 50 years old at the time of the accident. Neither party has submitted evidence which tends to show how the Petitioner's age may impact any permanent disability that Petitioner may have suffered based on her spinal condition. This factor carries no weight in the permanency determination regarding Petitioner's spine.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that the evidence supports the fact that Petitioner's left shoulder condition has impacted her future earning capacity based on the permanent restrictions indicated by Dr. Lee and Dr. Emanuel. As such, this factor does not carry any significant weight in the permanency determination with regard to Petitioner's spine.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that the greater weight of the evidence supports that the Petitioner's cervical and lumbar injuries relative to the 7/12/13 accident involved temporary strains which do not impact her permanent condition. The Petitioner had a significant cervical degenerative condition and related symptoms for several years prior to this accident, and the evidence indicates that the 7/12/13 accident did not structurally impact the Petitioner's cervical spine. While she did complain of increased cervical symptoms after the accident, the Arbitrator finds that her post-accident condition significantly mirrors her pre-accident condition. With regard to the lumbar condition, the Arbitrator notes that the Petitioner also has acknowledged a prior condition, and there are medical records which support this as well. While the Petitioner's medical records are replete with cervical and lumbar complaints as well as radicular symptoms, the Petitioner's complaints have been widespread and,

based on the greater weight of the medical and medical expert evidence in this case, these complaints have been somewhat non-anatomic, and the several physicians have found the Petitioner's complaints to be exaggerated and/or inconsistent with her objective and clinical findings. These inconsistencies make it very difficult to find that any ongoing symptoms can be validly connected to the 7/12/13 accident. The Arbitrator does believe that the Petitioner had symptoms related to the cervical and lumbar spine following the accident, but that any such symptoms were based on a minor aggravation of preexisting conditions in both spinal areas, and the inconsistencies make it very difficult to find any significant ongoing permanent partial disability to the cervical and lumbar spine is causally related to the 7/12/13 accident.

Based on the above factors, the record taken as a whole and a review of prior Commission awards with similar injuries similar outcomes, the Arbitrator finds that Petitioner sustained permanent partial disability to the cervical spine to the extent of the loss of use of 3.5% of the person as a whole, and sustained permanent partial disability to the lumbar spine to the extent of the loss of use of 3.5% of the person as a whole, pursuant to §8(d)2 of the Act.

With regard to the left shoulder, §8.1b of the Act is not applicable to the Petitioner's left shoulder injury because this injury is subject to §8(d)1 of the Act based on the Petitioner having permanent restrictions related to her left shoulder which have led to her partial incapacity from pursuing her usual and customary line of employment as an x-ray technician.

Petitioner testified that at the time of her work accident, she was employed by Respondent as an x-ray tech with an average weekly wage of $999.31, which was stipulated. She testified she is now employed by Respondent as a front desk worker due to permanent restrictions related to her left shoulder injury. This is not in dispute. Petitioner testified she currently earns $15.18 per hour. She also confirmed her payroll records for the 46 weeks prior to the date of hearing. (Rx18). Based on the evidence, the Petitioner, pursuant to §8(d)1, is capable of earning her current wage as the average amount she is able to earn in suitable employment.

Our courts have indicated that Section 8(d)1 is the preferred method of awarding permanent disability where applicable. This Section of the Act dictates that Petitioner is entitled to 66 2/3 percent of the difference between the average amount which she would be able to earn in the full performance of her duties in the occupation in which she was engaged at the time of the accident, and the average amount she is earning currently.

Petitioner's stipulated her average weekly wage on her date of accident was $999.31. The Arbitrator did not note that the Petitioner testified to the number of hours she worked per week that led to her receiving this wage. She testified she would be making essentially the same rate of pay were she still employed as an x-ray tech at the time of trial. Her average weekly wage in her current position is $596.96. This was calculated by dividing her non-overtime earnings in the last year ($27,460.33) by the number of weeks she worked (46). The difference between these amounts is $402.35, 66 2/3 percent of which equals $268.23.

Petitioner is therefore awarded $268.23 per week until she reaches 67 years of age, or five years from the date this award becomes final, whichever is later.

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

Rudolph A. Brida,
Petitioner,
vs.

20IWCC0008

NO: 19 WC 3334

Springfield Police Department,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 31, 2019, 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.

There is no bond for the removal of this cause to the Circuit Court by Respondent pursuant to §19(f)(2) of the 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: JAN 3 - 2020
o12/5/19
DLS/rm
046

Deborah L. Simpson

Barbara N. Flores

Marc Parker

8008300105

ILLINOIS WORKERS' COMPENSATION COMMISSION

NOTICE OF ARBITRATOR DECISION

20IWCC0008

BRIDA, RUDOLPH A
Employee/Petitioner

Case# **19WC003334**

SPRINGFIELD POLICE DEPARTMENT
Employer/Respondent

On 5/31/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.32% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1189 WOLTER BEEMAN LYNCH ET AL
FRANCIS J LYNCH
1001 S 6TH ST
SPRINGFIELD, IL 62703

0332 LIVINGSTONE MUELLER ET AL
DENNIS S O'BRIEN
PO BOX 335
SPRINGFIELD, IL 62705

20IWCC0008

STATE OF ILLINOIS)
)SS.
COUNTY OF SANGAMON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

RUDOLPH A. BRIDA,
Employee/Petitioner

v.

SPRINGFIELD POLICE DEPARTMENT,
Employer/Respondent

Case # **19** WC **3334**

Consolidated cases: _____

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Maureen Pulia**, Arbitrator of the Commission, in the city of **Springfield**, on **5/23/19**. By stipulation, the parties agree:

On the date of accident, **3/24/18**, 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 $**61,052.38**, and the average weekly wage was $**1,174.08**.

At the time of injury, Petitioner was **32** years of age, ***married*** with **2** dependent children.

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

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**.

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 $**704.45**/week for a further period of **68.75** weeks, as provided in Section **8(d)2** of the Act, because the injuries sustained caused **petitioner a 13.75% loss of use of his person as a whole**.

Respondent shall pay Petitioner compensation that has accrued from **3/24/18** through **5/23/19**, 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

5/24/19
Date

MAY 31 2019

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 32 year old police officer, sustained an accidental injury to his right shoulder that arose out of and in the course of his employment by respondent on 3/24/18.

On 3/24/18 petitioner was dispatched to a call at a home on East Cook. The victim was a woman who accused the suspect, her relative, of using her debit card without permission. The suspect was in the home in an upstairs bedroom. Petitioner and his fellow officer went upstairs to speak with the suspect. There were about 14 steep stairs up to a landing. From the landing were two shorter staircases up the left and right of the landing. Petitioner and his fellow officer entered the room and woke the suspect up. He was agitated, and the petitioner and his fellow officer tried to talk with him. As they tried to talk with the suspect he tried to leave the room. The suspect would not answer any of the officers' questions. He continued to try and get past them and out of the room. The petitioner and his fellow officer told the suspect that he was being temporarily detained. At that point, the suspect lunged at the petitioner with two hands. The petitioner tried to hold the suspect back with his right arm, and physically restrict him from leaving. The suspect sent the petitioner into the wall. Petitioner's fellow officer grabbed the suspect by the waist as he tried to get past him, to prevent him from going down the stairs. The officer's grip broke and he and the suspect fell down the steps to the landing. That officer injured his head. Petitioner, seeing this, ran down the stairs to the landing. He tried to secure handcuffs on the suspect. As he grabbed the suspect's arm, the suspect kicked with both feet striking petitioner in the chest, causing him to fall down the remaining 14-15 steps from the landing to the ground floor.

After the petitioner landed on the ground level he got up and saw his fellow officer still on the landing with the suspect. He returned up the stairs in order to secure the suspect in handcuffs. The suspect continued to fight back, kicking and punching the officers. Petitioner's fellow office finally got a grip on the suspect's waist. Petitioner then reached over the suspect in order to grab his arm and secure the handcuffs. All the while telling the suspect to stop resisting. Again, the petitioner continued to fight back and the petitioner, his fellow officer and the suspect fell down the 14-15 stairs from the landing to the ground floor. At the bottom of the steps, the suspect was on top of petitioner. Petitioner tried to push him off with his right hand enough so that he could reach his department issued taser. The petitioner then deployed the laser into the suspect's torso area. At that point, petitioner and his fellow officer were able to restrain the suspect and take him into custody.

Petitioner presented to the emergency room at Memorial Medical Center on 3/24/18. He gave a consistent history of the injury. He complained of back pain, and soreness in his right shoulder. Petitioner was examined and x-rays of petitioner's left rib cage were taken. Dr. Berg's diagnosis was right shoulder strain and left flank contusion. Petitioner was referred to his primary care physician, Dr. Morton.

On 4/9/18 petitioner presented to Dr. Morton. He provided a consistent history of the injury. Petitioner reported that his rib cage area was feeling better, but his right shoulder issue had continued. He reported discomfort when he tried to raise his right arm above shoulder level. Dr. Morton examined petitioner and assessed a right shoulder rotator cuff strain and chest wall contusion that was improving. Dr. Morton prescribed some physical therapy. Petitioner returned to Dr. Morton on 4/19/18 for unrelated sinusitis.

On 4/24/19 petitioner presented to the Orthopedic Department at Springfield Clinic on the referral of Dr. Morton for his right shoulder injury. Petitioner provided a consistent history of the accident. Physician's Assistant David Purves examined petitioner and took some x-rays of the right shoulder. His impression was right shoulder rotator cuff injury. Purves performed an injection into the subacromial space, and recommended a course of physical therapy.

Petitioner presented for an initial physical therapy evaluation on 5/18/18. He noted that his ribs had fully recovered. He also reported that his right shoulder continued to be painful with lifting overhead and reaching behind his back. Petitioner had full range of motion but demonstrated mild weakness and pain with subscapularis and supraspinatus testing. Grinding was also noted in the right shoulder with active motion. Six weeks of therapy at 1-2 times a week was recommended.

On 6/7/18 petitioner returned to Purves. He reported continued pain with activity. He noted that symptoms occur with activity away from the body, overhead, and at night with sleeping. Following an injection petitioner was assessed with right shoulder impingement syndrome. An MRI of the right shoulder was ordered due to lack of improvement.

On 7/13/18 petitioner returned to Purves. The results of the MRI were reviewed. Purves noted that the MRI showed acromial spur with abnormal signal in the distal supraspinatus tendon. Fluid was also seen within the suscapularis. No full thickness tear was seen. Some fluid was seen within both tendons consistent with tendinopathy and intratendinous delamination. Also seen was some increased signal in the region of the anterior labrum. He did not see any true labral pathology. Purves recommended continued conservative treatment. A 2nd injection was recommended but the petitioner stated that the 1st injection made him worse. Purves prescribed Meloxicam.

On 8/1/18 petitioner presented to Dr. Wottowa. Dr. Wottowa noted that petitioner's shoulder had actually gotten worse over the past few months. Following an examination and radiograph review. Dr. Wottowa's impression was mainly rotator cuff tendinitis, created and exacerbated by the fall. Since petitioner was unresponsive to injections and therapy, Dr. Wottowa performed a true impingement test, an injection of just lidocaine in the subacromial space. Since this improved petitioner's symptoms dramatically, Dr. Wottowa was of the opinion that the impingement portion of his problem was the source of his discomfort. Dr. Wottowa was

of the opinion petitioner could live with it, or consider a shoulder arthroscopy. Dr. Wottowa was of the opinion that petitioner living with it would be problematic for him because of his job. Petitioner decided on undergoing the surgery.

Petitioner continued working full duty until his surgery.

Petitioner underwent a preoperative history and physical on 8/23/18. On 8/30/18 petitioner underwent a right shoulder arthroscopy with a subacromial decompression, performed by Dr. Wottowa. Petitioner followed up postoperatively with Dr. Wottowa. This follow-up included a course of physical therapy and follow-up visits on 9/14/18, 10/15/18, 11/26/18, 12/12/18, and 1/9/19.

On 10/15/18 Dr. Wottowa noted that petitioner had done exceptionally well with his right shoulder. He noted that petitioner still had some discomfort over his right shoulder, but had done well in physical therapy. He noted that now that petitioner was doing exercises he had a little more discomfort. Petitioner's shoulder motion was outstanding, and he had full flexion, full abduction, and normal rotation and excellent strength. Petitioner showed mildly positive impingement signs, and tenderness directly at the acromion. Dr. Wottowa continued petitioner in therapy. Dr. Wottowa released petitioner to desk work.

On 11/1/18 petitioner told the therapist that his only pain was with pushup activities. On 11/13/18 he told the therapist he would get sore with working out and then it would feel better when he stopped. On 11/19/18 he told the therapist that he could do pushups in a different position to compensate for pain. On 11/29/18 he told the therapist he had turned a corner and was doing better, and hitting it hard at the gym. On 12/4/18 he reported that he was doing very well and doing his regular gym and lifting routine. On 12/11/18 petitioner was discharged from physical therapy. Petitioner's worst pain level was reported as a 2. His best pain level was a 0, and his current pain level was a 0. With regard to his current complaints, petitioner noted that he was feeling good and eager to return to full duty work at a police officer. He reported his aggravating factors as reaching out to the side. All of petitioner's therapy goals were reached.

On 12/12/18 Dr. Wottowa noted that petitioner was doing well. He had full active and passive range of motion of the shoulder. His drop arm testing was negative; super space strength was 5/5; and, had normal neurovascular function in the upper extremities. Dr. Wottowa noted that petitioner was doing well, and was going to continue a home exercise program and continue to progress activity as tolerated. Dr. Wottowa was of the opinion that petitioner could return to work. He instructed petitioner to follow-up in a month, and if he was doing well, would give him a full release at maximum medical improvement.

On 1/9/19 petitioner last followed up with Dr. Wottowa. It was noted that petitioner had no pain. Dr. Wottowa noted that the only thing bothering him was that he could not do pushups. Petitioner denied that he

had no pain. He stated that he had no pain with resting. An examination revealed full range of motion and normal strength, negative impingement signs, and well healed incisions. Dr. Wottowas's impression was that petitioner looked "like a million bucks". He gave petitioner a full release and return to full duty work without restrictions. He placed him at maximum medical improvement.

Since returning to work petitioner's primary complaint is pushing and pulling with his right arm in front of him. He testified that he has improved from pre-operative status. He reported no pain with rest, riding in a car, or at a desk. Petitioner testified that he still has pain with pushups.

Petitioner gave a history of a recent altercation with an intoxicated suspect at Walgreen's that escalated to the point where the suspect lunged at him and his fellow officer. As petitioner grabbed the suspect's right arm to secure it, the suspect pulled away and fell to the ground with his arms underneath him. Petitioner had to hold him down while his fellow officer tried to cuff him. While doing this he felt pain in his right arm, and tried to compensate for it with shifting of his body weight. Petitioner also reported increased pain in his right arm when he tried to come between a male and a female while he was trying to get the female and her baby away from the male suspect. He stated that he had difficulty doing this with his right arm and had to ultimately put his foot in the door to stop the suspect from trying to push him out the door and close it before petitioner could get the female and her baby outside to talk to her separately.

Petitioner testified that he also noticed problems while doing rifle firearm training. Petitioner testified that he has not yet had to qualify with his rifle since being released from care and back to full duty work.

Petitioner testified that he has had to figure out how to reconfigure his body movements when using his right arm to compensate for the pain in his right arm when he outstretches it. Petitioner also feels pain in his right arm when placing suspects in the police car, and after altercations with suspects. Petitioner testified that he cannot do a pushup motion without pain. He also suspected he would have difficulty with CPR, but has not yet done any CPR on anyone since being released from care and returned to full duty work.

Since being released from care petitioner is making more money than at the time of the injury. He is also performing his regular duty police officer duties without any restrictions or accommodations. Petitioner testified that he has not complained to any of his superior of any problems with his right shoulder. Petitioner testified that he has progressed steadily since released by Dr. Wottowa, and was told by Dr. Wottowa that he would continue to improve for about a year and a half.

WHAT IS THE NATURE AND EXTENT OF THE INJURY?

For injuries that occurred after 9/1/11, according to 820 ILCS 305/8.1B(b) the Commission shall base its determination of permanent partial disability based upon five factors including an AMA report, the occupation

of the injured employee, the age of the employee at the time of injury, the employee's future earning capacity and evidence of disability corroborated by treating medical records.

With regard to subsection (i) of §8.1b(b), neither party offered into evidence an AMA impairment report into evidence. The Arbitrator therefore gives no weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the petitioner was a 32 year old police officer at the time of the injury. On 12/12/18 petitioner was released from care to full duty work without restrictions. Petitioner has continued to work without restrictions or accommodations since being released to full duty work. Petitioner still has pain in his right arm when doing pushup or working with his right arm extended. For these reasons the arbitrator gives greater weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that the petitioner was a 32 year old police officer at the time of the injury. Petitioner was released from care to full duty work without restrictions. Nonetheless, the petitioner continues to experience pain in his right arm when his arm is extended in front of him or he is doing pushups. Petitioner also gave specific incidents of when his right arm/shoulder causes him pain while he is performing his duties as a police officer. The Arbitrator notes that given his age, petitioner could potentially have multiple decades of police work ahead of him. For these reasons the arbitrator gives greater weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the arbitrator notes that petitioner was released to full duty work without restrictions. Petitioner testified that he is making more money than he was on the date of injury. Therefore, the arbitrator gives lesser weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator finds the petitioner sustained an injury to his left ribs that resolved. He also sustained an injury to his right shoulder for which he underwent a cortisone injection and therapy with no lasting relief. Following the failure of conservative treatment, petitioner underwent a right shoulder arthroscopy with a subacromial decompression. Post-operatively he had regular follow-ups and physical therapy through December 2018. At that time he was released to desk duty, and on 1/9/19 he was released from care at maximum medical improvement. He was returned to full duty work without any restrictions. Dr. Wottowa noted that petitioner had no pain. He also noted that the only thing bothering petitioner was that he could not do pushups. Petitioner denied that he had no pain. He stated that he had no pain with resting. An examination revealed full range of motion and normal strength, negative impingement signs, and well healed incisions. Dr. Wottowas's impression was that petitioner looked "like a million bucks". Petitioner testified that his primary complaint is pushing and pulling with his right arm in from of him and doing pushups. Petitioner testified that

he has had to figure out how to reconfigure his body movements and body weight when using his right arm extended in front of him or while doing a pushup motion, especially while at work. Petitioner also still has complaints while doing rifle firearm training. He has not yet had to qualify with his rifle since his release to full duty work. Petitioner also suspected that he would have difficulty doing CPR, but has not needed to perform it since his release to full duty work. Petitioner is working his full duty job without restrictions and has not asked for any accommodations. Therefore, the arbitrator gives greater weight to this factor.

Based on the above factors, and the record taken as a whole, the Arbitrator finds the petitioner sustained a permanent partial disability to the extent of 13.75% loss of use of person as a whole pursuant to Section 8(d)2 of the Act.

SOINCC0008

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

Tim Aeschliman,

Petitioner,

20IWCC0009

vs.

NO: 17 WC 06484

Charles River Laboratories Inc.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issue(s) of accident and causation, medical expenses and prospective medical care, temporary total disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 8, 2018 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.

50IACC0006

20IWCC0009

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: JAN 6 - 2020
o110519
MEP/ypv
049

Maria Portela

Thomas J. Tyrrell

Kathryn Doerries

SOIMCC0003

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

AESCHLIMAN, TIM
Employee/Petitioner

Case# **17WC006484**

17WC033985

CHARLES RIVER LABORATORIES INC
Employer/Respondent

20 I W C C 0 0 0 9

On 2/8/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.65% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5847 THE LAW OFFICE OF DAVID HUNT
235 N E PERRY AVE
PEORIA, IL 61603

0000 RUSIN & MACIOROWSKI LTD
MARK COSIMINI
2506 GALEN DE SUITE 108
CHAMPAIGN, IL 61821

50 LMCC0008

20IWCC0009

STATE OF ILLINOIS)
)SS.
COUNTY OF PEORIA)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Tim Aeschliman
Employee/Petitioner

Case # 17 WC 006484

v.

Consolidated cases: 17 WC 033985

Charles River Laboratories, Inc.
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Douglas McCarthy, Arbitrator of the Commission, in the city of Peoria, on January 10, 2018. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

E. ☐ 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, 10-31-2016, Respondent **was** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $49,870.60; the average weekly wage was $959.05.

On the date of accident, Petitioner was 28 years of age, single, with 0 children under 18.

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

ORDER

Petitioner failed to prove he sustained accidental injuries which arose out of and in the course of his employment for Respondent.

Petitioner failed to prove his current condition of ill-being is causally related to the October 31, 2016 alleged work accident.

Petitioner's claim for prospective medical care is denied.

Petitioner's claim for the payment of TTD benefits is denied.

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

RULES REGARDING APPEALS Unless a *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 of at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

D. Douglas McCarthy

Signature of Arbitrator

2/1/18

Date

FEB 8 - 2018

STATEMENT OF FACTS

Petitioner was hired as a farm technician by Respondent in May 2006. Respondent's facility is a chicken farm utilized for the production of eggs. Petitioner testified Respondent's facility includes 11 chicken houses with as many as 9,000 to 10,000 chickens per house. Respondent's facility could have as many as 100,000 chickens at a time.

Petitioner's job duties include taking care of the chickens. He makes sure they are healthy and have sufficient food and water. He also performs various testing of the chickens to ensure their health.

Petitioner testified that one of the more difficult aspects of the job is culling roosters which is necessary to maintain an appropriate population of the chickens.

Petitioner further testified that between June 20, 2016 and June 26, 2016 he culled 48 roosters. He described the process as severing the brainstem of the rooster from the rooster's brain. He also described the process as cervically dislocating the rooster.

Petitioner explained he holds the legs of the rooster in his left hand, and grabs the chicken's neck between his right index and right middle fingers. He then pulls downward on the chicken's head with sufficient force to sever the brainstem from the brain. Petitioner described the process as a difficult procedure. He also testified culling 48 roosters in a short period of time is an unusual amount.

Petitioner testified that after that week in June 2016, he had a lot of pain and was not able to do as much. He went to see a physician at Ortho NY in Albany, New York. He underwent an MRI arthrogram and was released to return to work at his regular job.

Petitioner testified his shoulder got worse, but he was still able to perform his job duties.

Petitioner testified he sustained a second accident October 31, 2016. He testified he was in a chicken coop building a chicken pen. He was on the floor and he pulled himself up with his right arm by grabbing on to a chicken perch which is a steel bar. As Petitioner was pulling himself up, he felt a large pop and some pain in his right shoulder. He testified he had to leave immediately to seek medical attention.

Petitioner testified he was having shoulder pain prior to the second accident, but he was still able to perform his job duties. However, after the second accident, he was unable to lift his arm to perform the necessary job duties. Petitioner described the condition of his shoulder after the second accident as having a lot of pain. Petitioner testified he knew that he needed medical attention. On direct exam, Petitioner testified he went back to Ortho NY where another MRI arthrogram was performed. Petitioner was allowed to return to work with restrictions, and Respondent accommodated the restrictions.

Respondent terminated Petitioner's employment January 18, 2017.

Petitioner returned to Illinois after he was terminated from his employment by Respondent. He was evaluated by Dr. Brett Keller February 14, 2017. Petitioner testified that Dr. Keller advised Petitioner to undergo surgery as soon as possible.

At trial, Petitioner testified he was still having trouble sleeping, and he could not raise his shoulder above his head. He indicated he lacked mobility in his shoulder, and he was unable to perform everyday tasks like he used to.

Petitioner further testified that when he saw Respondent's examining physician, he described the culling actions required as part of his job duties. He also testified he described the rooster culling activities for Dr. Keller.

On cross exam, Petitioner acknowledged the roosters were not very heavy for him. The roosters weigh between 7 and 8 pounds, and Petitioner is 6 feet, 2 inches tall and weighs 250 pounds.

When asked about the number of roosters Petitioner culled, he acknowledged culling 22 roosters June 22, 2016 and not having any problems as a result of those activities. Petitioner then culled 20 additional roosters June 26, 2016, and he testified that was when he began having problems with his shoulder.

Petitioner denied experiencing a specific incident while culling roosters, rather, he felt kind of sore after the culling activities June 26, 2016.

Petitioner testified the culling of an individual rooster could take anywhere from 4-5 seconds up to 10-15 seconds depending upon how much of a struggle the rooster makes. Petitioner estimated that it would have taken him about an hour to catch and cull 20 roosters June 26, 2016.

When asked why he used his bad arm to pull himself up from the floor of the chicken coop October 31, 2016, Petitioner indicated it was his only option because of the cramped space he was in.

When asked why he waited three weeks between the incident October 31, 2016 and his next medical visit, Petitioner testified the delay was because he was swamped with work. During those three weeks, Petitioner continued performing his regular job duties.

Petitioner denied telling Dr. Kaback that he experienced several years worth of shoulder pain. Petitioner did acknowledge undergoing an MRI for his right shoulder in 2010. He testified he had the MRI performed, because he did not think his shoulder was perfect after undergoing

surgery. His primary concern seemed to be that he did not have a full range of motion for his backswing while golfing.

Petitioner also acknowledged that shoulder dislocations in the right arm were one of the reasons for going back to see the doctor in November 2016. Petitioner testified he was able to self-reduce his shoulder dislocations and put them back in place. He would either push his shoulder against a wall, or he would pull on his shoulder against his body.

Petitioner also acknowledged he had not received any treatment for his right shoulder since February 2017. He also indicated he has not made any attempts to return to work since being terminated by Respondent.

During the remaining portions of Petitioner's testimony, he talked about the shoulder dislocations. He indicated he moved the shoulder back into its original place. He also described the dislocations as meaning there was little to zero movement in the shoulder.

Petitioner testified that when he reduced the shoulder dislocations or subluxations, the joint did not move, his shoulder mobility did not return, and his pain did not decrease.

With respect to Petitioner's medical treatment, he underwent surgery on his right shoulder several years before the first alleged accident date. Surgery was performed October 24, 2007 consisting of a debridement of a posterior labral tear and a subacromial decompression. The diagnoses included a posterior labral tear and a right shoulder impingement syndrome. (Px.6)

Dr. Keller gave Petitioner a full-duty release February 12, 2008. (Px.6)

Petitioner returned for an MRI of the right shoulder both on March 10, 2010 and April 13, 2010. The report from March 10, 2010 indicates Petitioner had a tiny

subacromial-subdeltoid bursal effusion and a mild synovial hypertrophy of the acromioclavicular joint. (Px.6)

The report from the April 13, 2010 MRI indicates there was no evidence of a rotator cuff tear. Petitioner did have marrow edema at the distal clavicle which was thought to possibly be related to a fracture. Clinical correlation with a history of trauma was recommended. (Px.6)

Following the rooster culling activities June 26, 2016, Petitioner reported to Dr. Kaback at Ortho NY July 1, 2016. The history form indicates Petitioner was being seen for right shoulder pain. The treatment note indicates Petitioner was engaged in repetitive pulling-type work over the past several weeks, and he noticed a lot of popping and grinding pain in the right shoulder. (Px.4)

An MRI arthrogram was performed July 26, 2016. The study revealed anterior and posterior labral tears with a paralabral cyst at the posterior labrum. Additionally, fluid was identified which was thought to be consistent with a ganglion cyst. (Px.4)

Petitioner continued working in his regular capacity. He returned to see Dr. Kaback November 22, 2016 which is about three weeks after the reported incident from October 31, 2016. Petitioner provided a history of culling roosters in June 2016 which involved the extension of the right shoulder. Petitioner indicated he had immediate pain in his right shoulder. He also told Dr. Kaback he had two dislocations of the right shoulder since the previous visit with one occurring the previous day and with one occurring in his sleep. Petitioner told Dr. Kaback he was able to self-reduce each of the dislocations. No history of the October 31, 2016 incident was provided to Dr. Kaback. (Px.4)

On exam, Dr. Kaback did not identify any instability, but he still diagnosed Petitioner with right shoulder anterior instability. He imposed a restriction of no repetitive use with the right arm. (Px.4)

On December 27, 2016, another MRI arthrogram was performed of Petitioner's right shoulder. The report indicates there is a more extensive anterior labral tear, and the posterior labral tear was stable. The paralabral cyst on the posterior side of the labrum was enlarged. Similarly, the ganglion cyst was enlarged. (Px.4)

When Petitioner returned to see Dr. Kaback January 4, 2017, he advised he had three right shoulder dislocations since the previous evaluation with one of the dislocations occurring in his sleep. Petitioner was still working in a full-time capacity as of that office visit. (Px.4)

On exam, no atrophy was identified in the right shoulder or right upper extremity. Dr. Kaback recommended surgery for the anterior/inferior labral tear. For his progress report, Dr. Kaback indicated there was no temporary impairment. (Px.4)

When Petitioner returned to Illinois, he was evaluated by Dr. Brett Keller February 14, 2017. Petitioner provided a history of re-injuring his right shoulder June 26, 2016 while working on a farm. He reportedly pushed himself off the floor and felt a pop in his right shoulder. Petitioner told Dr. Keller that as he continued working around the farm, his pain level increased to the point where he was unable to lift his arm above his head. (Px.6)

Petitioner advised Dr. Keller that he dislocated his shoulder a few times, but he was able to relocate the shoulder on his own with severe pain. Dr. Keller recommended surgery on the right shoulder. (Px.6)

At the request of Respondent, Petitioner was evaluated by Dr. Scott Sagerman May 18, 2017. Petitioner provided a history to Dr. Sagerman of culling about 400 roosters

during June 2016. He also indicated that on June 26, 2016, he felt a pop and pain in his right shoulder and was then unable to use his arm. (Rx.4, Dep. Ex.2)

Petitioner described the procedure of culling roosters as requiring forceful use of the right arm to perform a cervical dislocation. Petitioner also told Dr. Sagerman that beginning in November 2016, his shoulder started dislocating, and he put it back in place himself six times. (Rx.4, Dep. Ex.2)

Additionally, Petitioner reported that in December 2016, he felt increased pain in his shoulder when pulling himself up from the floor in a chicken house. (Rx.4, Dep. Ex.2)

Dr. Sagerman diagnosed Petitioner with a right shoulder labral tear with instability. He was uncertain as to the cause of the condition. (Rx.4, Dep. Ex.2)

After reviewing additional information including a job description and Dr. Keller's deposition testimony, Dr. Sagerman rendered an opinion that Petitioner's work activities would not have caused or aggravated Petitioner's right shoulder condition. (Rx.4, Dep. Ex.3)

Both Dr. Keller and Dr. Sagerman testified by way of evidence deposition.

Dr. Keller testified September 1, 2017. (Px.7)

Dr. Keller is an orthopedic surgeon. (Px.7, p.3) He evaluated Petitioner on February 14, 2017. (Px.7, pp.4-5)

Petitioner provided a history to Dr. Keller of re-injuring his right shoulder when he was pushing himself off a floor and felt a pop in his right shoulder. (Px.7, p.5) Petitioner further reported to Dr. Keller that his right shoulder got worse with activities, and he was unable to lift his arm. He also reported he dislocated his shoulder a few times, but he was able to relocate the shoulder with severe pain. (Px.7, p.5)

Dr. Keller indicated he performed surgery on Petitioner's right shoulder October 24, 2007 for a posterior labral tear. He then allowed Petitioner to return to work with no restrictions February 12, 2008. (Px.7, p.7)

Dr. Keller had not seen the medical records from Ortho NY. He only reviewed the MRI films from December 27, 2016. He interpreted the films to show an anterior and posterior labral tear with a paralabral cyst with no evidence of a rotator cuff tear. (Px.7, p.8)

Dr. Keller acknowledged the language on the December 2017 MRI report in that it noted the anterior labral tear was more extensive, but he had not reviewed the films from July 26, 2016 to compare the changes. (Px.7, pp.9-10)

Dr. Keller testified his clinical exam was consistent with the MRI findings. (Px.7, p.10) Dr. Keller diagnosed Petitioner with the labral tears and a cyst as well as both anterior and inferior instability. He recommended an arthroscopic procedure to debride or possibly repair the torn labrum. He also recommended a subacromial decompression and a distal clavicle excision. (Px.7, p.11)

Dr. Keller took Petitioner off work as of February 14, 2017. He testified he has not seen Petitioner since February 14, 2017. (Px.7, p.12)

Counsel for Petitioner provided a hypothetical question to Dr. Keller including the history of Petitioner having to cull 40-50 roosters which was when the shoulder first began hurting. (Px.7, p.13) The hypothetical also indicated Petitioner's symptoms started after performing the culling activities for a week or two. Counsel for Petitioner also provided a history of Petitioner pulling himself up in the chicken coop. (Px.7, p.14)

Dr. Keller testified the culling maneuver could potentially cause a shoulder issue due to the force and repetition which was based upon Petitioner culling 40 roosters in a period of two days. (Px.7, p.15)

Dr. Keller also testified the pulling up incident was consistent with worsening the labral tear as noted on the second MRI. (Px.7, p.15)

On cross exam, Dr. Keller acknowledged Petitioner was a weightlifter, and he did not know whether Petitioner used proper form when lifting weights. (Px.7, pp.17-19)

When asked about the paralabral cyst, Dr. Keller testified it could have been there for several weeks, or it could have been in Petitioner's right shoulder for several years. (Px.7, pp.19-20)

When asked about the history provided by Petitioner, Dr. Keller testified the act of pushing up off a floor was different than the history provided by Petitioner's counsel. He also testified that pushing up off the floor would probably not cause a labral tear. (Px.7, p.20)

However, when the shoulder dislocates, it is typical for the labrum to tear. Dr. Keller conceded the three dislocations described by Petitioner would potentially explain the torn labrum. Dr. Keller further indicated that if Petitioner's right shoulder dislocated while he was sleeping, that suggests a considerable amount of instability. The surgery recommended by Dr. Keller was to stabilize the shoulder. (Px.7, p.22)

Dr. Keller indicated the dislocations described by Petitioner may not have been true dislocations but were more likely subluxations. He acknowledged the incidents described by Petitioner could have been true dislocations especially if Petitioner had significant instability. (Px.7, pp.22-23) Dr. Keller further acknowledged that if Petitioner was suffering from

dislocations or subluxations while sleeping, that would be consistent with significant instability. (Px.7, p.23)

Dr. Sagerman testified by way of evidence deposition October 24, 2017. (Rx.4)

Dr. Sagerman is an orthopedic surgeon who specializes in upper extremities. He performs shoulder surgeries on a regular basis. (Rx.4, pp.4-5)

Dr. Sagerman performed an IME at the request of Respondent May 18, 2017. (Rx.4, p.5)

Petitioner provided a history of culling 400 roosters during the month of June. He further reported that on June 26, 2016, he was culling roosters and felt a pop in his right shoulder. Petitioner also indicated he was then unable to use his right arm after the pop occurred. (Rx.4, p.6)

Petitioner told Dr. Sagerman that the culling procedure required the forceful use of the right arm to perform a cervical dislocation of the roosters. (Rx.4, pp.6-7)

Petitioner also reported to Dr. Sagerman that in November 2016, his right shoulder started dislocating. Petitioner indicated he put the shoulder back in place himself on six occasions. He then reported he experienced increased pain in December 2016 when pulling himself up off the floor. Petitioner complained of pain and popping in his right shoulder at the time of the IME. (Rx.4, p.7)

On exam, Dr. Sagerman noted Petitioner's muscle contour was normal and symmetric. Petitioner's range of motion was limited, and he complained of tenderness in the anterior glenohumeral joint and in the subacromial region. Petitioner also showed apprehension with passive range of motion. Rotation strength was grossly normal with give-way weakness and guarding. (Rx.4, p.8)

Dr. Sagerman rendered an opinion that the MRI findings were consistent with tears of the glenoid labrum. He diagnosed Petitioner with right shoulder labral tears with instability. He further indicated surgery would be a reasonable option. He did not believe Petitioner needed to have any restrictions imposed on his activities. (Rx.4, p.9)

Following the IME, Dr. Sagerman reviewed additional materials including the treatment records from Dr. Kaback and Petitioner's job description. He noted the history provided to Dr. Kaback was that Petitioner had several years worth of shoulder pain. The job duty information provided to Dr. Sagerman revealed Petitioner culled 53 roosters during June 2016. (Rx.4, p.10)

Dr. Sagerman concluded that causation was undetermined, but Petitioner's work activities would not have caused the labral tear or instability in the absence of a significant trauma to the shoulder. He did not believe there was any causal relationship between the right shoulder labral tear with instability and the claimed work accidents. (Rx.4, p.11)

Dr. Sagerman also testified that after reviewing Dr. Keller's deposition transcript, his opinions did not change. He did not believe the culling of roosters would cause or aggravate Petitioner's right shoulder condition. Similarly, he did not believe Petitioner pulling himself up would cause or aggravate the condition. (Rx.4, p.13)

When explaining his causal connection opinion, Dr. Sagerman testified the mechanism of culling roosters is not of the magnitude of trauma that would cause or aggravate the condition in Petitioner's shoulder. He further explained Petitioner's job activities did not result in the worsening of his condition. (Rx.4, pp.13-14)

On cross exam, Dr. Sagerman further explained that a person cannot apply enough force to cause a labral tear or dislocate his own shoulder. (Rx.4, pp.16-17)

At the conclusion of Petitioner's testimony at trial and the submission of each party's exhibits, the Arbitrator took the matter under advisement.

CONCLUSIONS OF LAW

In support of the Arbitrator's Decision relating to (C), Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?, the Arbitrator makes the following findings:

Petitioner alleged he sustained injuries to his right shoulder as a result of his job duties June 26, 2016. Those allegations are set forth in case number 17 WC 033985. This case involves an alleged aggravation of the shoulder injury as a result of an incident which occurred October 31, 2016. Petitioner alleges he was in a confined space building a chicken coop, and he attempted to pull himself up with his right arm. He grabbed a perch which is a steel bar, and he pulled himself up with his previously injured right arm.

At trial, Petitioner testified he experienced immediate and severe pain, and he knew he needed to obtain immediate medical treatment.

Petitioner did not receive treatment for about three weeks. He testified that he was still performing his regular job duties, and he was too swamped with work to go to the doctor.

When Petitioner saw Dr. Kaback November 22, 2016 which is about three weeks after the October 31, 2016 incident, he did not provide a history of the October 31, 2016 incident. He only provided a history of culling roosters in June 2016 and also of experiencing two shoulder dislocations since the previous visit with the doctor July 1, 2016. Petitioner reported that one dislocation occurred the previous day (November 21, 2016) and one occurred in his sleep. Petitioner told Dr. Kaback he was able to self-reduce each of the dislocations.

Petitioner never told Dr. Kaback about anything which occurred October 31, 2016.

When Petitioner returned to see Dr. Kaback January 4, 2017, he again talked about shoulder dislocations, but no mention was made of Petitioner pulling himself up and worsening his right shoulder condition.

Petitioner's next medical visit was with Dr. Keller February 14, 2017. Petitioner provided a history of pushing himself off the floor and feeling a pop in his right shoulder. He did not provide any history of the rooster culling activities June 26, 2016 or of an incident where he pulled himself up off the floor.

During his evidence deposition, Dr. Keller conceded that the history provided by Petitioner was different than the history contained in the hypothetical questions posed by Petitioner's attorney.

Even though Petitioner did complete an accident report, the complete lack of any reference to the October 31, 2016 incident to the medical providers cannot be overlooked. The treatment provided to Petitioner for his right shoulder was never for any injury sustained October 31, 2016.

Here, Petitioner never provided a history of the October 31, 2016 incident to his treating physicians. In fact, the mechanism of injury provided to Dr. Keller was exactly the opposite of the mechanism testified to by Petitioner.

With Petitioner not providing a history of the alleged accident October 31, 2016 to any of his treating doctors, it is clear he was not seeking treatment for any injury sustained as a result of that alleged incident. Consequently, the Arbitrator finds Petitioner failed to prove he sustained accidental injuries as a result of the described incident October 31, 2016. The Arbitrator concludes Petitioner failed to prove he sustained accidental injuries which arose out of and in the course of his employment for Respondent as a result of the described incident October 31, 2016.

In support of the Arbitrator's Decision relating to (F), Is Petitioner's current condition of ill-being causally related to the injury?, the Arbitrator makes the following findings:

The Arbitrator adopts and incorporates herein the findings set forth in Section (C) above.

With respect to the medical opinions, Dr. Keller testified the October 31, 2016 incident described to him by Petitioner's counsel during his evidence deposition would be an unlikely cause of a labral tear. (PX 7 at 21) He said rather reluctantly that the act of pushing himself off the floor probably just aggravated the condition. (Id at 16)

The Arbitrator finds that Dr. Sagerman basically agrees with Dr. Keller. He testified that the act of pulling himself up off the floor with his right hand and arm would not be sufficient to cause or aggravate a torn labrum or an unstable shoulder.

Finally, Petitioner waited over three weeks to seek medical care and when he did, on November 22, 2016, he failed to tell his doctor about the event. (PX 4)

Based upon the foregoing, the Arbitrator finds Petitioner failed to prove his current condition of ill-being is causally related to the October 31, 2016 alleged work accident in that there is no credible evidence to support a conclusion that the right shoulder condition was caused or aggravated by the October 31, 2016 incident.

In light of the above conclusions, all other issue are moot.

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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

Tim Aeschliman,

Petitioner,

20IWCC0010

vs.

NO: 17 WC 33985

Charles River Laboratories Inc.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner and Respondent herein and notice given to all parties, the Commission, after considering the issues of accident and causation, medical expenses and prospective medical care, 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 February 8, 2018 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

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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 $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.

DATED: JAN 6 - 2020
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Maria Elena Portela
Maria Portela

Thomas J. Tyrrell
Thomas J. Tyrrell

DISSENT

I respectfully dissent from the majority opinion because Petitioner has failed to prove by a preponderance of evidence that he sustained accidental injuries under a repetitive trauma theory and that his condition of ill-being is causally related to his work activities of June 26, 2016.

The claimant has the burden of proving, by a preponderance of the evidence, that he suffered a disabling injury that arose out of and in the course of his employment. Included within that burden of proof is that his current condition of ill-being is causally connected to a work-related injury. *Sisbro, Inc. v. Industrial Comm'n.*, 207 Ill.2d 193, 797 N.E.2d 665, 278 Ill.Dec 70 (2003). A claimant who alleges injury based on repetitive trauma must show that the injury is work related and not the result of the normal degenerative aging process. *Peoria County Belwood Nursing Home v. Industrial Comm'n.*, 115 Ill.2d 524, 530, 505 N.E.2d 1026, 106 Ill.Dec. 235 (1987). A claimant who seeks an award of benefits under a repetitive trauma theory is held to the same standard of

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proof as a claimant seeking benefits for a sudden, traumatic injury. *Durand v. Indus. Comm'n.*, 224 Ill.2d 53, 64 (2006). In repetitive trauma cases, the claimant generally relies on medical testimony establishing a causal connection between the work performed and claimant's disability. *Nunn v. Industrial Comm'n.,* 157 Ill.App.3d 470, 477, 510 N.E.2d 502, 109 Ill.Dec 634 (1987). "In those cases where the courts sustained a theory of repetitive trauma, the claimant in each one conclusively established a repetitive job task. In each case, the claimant performed the same task in a repetitive fashion on a daily basis." *Williams v. Industrial Comm'n*, 244 Ill. App. 3d 204, 211, 614 N.E.2d 177, 181, 185 Ill. Dec. 43, 47 (1st Dist. 1993).

In this case, Petitioner had an extensive pre-existing condition requiring right shoulder arthroscopy with debridement of a posterior labral tear and a subacromial decompression in 2007. (RX4) After discharge from care, Petitioner resumed weight lifting activities. (PX7, p. 18) Approximately three years later, Petitioner's right shoulder was interfering with activities of daily living and he sought medical care. (T. p. 40) Petitioner underwent two MRI scans because he felt his shoulder was not perfect. Petitioner, a self-described avid golfer, testified he did not have full range of motion when executing his golf swing and his back swing. (T. p. 40) On May 25, 2010, Dr. Keller noted Petitioner reported right AC joint pain resolved after receiving an injection on a previous visit and he may return to work without restrictions. (PX6) Petitioner provided a history of several years of shoulder pain to Dr. Kaback on November 22, 2016. (PX4)

Dr. Sagerman, Respondent's IME, testified Petitioner had a structural injury in 2007 necessitating surgery. Further, he opined the labral tear detected in 2007 could cause a shoulder to dislocate. (RX4, p. 7) Petitioner told his treating physician, Dr. Kaback, he had two dislocations between June and a November 22, 2016, visit and, notably, one occurred while he was sleeping. (T. p. 41) However, at arbitration, Petitioner testified he did not have any shoulder dislocations between June, 2016 and October, 2016. (T. p. 50) He testified it was after October 31, 2016, when he was pushing himself off the floor, when his right shoulder started to dislocate. (T. p. 41) Petitioner filed claim 17 WC 6484, concerning this October 31, 2016 work-related accident, which was consolidated with the present case. That case was found non-compensable and Petitioner appealed. Petitioner also advised his treating physician that since November, 2016, his right shoulder has been dislocating a lot and he reduced it himself 6 times. Petitioner testified that when his shoulder dislocated, he was able to put it back into place by pushing his shoulder up against a wall. (T. p. 42) Petitioner's testimony shows his shoulder dislocations occurred spontaneously and without incident and reflects the effects of a longstanding pre-existing condition.

The MRI arthrogram performed on July 26, 2016, revealed anterior and posterior labral tears, the posterior labral tear associated with a para labral cyst, and another fluid collection was noted extending into the region of the suprascapular and spinoglenoid notch area, felt to be consistent with a ganglion. (PX4) Dr. Keller admitted the presence of the para labral cyst indicated the labral tear was potentially pre-existing and could have potentially been present for several years. (PX 7, p. 20)

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Irrespective of any culling activity at work, Petitioner and Respondent's medical experts, Drs. Keller and Sagerman, opined dislocations typically cause labrum tears to occur. Dr. Keller conceded that the three dislocations described by Petitioner could potentially explain the torn labrum. (PX7, p. 22) Also, because one of the dislocations occurred while Petitioner was sleeping, it shows there was considerable instability in the shoulder. (PX7, p. 22) Dr. Sagerman testified that the worsening of the labrum tear as shown on the December 27, 2016, MRI happened after the dislocations which put additional strain on the labrum. (RX4, p. 19)

Based on the foregoing, Petitioner has failed to prove his condition is causally related to his work activities.

Dr. Sagerman further testified that the procedure for culling roosters, in this case cervical dislocation, would not cause or aggravate the Petitioner's right shoulder condition. (RX4, p. 13) Specifically, in the absence of a significant trauma, the Petitioner's work activities would not cause or aggravate a labral tear. (RX4, p. 13) Dr. Sagerman was posited a hypothetical question that asked him to assume Petitioner had to use a great deal of force to perform the cervical dislocation, he performed it 53 times in June, and had no symptoms before but symptoms after, would the condition of the shoulder be causally related to the activity. Dr. Sagerman testified that the activity described would not be enough force to cause a labral tear **or** dislocate a person's shoulder. Further, there was no connection between the mechanism of injury to the pathology detected on the MRI. Dr. Sagerman's opinion was based on his physical examination, his review of Ortho New York/Dr. Kaback's treating records, his review of a written job description that indicated Petitioner culled 53 roosters during the month of June, his review of both recent and past radiological images of Petitioner's right shoulder, review of Dr. Keller's treating records from 2007 and 2010 as well as Dr. Keller's evidence deposition testimony. (RX4)

Reliance on Dr. Keller's causation opinion is misplaced. First, Dr. Keller's medical records state Petitioner reinjured his right shoulder on June 26, 2016, as a result of pushing himself off the floor while working on the farm. (PX6) Dr. Keller testified this action would not cause a labral tear. (PX7, p. 20) Second, the medical records do not reference any repetitive activity or culling activity as the cause of Petitioner's right shoulder complaints. (PX7, p. 21) Thus, his causation opinion causally relating the right shoulder condition to the culling activity, specifically cervical dislocation, is not supported by his own records.

Third, Dr. Keller was given a hypothetical question based on facts not in evidence. Dr. Keller was asked to assume Petitioner's culling activity required a very difficult heavy maneuver as far as force and he did that for a week or two before his symptoms started. Dr. Keller admitted on cross-examination it usually takes "a pretty significant force or trauma" to cause Petitioner's shoulder condition. But Petitioner did not testify his activity involved significant force or was a very difficult heavy maneuver. In fact, Petitioner testified he did not know how many pounds was used to perform the activity. (T. p. 22) Notably, the evidence shows the chickens weighed 5-7 pounds and Petitioner stood 6'2" tall and weighed 250-260 pounds. Additionally, Petitioner never testified he performed this activity for one to two weeks before symptoms became manifest. Finally, Dr. Keller

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admitted that it was difficult to say if the culling impacted the front or the back of the shoulder. "It's just a forceful maneuver of the shoulder that is likely—could potentially injure something in the shoulder." (PX7, p. 24) He couldn't say if it involved the front, the back or the rotator cuff. Dr. Keller's opinion was based on assumptions and conjecture as to force, weight, repetition, and location.

The credible medical evidence shows the employment tasks did not present sufficient force to cause Petitioner's right shoulder condition.

Based on the foregoing, I find Petitioner has failed to prove by a preponderance of the evidence that he sustained a compensable accident under a repetitive trauma theory and that his current condition of ill-being is related to the accident of June 26, 2016. Consequently, I would also vacate the TTD award for the period of January 18, 2017, through January 10, 2018, and the award for prospective medical related to the right shoulder.

Kathryn A. Doerries

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

AESCHLIMAN, TIM
Employee/Petitioner

Case# **17WC033985**

17WC006484

CHARLES RIVER LABORATORIES INC
Employer/Respondent

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On 2/8/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.65% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5847 THE LAW OFFICE OF DAVID HUNT
245 N E PERRY AVE
PEORIA, IL 61603

0000 RUSIN & MACIOROWSKI LTD
MARK COSIMINI
2506 GALEN DR SUITE 108
CHAMPAIGN, IL 61821

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STATE OF ILLINOIS)
)SS.
COUNTY OF PEORIA)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

TIM AESCHLIMAN
Employee/Petitioner

v.

CHARLES RIVER LABORATORIES, INC
Employer/Respondent

Case # **17** WC **033985**

Consolidated cases: **17 WC 006484**

An *Application for Adjustment 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 **01/10/2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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. [ ] Were the 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 _____

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FINDINGS

On the date of accident, **06/26/2016**, Respondent ***was*** operating under and subject 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 $**49,870.60**; the average weekly wage was $**959.05**.

On the date of accident, Petitioner was **28** years of age, ***single*** with **0** dependent child.

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(b) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $639.36/week for 51 1/7 weeks commencing 01/18/2017 through 01/10/2018, as provided in Section 8(b) of the Act.

Further, the Respondent shall authorize and pay for the Arthroscopic procedure recommended by both treating physicians.

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

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

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

D. Dylan McCarty

Signature of Arbitrator

2/1/2018
Date

ICArbDec19(b)

FEB 8 - 2018

ATTACHMENT TO ARBITRATOR'S DECISION

Tim Aeschliman v. Charles River Laboratories, Inc.

IWCC No.: 17 WC 033985

Consolidated with 17 WC 006484

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? And (F) was the Petitioner's condition of ill being causally related to his work activity,** the Arbitrator notes as follows:

The Petitioner is alleging a right shoulder injury due to repetitive trauma. In those cases, the issues of whether there was an accident arising out of the employment and causation are analyzed as one.

The Petitioner testified at Arbitration that he was employed by the Respondent, Charles River Laboratories, Inc. as a farm technician. The Petitioner stated that the farm in question was a chicken farm designed to produce eggs on a massive scale. He testified that there were approximately eleven chicken houses and that each housed approximately 10,000 chickens. His job was to make sure that the chickens assigned to him were taken care of. The Petitioner testified that one of those duties included making sure that the balance between the roosters and the hens in any particular house was maintained. If this ratio became unbalanced, it was his job to restore that balance by lessening or culling the appropriate number of roosters in said coop. The Petitioner testified that in the weeks leading up to June 26, 2016 there was such an imbalance and, in the week or so leading up to June 26, 2016 he had to cull approximately 48 roosters. The Petitioner testified that

the process of culling these roosters involved severing the brain stem of the rooster by cervical dislocation. The Petitioner describing this culling process by stating that he would hold the rooster's feet in his left hand and place the rooster's neck between the index and middle fingers of his right hand. He would then pull downward with his right arm away from the rooster's feet until he felt the rooster's brain stem separate and its neck cervically dislocate. The Petitioner testified that this was a difficult maneuver and that he was used a great deal of force in order to accomplish it. Petitioner testified that the number of roosters culled between June 20 and 26, 48, was a higher number than usual. The Petitioner testified that on June 26, 2016, he spent about one hour culling 20 roosters. He said after that day, he began to experience pain and discomfort in his right shoulder. The Petitioner filled out a First Report of Accident and Injury on June 27, 2016 stating that he had reinjured his right shoulder that he had previously had a surgery on as a result of culling roosters (Petitioner's Exhibit 1). The Petitioner first sought medical treatment from Ortho NY on July 1, 2016 where he told the treating physician that he was performing repetitive pulling type work and injured his previous repaired right shoulder. At that time an MRI Arthrogram of the right shoulder was ordered. This test, performed on July 26, 2016, showed that the Petitioner has suffered Anterior and Posterior Labral Tears.

The Petitioner testified that despite these findings, he returned to work for the Respondent performing his regular job duties. He further said that his shoulder pain got worse as he performed his job. The Petitioner then testified that on October 31, 2016 while building a chicken pen, he was pulling himself up from the floor with his right arm using a steel bar and felt a large pop and pain in his right shoulder. Once again, the

Petitioner immediately filled out a First Report of Accident and Injury for the Respondent. In this form, he stated that he was building a pen for an upcoming Pre Lay and was using a perch to pull himself up from the floor with his already injured shoulder and felt a pop in his shoulder. (Petitioner's Exhibit 2).

The Petitioner once again followed up for medical treatment with Ortho NY on October 22, 2016. Once again an MRI Arthrogram was ordered. This was performed on December 27, 2016 and said test found a more extensive Anterior Labral Tear than was previously identified in the July 26, 2016 test. Following this test, the physician at Ortho NY recommended that he undergo an arthroscopic repair to his right shoulder.

The Respondent called no witnesses to dispute the Petitioner's testimony regarding these occurrences. The Petitioner's testimony is corroborated by the incident reports filled out immediately following the injuries.

The Petitioner testified at Arbitration that for unrelated reasons, his employment with the Respondent was terminated effective January 18, 2017. Prior to that date, the Respondent had been accommodating the light duty restrictions placed on him by Ortho NY of no repetitive overuse of his right arm and desk work only. (Petitioner Exhibit 4). The Petitioner testified that he had initially began working for the Respondent in Illinois, where all his family resided, and had only recently transferred out to the New York facility. Once he was terminated from his employment, the Petitioner testified that he moved back to the Illinois area. The Petitioner testified that he then sought treatment from Dr. Brett Keller, an orthopedic surgeon practicing in Bloomington, Illinois. Dr. Keller's notes and deposition were admitted into evidence. He had previously done

surgery on the Petitioner's right shoulder on October 24, 2007, performing a debridement of a posterior labral tear and a subacromial decompression. (PX 6)

The Petitioner first saw Dr. Keller for these new problems on February 14, 2017. After reviewing the previous testing done in New York, it was Dr. Keller's opinion that the Petitioner was suffering from an Anterior-Posterior Labral Tear with a Para labral Cyst and with no Rotator Cuff Tear. (Petitioner Exhibit 7, p. 8). Dr. Keller testified that the Petitioner symptoms were consistent with the findings on the MRI Arthrograms and recommended that the Petitioner undergo a right shoulder arthroscopy with Labral Debridement versus repair, a sub acromial decompression and a distal clavicle excision. (Petitioner Exhibit 7, p. 10-11). Dr. Keller was then given an extensive hypothetical consistent with the Petitioner's testimony at Arbitration, and was then asked, if said facts were proven at Arbitration, whether he believed that the culling motion which the Petitioner had to perform 40-50 times shortly before he began treating were responsible for the tears which were seen on the MRI. Dr. Keller responded:

"Assuming that the motion is like you showed me where you're pulling away, pulling down and it does require a significant force... I think that certainly is a maneuver and action that could potentially relate – you know, cause his shoulder issue just due to the force and the repetition." (Petitioner Exhibit 7, p. 14-15).

Dr. Keller was then asked if the second accident, wherein the Petitioner was pulling himself up from a prone position on the floor by using a bar was a mechanism consistent with the worsening that he saw on the second MRI. He testified that the act of pushing himself off the floor was unlikely to have caused a torn labrum. He said that the Petitioner pulling himself up probably just aggravated the injury. (PX 7 at 21, 16) Finally, Dr. Keller was asked whether or not these incidents have caused the need for the surgery which Dr. Keller had recommended. Dr. Keller responded:

"My opinion that his injury is related to his accident or issue at work that he's described assuming what you've told me is true." (Petitioner Exhibit 7, p. 16).

At the request of the Respondent, the Petitioner was examined by Dr. Scott Sagerman. It was Dr. Sagerman's opinion that the Petitioner's current condition of ill-being was not casually related to the work activities. Dr. Sagerman felt that in the absence of a significant trauma, the Petitioner's work activities would not cause a Labral tear. Dr. Sagerman opined that the procedure of culling roosters was not a significant enough trauma to cause the Labral tear. Dr. Sagerman went on to state that he did not believe the Petitioner's second accident, where he pulled himself up off the floor using the steel bar was causative because the tears had already been demonstrated on a previous MRI. (Respondent's Exhibit 4, p. 11-13). On cross examination, Dr. Sagerman was asked whether the second accident caused the worsening of the Petitioner's shoulder which was demonstrated between the two different MRI Arthrograms taken. Dr. Sagerman opined that it did not and, that it was his opinion that the dislocations that the Petitioner described were responsible for the worsening. When Dr. Sagerman was informed that the Petitioner's testimony would be that said dislocations did not occur until after the second accident, Dr. Sagerman stated that that would not change his opinions. (Respondent's Exhibit 4, p. 18-21). Dr. Sagerman then reluctantly agreed that the Labral tears found in 2016 were not present in the Petitioner's last MRI taken in 2010. Dr. Sagerman then reiterated that he did not feel the culling motion was a significant enough force to cause Labral tears. Dr. Sagerman then testified that while it would have to be something more traumatic then the culling, he had no history of any other incidents or accidents up until the culling that would explain how the Petitioner developed the Labral tears found on MRI. (Respondent's Exhibit 4, p. 22-24).

Based upon the foregoing, the Arbitrator finds that the opinions of Dr. Keller are more persuasive than those of Dr. Sagerman. Dr. Keller's testimony regarding causation is consistent with the Petitioner's testimony at Arbitration, namely that his problems began after the culling motions necessary as part of his job duties leading up June 26, 2016. As stated above, Dr. Keller felt the force and repetition involved in the culling process provided the basis for his opinions.

While Dr. Sagerman testified clearly in his deposition that the act of culling the roosters was not of the magnitude of trauma that would cause or aggravate the injury, the Arbitrator questions how he arrived at that opinion. Dr. Sagerman initially saw the Petitioner for a Section 12 examination at the request of the Respondent. In his initial report, dated May 22, 2017, he agreed that the Petitioner had a torn labrum. He also reviewed the medical records from the Petitioner's earlier shoulder care from 2007 through 2010. He said that there was no indication of any ongoing treatment for the shoulder after 2010. With respect to causation, Dr. Sagerman said that he " would like to view a demonstration of the culling process to confirm the mechanism of injury..." (Dep. X 2, RX 4)

The doctor then authored a second report dated July 12, 2017, after being provided additional information by the Respondent. In the report, Dr. Sagerman writes that he had received a job description along with information as to the number of roosters culled by the Petitioner. He also writes, however, that there was no description of the physical demand for culling roosters, something which he had requested in his earlier report. Despite not having this information, the doctor wrote that the performance of the

patient's work activities would not cause a labral tear or shoulder instability. (Dep. X 3, RX 4)

While Dr. Sagerman later reiterated his opinions on causation in both a written note and during his deposition, the Arbitrator finds those opinions to lack credibility. He wrote that he needed a demonstration to give his opinion. The Respondent then sent him some materials but not a demonstration. With only that information, how was he able to provide his causation opinion, found in his second report?

Dr. Sagerman also implied in his deposition that the Petitioner's injuries were somehow related to his prior shoulder injuries referred to above. He testified that the Petitioner had a prior structural injury and had continued pain, suggesting the new pathology came on between 2010 and 2016. (RX 4 at 11-12) This testimony conflicts with the doctor's initial report. After reviewing all of the medical records, he wrote that there was no indication of any ongoing shoulder symptoms after his release in 2010. (Dep. X 2, RX 4)

Based upon the above evidence, the Arbitrator finds that the work activity engaged in by the Petitioner culling roosters between June 20 and 26, 2016 was an accidental injury arising out of his employment which was causally related to his present condition of ill being.

In support of the Arbitrator's decision regarding **(K) Is Petitioner entitled to any prospective medical care?**, the Arbitrator notes as follows:

Having found that the Petitioner did sustain an accident which arose out of and in the course of his employment with the Respondent, and having further found that the Petitioner's current condition of ill-being is causally related to said accidents, the

Arbitrator hereby finds that the surgery recommended by both the doctor from Ortho NY and Dr. Brett Keller is both reasonable and necessary and orders the Respondent to authorize said surgical treatment.

In support of the Arbitrator's decision regarding **(L) What temporary benefits are in dispute? TTD**, the Arbitrator notes as follows:

The Petitioner testified at Arbitration that he was returned to work following the October 31, 2016 incident by the doctors at Ortho NY with a restriction of no repetitive overuse of his right arm and desk work only. (Petitioner's Exhibit 4). The Respondent accommodated said restriction until the Petitioner was terminated on January 18, 2017. The Petitioner testified that at no point have said restrictions been removed. Additionally, the Petitioner came under the treatment of Dr. Brett Keller who removed the Petitioner entirely from work pending the surgical procedure which he had recommended. Having found that the Petitioner did sustain accidents which arose out of and in the course of his employment with the Respondent, and having further found that the Petitioner's current condition of ill-being is casually related to said accidents, the Arbitrator further finds that the Petitioner's inability to return to work is also casually related to said accidents. Given that the Petitioner has been recommended for an Arthroscopic procedure for his right shoulder problems, the Petitioner is clearly not at maximum medical improvement. Since the Respondent chose to terminate the Petitioner rather than continue to accommodate said restrictions, the Arbitrator finds that the Respondent owes Temporary Total Disability benefits from the date of said termination

of January 18, 2017 through the date of Arbitration of January 10, 2018 for a period of 51 1/7 weeks.

DISCARDED

STATE OF ILLINOIS)
) SS.
COUNTY OF SANGAMON)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

LORI CROWDER,

Petitioner,

20IWCC0011

vs. NO: 14 WC 15569

CITY OF SPRINGFIELD,

Respondent.

DECISION AND OPINION ON REMAND

This matter comes before the Commission on remand from the Appellate Court which found, in its November 7, 2018, Rule 23 Order that "the Commission's finding that Petitioner failed to prove that her injury arose out of her employment was against the manifest weight of the evidence and it committed error in denying claimant compensation under the Act." *App.Ord. at ¶1.*

On October 14, 2016, the Commission had affirmed the Arbitrator's decision that "petitioner's injury resulted from a personal risk, and that the general public was exposed to the identical risk." *Arb.Dec. at 6.* The dissenting Commissioner wrote, "Petitioner was exposed to a greater risk than the general public because she regularly used the entry and walkway where she fell while on break." *Comm.Dec. at 2.* The dissent further opined that Petitioner's injuries "also arose out of her employment under the personal comfort doctrine." *Id.* The Sangamon County circuit court affirmed the Commission's decision.

The Appellate Court found, "a risk-analysis is unnecessary if the injury occurred on the premises due to an unsafe or hazardous condition" *(App.Ord. at ¶15)* and "the fact that this walkway was used by the general public is immaterial to the issue of compensability because claimant's injury was caused by a hazardous condition on the employer's premises." *Id. at ¶16.* It explained, "The key factors that guide our decision in this case are as follows: (1) claimant's injury occurred on the employer's premises, and (2) the injury was due to or caused by a dangerous condition or defect on the employer's premises. No consideration is given as to whether claimant's risk was any greater than that of the general public." *Id at ¶17.* The Court, however, disagreed with claimant's alternative argument that her injuries were compensable under the "personal comfort doctrine." The Court reversed the Commission's decision and remanded this cause to the Commission for further proceedings.

20IWCC0011

Based on the Court's order regarding the issue of accident, the Commission finds that Petitioner's left ankle fracture is clearly causally related to that accident and addresses the remaining issues below.

Petitioner is entitled to the medical expenses contained in Petitioner's Exhibit 5 pursuant to §8(a) of the Act, subject to the fee schedule in §8.2 of the Act. 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.

The Commission finds that Petitioner was temporarily totally disabled (TTD) for 11 weeks representing the period from February 14, 2014 through May 1, 2014. The parties stipulated that Petitioner's Average Weekly Wage (AWW) was $697.92, which equates to a TTD benefit rate of $465.28 per week.

Regarding Petitioner's permanent partial disability award, since her accident occurred on or after September 1, 2011, the five factors in §8.1b(b) of the Act are weighed as follows:

i) No AMA Impairment Rating was submitted by either party so this factor is given no weight.

ii) Petitioner's occupation is Administrative Zoning Secretary. She performs office work including typing, calling, filing and getting the City Council packets ready. *T.13.* Following her treatment, Petitioner was returned to full duty. We find that although Petitioner sustained a severe tri-malleolar fracture of her ankle, her job is sedentary and not likely to aggravate her residual symptoms as much as a more physical job would. We give this factor significant weight.

iii) Petitioner was 43 years old at the time of her injury. We find that no evidence was introduced to support a finding that her age affects her level of disability and, therefore, we give this factor no weight.

iv) Similarly, no evidence was introduced to indicate that Petitioner's future earning capacity is reduced due to her injury. We give this factor no weight.

v) Regarding evidence of disability corroborated by the treating medical records, Petitioner testified that she is depressed because she has a lot of problems with her ankle, which hurts "everyday all the time." *T.19.* She does not have full mobility due to the hardware in her ankle and is unable to walk down stairs with one foot in front of the other. *Id.* She cannot run but does try to walk, although not for long periods of time, and she elevates her foot as soon as she gets home because it still swells up "almost everyday" depending on how much she is on it. *T.20.* Petitioner now wears tennis shoes, which provide better stability than sandals. *T.21.* She has difficulty walking up even slight hills. *Id.* Petitioner does not take any prescription pain medication but does take Aleve in the morning before work and then at home, if necessary, but she tries not to take it every day. *T.22.* Her ankle hurts more in bad weather and she wears compression socks at times. *T.23.*

At Petitioner's last office visit to Springfield Clinic, on January 22, 2015, it was noted that she still had occasional stiffness and pain with quite a bit of swelling on strenuous activity. *Px4.* We note that, despite Petitioner's complaints of constant pain and difficulties, she had not returned for any medical treatment in the last six months. *T.38.* Nevertheless, we find that Petitioner's testimony regarding her disability is corroborated, in large part, by her medical records. We give this factor the most weight.

After considering all the above factors, we find Petitioner is entitled to 41.75 weeks of

20IWCC0011

permanent partial disability benefits representing the loss of use of 25% of the left foot. Based on Petitioner's Average Weekly Wage, her permanent partial disability benefit rate is $418.75 per week.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $465.28 per week for a period of 11 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $418.75 per week for a period of 41.75 weeks, as provided in §8(e)11 of the Act, for the reason that the injuries sustained caused the loss of use of 25% of Petitioner's left foot.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the medical bills contained in Petitioner's Exhibit 5 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 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 interest under §19(n) of the Act, if any.

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

Pursuant to §19(f)(2) of the Act, Respondent is not required to file an appeal bond in this case. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JAN 6 - 2020

Maria Elena Portela

Maria E. Portela

SE/
O: 10/22/19
49

Thomas J. Tyrrell

Kathryn A. Doerries

Kathryn A. Doerries

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MARIAH MADDUX,

Petitioner,

20IWCC0012

vs. NO: 15 WC 28741

UNITED AIRLINES, INC.,

Respondent.

DECISION AND OPINION ON REMAND

This matter comes before the Commission on remand from the Circuit Court of Cook County, which found in its February 28, 2019, Memorandum Opinion and Order:

> The Commission erred in its legal analysis and its decision is reversed. According to long-standing Illinois Supreme Court and Appellate Court precedent, traveling employees are entitled to workers' compensation benefits so long as they were engaged in reasonable and foreseeable behavior at the time of the injury, without regard to the nature of the risk. Moreover, even if the nature of the risk were relevant to the compensability of a traveling employee's injury, as one Illinois Appellate Court opinion appears to suggest, Petitioner was nevertheless entitled to compensation under the "street risk" doctrine. *Cir.Ord. at 1.*

On June 20, 2018, the Commission affirmed the Arbitrator's decision finding Petitioner failed to prove that she sustained a compensable injury that arose out of her employment by Respondent. The dissenting (and partially concurring) Commissioner performed a traveling employee analysis and wrote:

> In the instant case, it is reasonable and foreseeable that the Petitioner would have gotten dinner after arriving at the Respondent-mandated hotel after an evening flight, thus satisfying the third prong that her accident arose out of her employment. She was

> carrying a box of food back to her room when she "took a tumble" in the hall and rolled into the wall. Based on the above analysis, Petitioner's accident arose out of and in the course of her employment. *Comm.Dec. at 3.*

The Circuit Court concluded its traveling employee analysis by stating, "Where, as here, a traveling employee is injured while engaged in a reasonable and foreseeable course of conduct, any injury she may suffer is compensable. The Commission erred in failing so to conclude." *Cir.Ord. at 5.*

Based on the finding of a compensable accident, the Court reversed the Commission's denial of penalties under Section 19(l). The Court found, "as Employer has offered no legal justification for its denial of benefits, penalties under 19(l) must be awarded." *Id. at 6.* However, the Court found:

> Because of the different standard and especially because of the discretionary nature of awards of penalties and attorneys' fees under sections 16 and 19(k), the court declines to order an award pursuant to these sections, but rather remands to the Commission to determine the matter anew. The court does note, however, that a legally baseless defense to a claim can in appropriate circumstances constitute a sufficient basis for awarding such penalties and fees." *Id. at 6-7 (citation omitted).*

The Court ordered, "On remand, the Commission must not only determine the amount to award Petitioner as compensation, but must also enter an award under section 19(l). The Commission must also determine whether to award Petitioner penalties and attorneys' fees under sections 16 and 19(k) of the Act." *Id. at 7.*

Based on the Court's order regarding the issue of accident, the Commission finds that Petitioner's right leg, right wrist, lumbar spine, cervical spine, left hip and left shoulder conditions are causally related to the accident on May 19, 2015, and we address the remaining issues below.

We find that Petitioner's medical expenses have been reasonable, necessary, and causally related to her accident and Petitioner is entitled to the medical bills contained in Petitioner's exhibits pursuant to §8(a) of the Act, subject to the fee schedule in §8.2 of the Act. 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.

We further find that Petitioner is entitled to prospective medical treatment as recommended by Dr. Grover and Dr. Milford including, but not limited to, cervical and lumbar injections and a left shoulder MRI.

The Commission finds that Petitioner was temporarily totally disabled (TTD) for 44-4/7 weeks representing the period from May 22, 2015, when Petitioner was restricted from full duty work, through the date of hearing on March 28, 2016. The parties stipulated that Petitioner's Average Weekly Wage (AWW) was $699.99, which corresponds to a TTD benefit rate of

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$466.66 per week.

The Circuit Court found that Petitioner is entitled to late-payment penalties under §19(l) of the Act. Petitioner's brief argues that Respondent delayed payment for 311 days, which is based on Petitioner's calculation of the time period claimed for unpaid TTD benefits (5/22/15 through 3/28/16). Again, the Commission calculates this as 312 days but awards 311 days as requested by and stipulated to by Petitioner. Petitioner is therefore entitled to §19(l) penalties of $9,330.00 ($30 per day x 311 days).

Pursuant to the Court's instruction, we have considered "whether to award Petitioner penalties and attorneys' fees under sections 16 and 19(k) of the Act" and have declined to do so. We note that at least some of Petitioner's medical expenses were paid by Respondent's group health insurance carrier under §8(j) of the Act. These payments are to be considered when determining whether to award penalties under §19(k) of the Act. We also note that the original Arbitrator along with a unanimous Commission panel on review, including the dissenting (and partially concurring) Commissioner, found that Respondent's behavior and delay did not rise to the unreasonable or vexatious level required to award penalties under §19(k) of the Act or legal fees as provided in §16 of the Act, nor did Respondent assert a frivolous defense.

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 Respondent pay to Petitioner the sum of $466.66 per week for a period of 44-4/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the medical bills contained in Petitioner's exhibits 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 pay for prospective medical treatment as recommended by Dr. Grover and Dr. Milford including, but not limited to, cervical and lumbar injections and a left shoulder MRI.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner additional compensation of $9,330.00 as provided in §19(l) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's requests for additional compensation pursuant to §19(k) of the Act and for legal fees as provided in §16 of the Act are hereby denied.

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

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benefits for which Respondent is receiving credit under this order

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $40,000.00. 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: JAN 6 - 2020

Maria Elena Portela
Maria E. Portela

Thomas J. Tyrrell
Thomas J. Tyrrell

Kathryn A. Doerries
Kathryn A. Doerries

SE/
O: 10/22/19
49

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

STEVIE LEWIS,

Petitioner,

vs.

NO: 14 WC 22576

SOUTHERN ILLINOIS HEALTHCARE, INC., d/b/a Memorial Hospital of Carbondale,

Respondent.

20IWCC0013

DECISION AND OPINION ON REVIEW

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

The Commission affirms and adopts that part of the Arbitrator's Decision finding that Petitioner sustained an accident arising out of and in the course of her employment on May 2, 2014; that the MRI spectroscopy was not reasonable and necessary treatment to cure or relieve the effects of the accidental injury; that the epidural steroid injections received after July 2, 2014, were not reasonable and necessary to cure or relieve the effects of the accidental injury; and that the Petitioner's bilateral shoulder condition was not causally related to the May 2, 2014, accident. The Commission reverses the Arbitrator's Decision finding that Petitioner's current condition of ill-being regarding her lumbar spine is causally related to the May 2, 2014, accident and vacates the Arbitrator's award of prospective medical treatment, specifically the L5-S1 fusion, for the reasons explained below.

It is the function of the Industrial Commission to decide questions of fact and causation

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(*Stewart Warner, Datafax Corp. v. Industrial Comm'n.* (1979), 76 Ill. 2d 464; *County of Cook v. Industrial Comm'n.* (1977), 69 Ill. 2d 10), to judge the credibility of witnesses (*Watts v. Industrial Comm'n.* (1979), 77 Ill. 2d 30, *Sahara Coal Co. v. Industrial Comm'n.* (1977), 66 Ill. 2d 353), and to resolve conflicting medical evidence (*Health & Hospitals Governing Comm'n. v. Industrial Comm'n.* (1979), 75 Ill. 2d 159; *Moore v. Industrial Com.* (1975), 60 Ill. 2d 197). *O'Dette v. Industrial Comm'n.* 79 Ill. 2d 249, 253, 403 N.E.2d 221, 223-224, 1980 Ill. LEXIS 297, *6-7, 38 Ill. Dec. 133, 135-136.

Findings of Fact and Conclusions of Law

The Commission affirms and adopts the Arbitrator's Findings of Fact, noting that this case was consolidated with case 13 WC 23310, and the consolidated cases were tried in a Section 19(b) proceeding. Only the instant case, 14 WC 22576, was reviewed.

Petitioner, a Certified Nursing Assistant, sustained a work-related accident on May 13, 2013, the subject of case 13 WC 23310. Petitioner underwent lumbar spine surgery--an L5 laminectomy and L5-S1 discectomy--performed by neurosurgeon Dr. Taveau, on August 5, 2013. (PX26) Dr. Taveau released Petitioner to return to work without restrictions on April 11, 2014. (PX26)

On May 2, 2014, Petitioner was performing her work-related duties which included lifting patients. After working a portion of her shift, she began to experience low back pain and right-sided pain which she had not experienced with the previous injury. (T. pp. 31-32)

The Commission strikes the Arbitrator's Conclusions of Law on pages 11 through 15 of the Arbitrator's Decision and substitutes the following Conclusions of Law:

Accident

Petitioner sustained an accidental injury arising out of and in the course of her employment on May 2, 2014. On that date, Petitioner was taking care of nine patients, four of which were "total lift" patients. Petitioner's job assignment required a significant amount of lifting. After working a portion of her shift, Petitioner sat down for lunch and experienced a cold sensation, first centrally located in her lower back and then on the right side, unlike that which she experienced with the prior injury. (T. pp. 30-32)

Petitioner reported the incident to Respondent that same day and a written report was prepared. Respondent directed Petitioner to Dr. Austin for medical treatment. Petitioner completed a form indicating her back was painful because of activity and heavy lifting. (PX33) On May 6, 2014, Petitioner saw her primary care physician, Dr. Alexander, and advised she had a sudden onset of back pain while at work on Friday. Respondent presented no rebuttal witness at trial regarding the accident of May 2, 2014. (T. pp. 32-33)

The Commission finds Petitioner proved by a preponderance of the evidence she sustained an accident arising out of and in the course of her employment on May 2, 2014.

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Causal Connection

The Commission concludes Petitioner's current conditions of ill-being, specifically her lumbar spine and her bilateral shoulder condition, are not causally related to the accident of May 2, 2014. In support of this conclusion the Commission finds the following:

Lumbar Spine

The Petitioner saw her primary care physician, Dr. Alexander, on May 6, 2014, and stated she had reinjured her lumbar spine at work on May 2, 2014. Dr. Alexander took her off work. (PX2) She underwent an MRI of the lumbar spine on May 16, 2014, which showed the previous laminectomy at the L5-S1 level, no evidence of central canal stenosis or recurrent disc protrusion, and enhancing scar tissue within the lateral recesses bilaterally at the L5-S1 level which may be affecting the descending nerve roots. (PX17)

Petitioner returned to her surgeon, Dr. Taveau, on May 19, 2014, and reported intermittent right leg pain. Dr. Taveau's physical exam revealed she was neurologically intact. He agreed with Dr. Alexander that Petitioner should remain off work. (PX26)

Despite the radiologist's finding that the MRI scan of May 16, 2014, did not reveal evidence of a recurrent disc herniation, Dr. Taveau opined there was a recurrent disc herniation, paracentral right, that appeared to be impinging on the right L5 descending sacral nerve root. He ordered flexion/extension x-rays of her lumbar spine and an NCV study. Dr. Taveau recommended conservative therapy. If surgery was required, he would recommend an L5-S1 posterior lumbar interbody fusion (PLIF). (PX26)

When Petitioner returned to Dr. Taveau on May 28, 2014, she advised she went to the emergency room over the weekend for back and leg pain and was released. He noted that the flexion/extension x-rays revealed no evidence of instability. He released her to attend school and recommended she do low impact exercise such as swimming, elliptical machines or walking. He kept her off work. (PX26)

On June 6, 2014, the Petitioner underwent an EMG/NCS study which was consistent with right L5/S1 radiculopathy, but clinical correlation was recommended.

On June 26, 2014, Petitioner consulted Dr. Brent Newell, a pain management doctor. Dr. Newell reviewed the May 16, 2014, MRI scan of the lumbar spine and opined there was enhancing scar tissue in the L5-S1 disc affecting the S1 nerve root, but no herniation. (PX13).

Dr. Taveau testified on December 15, 2014, via evidence deposition. He testified that on May 28, 2014, the last date he rendered care, he released Petitioner to participate in activities at school, including the didactic and clinical portions, without restrictions. It was stipulated at Arbitration that the job duties of a CNA were the same or substantially similar to the physical requirements of Petitioner's nursing school clinicals. Dr. Taveau continued to recommend conservative treatment, finding Petitioner was neurologically intact and she did not have any spinal instability. (PX34, 74-75)

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The Commission notes the letter prepared by Dr. Taveau on August 19, 2014, restricting Petitioner from returning to work. The Commission finds significant Dr. Taveau's testimony that he did not examine Petitioner on that date nor had he examined Petitioner since her last visit on May 28, 2014, yet he restricted her from returning to work. Thus, the Commission finds Dr. Taveau's opinion regarding her ability to return to work not credible.

Petitioner voluntarily resigned her position with Respondent on September 1, 2014. It was stipulated at Arbitration that Respondent had a policy of accommodating light duty work for employees with workers' compensation claims.

On October 30, 2014, Petitioner underwent a second MRI scan of the lumbar spine. The radiologist found postoperative laminectomy/microdiscectomy changes at L5-S1 when compared to the prior exam, decreased contrast enhancing epidural granulation/fibrosis compared to the prior exam, no recurrent or residual disc herniation or significant central spinal canal stenosis, and minimal left L4-5 and mild-moderate left L5-S1 foraminal stenosis.

Petitioner began treating with Dr. Gornet on November 20, 2014. He opined the MRI scans of the lumbar spine performed on May 16, 2014 and October 30, 2014, showed large annular tears at L5-S1. On examination, Petitioner was able to bend and forward flex with her hands to the mid-lower legs and she returned to standing with a smooth rhythm. He recommended she undergo a CT myelogram and another MRI scan. He recommended an anterior fusion at L5-S1 despite not having the results of the new tests he had ordered. Dr. Gornet documented that he believed Petitioner sustained a disc injury as a result of the May 13, 2013, work-related accident and her condition was aggravated by her second accident of May 2, 2014. (PX23)

At Respondent's request Petitioner underwent a Section 12 examination with Dr. Zelby. In his January 14, 2015, report, Dr. Zelby noted Petitioner underwent an L5 laminectomy and L5-S1 discectomy in August 2013 and returned to work April 17, 2014. She worked three weeks full duty and has been off since May 2, 2014. Dr. Zelby reviewed the CT scan of the lumbar spine, dated December 5, 2014, which showed modest degenerative changes as well as the prior L5 laminectomy, the MRI scan dated October 30, 2014, which showed no evidence of a disc protrusion, the MRI scan of December 5, 2014, which was unchanged, and the MRI scan of June 6, 2013, and August 1, 2013, both which pre-dated the current accident. Dr. Zelby opined that there was no evidence of a recurrent disc herniation, which was consistent with the opinion of the radiologist. In regard to the presence of an annular tear, Dr. Zelby opined this was not significant and was not a basis to perform lumbar surgery. (RX1)

Dr. Zelby's findings on examination were essentially normal and there were no objective findings to explain the persistence and severity of her symptoms. He found multiple positive Waddell signs with significant symptom magnification. He opined that there was no medical basis for Petitioner to undergo a fusion at L5-S1. Further, Petitioner could work at a Medium-Heavy physical demand level and Petitioner was at maximum medical improvement (MMI) as of January or February 2014.

On March 9, 2015, Petitioner underwent an MRI of the lumbar spine, a lumbar spine

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myelogram and CT scan post myelogram The MRI scan of the lumbar spine revealed post-surgical changes involving the posterior paraspinous soft tissues and ventral epidural space consistent with postsurgical granulation tissue at the L5-S1 level, no evidence of a recurrent L5-S1 disc herniation, mild to specification with diffuse annular disc bulge, no central canal stenosis, and minimal bilateral neural foraminal exit stenosis. Further, there was no other significant disc desiccation, disc profile abnormality, central canal stenosis or neural foraminal exit stenosis throughout the remainder of the lumbar spine. (PX20)

The CT scan of the lumbar spine post myelogram showed normal alignment of the lumbar spine. There was mild disc desiccation with diffuse annular disc bulge, no central canal stenosis, and minimal bilateral neural foraminal exit stenosis. It was further noted there was no other significant disc profile abnormality, central canal stenosis or neural foraminal exit stenosis throughout the remainder of the lumbar spine and no facet arthropathy throughout the lumbar spine. (PX7)

Petitioner saw Dr. Gornet on March 9, 2015. Dr. Gornet noted Petitioner continues to rely on narcotics which is inappropriate. He further stated if she cannot be weaned off narcotics that she is taking on a regular basis, then no further treatment should be provided, and she should be at MMI. Dr. Gornet also expressed concerns about symptom magnification. Dr. Gornet stated that if Petitioner can demonstrate that she is weaned off all narcotics and can demonstrate further that she is a reasonable candidate for intervention, consideration could be given to treating her at only the L5-S1 level with an anterior lumbar fusion. (PX23)

In April 2015, Petitioner began treating with Dr. Fleming at Neuroscience Institute, who replaced Dr. Taveau. M. Bryant, Physician's Assistant for Dr. Fleming, saw Petitioner on April 13, 2015. He reviewed the December 2014 MRI scan of the lumbar spine and the radiology notes and found no evidence of a recurrent disc herniation. He also reviewed Petitioner's x-rays of her lumbar spine and found no evidence of instability in her spine.

PA Bryant added an Addendum to the April 13, 2015, office note stating he and Dr. Fleming reviewed the new imaging studies and compared them to the older imaging studies. He reiterated, "there is not a recurrent disc herniation at the L5-S1 level. There is no significant stenosis at L4-5 or L5-S1. This also concurs with the radiology report on the new studies as well as her previous studies last year. Dr. Fleming agreed to see her in clinic if she desires." (PX6)

Petitioner saw Dr. Criste, pain management doctor, on April 29, 2015, upon referral from Dr. Fleming. He noted Petitioner had seen two neurosurgeons who gave conflicting opinions. It was noted Dr. Fleming felt surgery would not be helpful, and he referred her for consideration for a spinal cord stimulator. (PX26, p. 88) Petitioner declined and requested an epidural steroid injection to which he agreed. Dr. Criste encouraged her to obtain a third medical opinion. On May 27, 2015, Petitioner advised Dr. Criste that she felt great and stopped taking her pain medication. (PX6)

In August 2015, Petitioner resumed registered nursing school at Shawnee Community College. (T. p. 53)

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Petitioner continued with physical therapy and on August 24, 2015, Petitioner reported no bilateral lower extremity radiculopathy. She rated her low back pain on a scale of 1/10 as currently at 0/10, and at its worst at 4/10. (PX14)

On August 27, 2015, Petitioner reported to the physical therapist that she had no pain in her lower back or leg region. She was feeling much better. By September 17, 2015, she reported she had returned to running at regular intervals. By September 22, 2015, she reported "abolished radicular symptoms" and improved activity tolerance. Likewise, on October 5, 2015, Petitioner reported to Dr. Gornet she was no longer taking narcotics and she was doing better. Her diagnosis was discogenic pain with annular tear and previous surgery at L5-S1. (PX 23) She was discharged from physical therapy on October 19, 2015. (PX14)

Dr. Gornet testified on September 2, 2015, that Petitioner had more of a structural problem at L5-S1 because of the prior discectomy and laminectomy which caused a destabilization of her spine at L5-S1 as well as an annular tear. Dr. Gornet opined the only way to stabilize the spine was to perform a fusion. (PX35. 22, 35-37).

Petitioner returned to Dr. Gornet on January 4, 2016. He noted that she was in nursing school. Dr. Gornet attributed Petitioner's condition of ill-being to the first accident on May 13, 2013, and the subsequent surgery. He opined the surgery caused destabilization of that segment of the spine. He ordered an MRI spectroscopy at L3-L4, L4-L5, and L5-S1 and he noted if Petitioner continued to have symptoms then the anterior fusion surgery at L5-S1 would be appropriate. (PX23)

Dr. Gornet next saw Petitioner on March 24, 2016, and he noted the MRI spectroscopy was positive for the presence of painful chemicals at L5-S1 and L4-L5. He described his exam of Petitioner as non-focal and recommended the anterior fusion at L5-S1.

Dr. Treister was deposed on December 19, 2016, and testified that Dr. Gornet's proposed anterior lumbar fusion at L5-S1 was not reasonable and necessary and he did not certify the procedure. (RX4, pp. 13-14) Dr. Treister opined an annular tear by itself should not be an indication for surgery. (RX4, p. 29) He stated that once a person has had a surgical intervention, an annular tear will always be found. (RX4, p. 30) Dr. Treister also noted Petitioner had been treated for anxiety and depression and that she should be evaluated before proceeding with surgery. (RX4, pp. 31-32) Dr. Treister noted Petitioner's Waddell findings when examined by Dr. Zelby and he noted that after one of the injections, Petitioner reported that her symptoms worsened. (RX4, pp. 22-23)

Dr. Treister reviewed Dr. Gornet's medical records. Specifically, in his progress report dated December 8, 2014, Dr. Treister noted a lack of description of Petitioner's subjective complaints or any findings on exam which comprise the basis for making any assessment. (RX4, pp. 17-20) He noted that when Dr. Gornet evaluated Petitioner on November 20, 2014, his findings correlated with nerve root pressure at L4-L5, not at L5-S1, and Dr. Gornet did not document any subjective complaints correlating to L5-S1. (RX4, pp. 15-16)

Dr. Treister testified the MRI spectroscopy was not generally used to evaluate spinal

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conditions. (RX4, pp. 35-26) The use of an MRI spectroscopy is in the earliest stages of experimental consideration and the test would be positive with any disc that had previously undergone spinal surgery. Furthermore, Dr. Treister testified, an L5-S1 fusion was not indicated because the pathology has to be defined by correlating subjective complaints, objective findings and radiologic testing. Here, there were no correlations substantiating the need for surgery. (RX4, pp. 36-40)

Dr. Gornet was deposed again on January 23, 2017. Dr. Gornet testified he was treating an objective structural problem at L5-S1. He further testified he objectively measured painful chemicals in the disc through the use of the MRI spectroscopy. Dr. Gornet relied on the EMG findings which he found were consistent with his findings of radiculopathy at L5-S1. He testified he did not record exam findings on every visit because there was no change as Petitioner's complaints remained essentially the same. Dr. Gornet testified Petitioner was no longer on narcotics and had a treatable condition.

On cross-examination, Dr. Gornet conceded that only three offices in the country use a spectroscopy to evaluate spinal patients. Dr. Gornet agreed that the presence of an annular tear, in and of itself, was not the basis for a surgical recommendation as many other factors need to be considered. (PX36, 28-31)

Dr. Zelby examined Petitioner again on April 23, 2018. His examination findings were objectively normal. Notably, he again found the presence of symptom magnification. He opined that the numerous epidural steroid injections Petitioner had received were not medically necessary because she had no condition which would be relieved by steroid injections. He opined the annular tear was of no clinical significance and the use of an MRI spectroscopy was not reasonable for determining treatment in spinal conditions. Dr. Zelby opined there was no objective evidence to support performing an L5-S1 fusion. (RX5)

Petitioner returned to Dr. Gornet on June 25, 2018, and again complained of low back and right leg pain. Dr. Gornet noted Petitioner had structural back pain and an annular tear at L5-S1 and again recommended a fusion at L5-S1.

Dr. Zelby was deposed a second time on July 9, 2018. Dr. Zelby opined that Petitioner had no residual recurrent disc issues or findings of radiculopathy. (RX6, pp. 21-22) He testified that it is pretty much mainstream spine knowledge that annular tears and lumbar discs heal completely in three to four months. Dr. Zelby testified he was trained in the use of spectroscopy, but he was not one of the three in the country to use it in his practice. In his practice it would be used for predictive value to determine if a brain tumor will recur after radiation treatment.

Dr. Zelby testified that epidural steroid injections were not reasonable and necessary to cure any condition in her spine. He testified on cross-examination that, "Ms. Lewis has no condition in her spine treated (sic) with the ongoing use of narcotic medications and their continued use is counterproductive for Ms. Lewis." (RX6, p. 49) He testified that multiple injections over a 42-month period would not be a reasonable treatment for chronic low back pain. (RX6, p. 50).

Dr. Zelby testified that even if an annular tear existed, independent of a disc herniation, if

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it were acute, in three or four months it was no longer a source of pain for Ms. Lewis. (RX6, p. 51). He addressed whether discectomies cause structural disc injuries and whether every patient who undergoes a discectomy needs a fusion to which he responded, "Absolutely not. I mean, I do probably sixty or eighty lumbar micro discs a year and in that group, I send people back to heavy physical labor all the time." (RX6, p. 52)

Dr. Gornet was deposed for the third time on August 13, 2018. On cross-examination, Dr. Gornet was asked about Petitioner's multiple steroid injections and whether they related to her avascular necrosis. Dr. Gornet testified that getting AVN from steroids is not due to a cumulative effect:

> ... as far as in studying under probably the leading person for avascular necrosis in the country, David Hungerford, who redeveloped all the scales, injections for steroids and the response of avascular necrosis is idiosyncratic. Which what that means is you can do one injection and the patient can get AVN, avascular necrosis. And so it's not a cumulative effect. And so we don't quite understand why that is. And so, we have seen it with patient's getting one injection and they get a result of AVN. (PX39, 16-18)

On September 21, 2018, Dr. Treister performed another Utilization Review regarding the reasonableness and necessity of the L5-S1 fusion and the multiple steroid injections. Dr. Treister opined the initial injections received were reasonable, specifically injections administered June 9, 2014, and July 2, 2014. Dr. Treister noted there was no consideration given to the cumulative effect of the steroid injections Petitioner had received. He also opined that more likely than not the avascular necrosis (AVN) was referable to the cumulative effect of the steroid injections. (RX7)

Dr. Treister was deposed on September 24, 2018. Dr. Treister opined that there were no objective findings of radicular symptoms and moreover, Petitioner was not improving following the injections. He testified there was no medical basis to justify Petitioner having received 17 epidural steroid injections. (RX8, 21-23, 26-28).

Petitioner testified she wanted surgery for "quality of life." She testified that she lives with pain every single day. She wants to have kids. She wants to be able to wake up in the morning and know that "I'm not at risk of hurting myself worse every single day." She testified she has constant pain in her back. She is having a hard time sitting and has pain that radiates down both legs. She also testified she has neck pain that is an overall generalized pain that generates from her low back. (T. pp.60-62)

The Commission finds Petitioner has failed to prove by a preponderance of the evidence her current condition of ill-being in her lumbar spine is related to the accident of May 2, 2014. The Commission relies on the opinions of Dr. Zelby, Dr. Treister and Dr. Fleming that there was no evidence of a herniated disc or spinal instability on the diagnostic tests. The Commission finds these opinions to be more persuasive than the opinion of Dr. Gornet.

The Commission is not persuaded by Dr. Gornet's opinion that Petitioner requires a lumbar fusion as a result of spinal instability. First, his opinion that Petitioner has sustained spinal

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instability is disputed by Petitioner's other treating physicians, Dr. Fleming, Dr. Taveau and Physician's Assistant M. Bryant. Second, his reliance on a spectroscopy to form the basis of his opinion is unreliable. The fact that Dr. Gornet concedes that only three offices in the country are relying upon the procedure supports Dr. Treister's opinion that the procedure is experimental. Further, Dr. Zelby's testimony that it is not a diagnostic tool used for spinal conditions but used as a predictive value for brain tumor patients is persuasive.

The Commission relies upon Dr. Treister's opinions that under the Official Disability Guidelines, that Petitioner's objective findings do not correlate with her subjective complaints and the lumbar fusion is not reasonable and necessary.

The Commission finds Dr. Zelby's and Dr. Treister's opinions, that the lumbar fusion surgery at L5-S1 is not reasonable and necessary, to be more persuasive than Dr. Gornet's. The Commission relies upon Dr. Zelby's opinion that the results of the March 19, 2015, MRI scan of the lumbar spine at L5-S1 and the CT scan confirms resolution of the stenosis and neural impingement and there is no stenosis or neural impingement at any level. The Commission further finds this comports with Dr. Fleming's opinion that Petitioner is not a surgical candidate.

Based on the foregoing, the Commission finds Petitioner has failed to prove her current condition of ill-being in her lumbar spine is causally related to the work-related accident.

Bilateral Shoulder Condition

In regard to Petitioner's bilateral shoulder condition, the Commission finds it is not causally related to the accident of May 2, 2014. Petitioner's treating physician, Dr. Paletta, and Respondent's Utilization Review physician, Dr. Treister, both opined the avascular necrosis was related to Petitioner's epidural steroid injections. The Commission agrees with the Arbitrator's conclusion that the epidural steroid injections after July 2, 2014, were not medically reasonable and necessary to cure the effects of the accident of May 2, 2014. Thus, the condition caused by unreasonable and unnecessary treatment is not related to the accident.

Medical

The Commission concludes that, except as noted herein, the medical treatment provided to Petitioner was reasonable and necessary and Respondent is liable for payment of the medical bills incurred therewith.

In regard to the epidural steroid injections, Respondent is liable for payment of the injections administered on June 9, 2014, and July 2, 2014, (steroid injections administered in May through July 2013 were awarded in 13 WC 23310), but denies the epidural steroid injections subsequent to July 2, 2014, because they were unreasonable and unnecessary.

Respondent is not liable for payment of medical treatment provided to Petitioner for her bilateral shoulder condition because it is caused by or related to the excessive epidural steroid injections, which the Commission has determined to be not medically reasonable and necessary.

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In regard to the MRI spectroscopy, Respondent is not liable for payment of the medical services incurred in connection with that diagnostic procedure because it was medically unreasonable and unnecessary.

Respondent shall pay reasonable and necessary medical services as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule and as identified in Petitioner's Exhibit 1, except for: 1) medical charges for epidural steroid injections administered to Petitioner after July 2, 2014; 2) medical charges for Petitioner's bilateral shoulder condition; and 3) the MRI spectroscopy.

In regard to the epidural steroid injections administered to Petitioner, from May 2013, through December 2016, Petitioner underwent 19 steroid injections. Respondent's utilization review physician, Dr. Treister, opined that the first 2 injections administered after the accident of May 2, 2014 (June 9, 2014, and July 2, 2014) were medically reasonable and necessary, but the injections administered thereafter were not. He noted there was no consideration of the cumulative effect of these injections and he opined they contributed to the development of Petitioner's avascular necrosis. Petitioner's treating physician, Dr. Paletta, also opined the avascular necrosis was secondary to the steroid injections.

In regard to Dr. Gornet's use of the MRI spectroscopy, Respondent's utilization review physician, Dr. Treister, opined that measurement of the chemical content of the disc which has been operated upon has no significance. Dr. Gornet agreed it was only used as a diagnostic tool in spine cases in three offices in the country. The Commission finds that Dr. Treister's opinion is more persuasive than Dr. Gornet's opinion and is not persuaded that this diagnostic procedure was medically reasonable and necessary.

Prospective Medical

The Commission concludes Petitioner is not entitled to prospective medical treatment, the L5-S1 fusion surgery, recommended by Dr. Gornet.

In support of this conclusion the Commission notes the following:

Dr. Gornet opined Petitioner has a structural instability at L5-S1 and a fusion procedure is the only way to stabilize the spine. The Commission finds more persuasive the opinions of Dr. Zelby, Dr. Taveau and Dr. Fleming who find no instability in Petitioner's spine. The Commission further finds Dr. Gornet's reliance upon the spectroscopy results undermines his opinion. The Commission relies upon the opinion of Dr. Zelby that the Petitioner has no spine instability and the opinion of Dr. Treister that the fusion surgery is not reasonable and necessary.

TTD

The Commission concludes Petitioner is entitled to temporary total disability benefits of eight weeks (8) weeks commencing May 6, 2014, the date Dr. Alexander authorized Petitioner off work, through June 30, 2014. Petitioner was receiving medical treatment and authorized to be off work for the aforesaid period of time until she returned to work on light duty.

The Commission acknowledges Petitioner was authorized to be off work from April 27,

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2017, through April 30, 2018, while being treated for bilateral shoulder condition. However, the Commission found this bilateral shoulder condition was not work-related. Accordingly, Respondent is not liable for temporary total disability benefits for that time period.

All else is affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 25, 2019, is hereby modified for the reasons stated herein, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Arbitrator's award of prospective medical for the lumbar fusion surgery is vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $242.87 per week for a period of eight weeks, beginning May 6, 2014 through June 30, 2014, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay reasonable and necessary medical services as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule and as identified in Petitioner's Exhibit 1, except for: 1) medical charges for epidural steroid injections administered to Petitioner subsequent to July 2, 2014; 2) medical charges for Petitioner's bilateral shoulder condition; and 3) the MRI spectroscopy.

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 $2,100.00. 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: JAN 6 - 2020
KAD/bsd
O11/5/19
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Kathryn A. Doerries

Kathryn A. Doerries

Maria Elena Portela

Maria E. Portela

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

LEWIS, STEVIE
Employee/Petitioner

Case# **14WC022576**

13WC023310

SOUTHERN ILLINOIS HEALTHCARE INC D/B/A MEMORIAL HOSPITAL OF CARBONDALE
Employer/Respondent

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On 2/25/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.45% 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:

0250 HOWERTON DORRIS STONE LAMBERT
DOUGLAS N DORRIS
300 W MAIN ST
MARION, IL 62959

0639 FEIRICH MAGER GREEN RYAN
BRIAN SMITH
2001 W MAIN PO BOX 1570
CARBONDALE, IL 62903

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STATE OF ILLINOIS)
)SS.
COUNTY OF WILLIAMSON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Stevie Lewis
Employee/Petitioner

Case # 14 WC 22576

v.

Consolidated cases: 13 WC 23310

Southern Illinois Healthcare, Inc. d/b/a Memorial Hospital of Carbondale
Employer/Respondent

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An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Herrin, on January 8, 2019. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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, May 2, 2014, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $18,944.12; the average weekly wage was $364.31.

On the date of accident, Petitioner was 26 years of age, single with 0 dependent child(ren).

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

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

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

ORDER

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibit 1, except for all of the medical charges for epidural steroid injections administered to Petitioner subsequent to July 2, 2014, all of the medical charges for Petitioner's bilateral shoulder condition and the MRI spectroscopy, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

Respondent shall authorize and pay for prospective medical treatment including, but not limited to, the fusion surgery recommended by Dr. Matthew Gornet.

Respondent shall pay Petitioner temporary total disability benefits of $242.87 per week for eight and three-sevenths (8 3/7) weeks, commencing May 2, 2014, through June 30, 2014, as provided in Section 8(b) of the Act.

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

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

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

William R. Gallagher, Arbitrator
ICArbDec19(b)

February 22, 2019
Date

FEB 25 2019

Findings of Fact

Petitioner filed two Applications for Adjustment of Claim which alleged she sustained accidental injuries arising out of and in the course of her employment by Respondent. In case 13 WC 23310, Petitioner alleged that on May 13, 2013, "While working Petitioner sustained injuries during the course of employment" to the "MAW" (Arbitrator's Exhibit 2). In case 14 WC 22576, Petitioner alleged that on May 2, 2014, "While working Petitioner sustained injuries during the course of employment" to the "MAW" (Arbitrator's Exhibit 3). The cases were consolidated and tried in a 19(b) proceeding. Petitioner sought an order for payment of medical bills and temporary total disability benefits as well as prospective medical treatment. The prospective medical treatment sought by Petitioner was fusion surgery at L5-S1 that was recommended by Dr. Matthew Gornet, an orthopedic surgeon (Arbitrator's Exhibit 1).

Respondent stipulated Petitioner sustained a work-related accident on May 13, 2013, but disputed Petitioner sustained a work-related accident on May 2, 2014. Respondent disputed causal relationship in regard to both cases as well as the reasonableness and necessity of both past and prospective medical treatment (Arbitrator's Exhibit 1).

At trial, counsel for Petitioner and Respondent stipulated to the following: (1) Respondent had a policy of accommodating light duty work for employees with workers' compensation claims; (2) Petitioner voluntarily resigned her employment with Respondent on September 1, 2014; and (3) the job duties of a CNA were the same or substantially similar to the physical requirements of Petitioner's nursing school clinicals.

Petitioner worked for Respondent as a CNA. On May 13, 2013, Petitioner sustained an injury to her low back while lifting a patient. At trial, Petitioner testified she experienced a "jolting" pain in her back which went into her left leg.

Subsequent to the accident, Petitioner sought medical treatment from Dr. James Alexander, her family physician, who evaluated her on May 23, 2013. At that time, Petitioner complained of low back pain with radiating pain in the left buttock and pelvic area. Dr. Alexander diagnosed Petitioner with a lumbar sprain and administered an epidural steroid injection into the left hip. He also ordered an MRI scan (Petitioner's Exhibit 2).

The MRI was performed on June 6, 2013. According to the radiologist, the MRI revealed a central bulging of the L5-S1 disc which resulted in mild encroachment on the ventral thecal sac (Petitioner's Exhibit 16).

Dr. Alexander saw Petitioner in June, 2013, and opined she had lumbosacral disc degeneration. He treated the condition conservatively with medication and physical therapy, but subsequently referred Petitioner to Dr. Jon Taveau, a neurosurgeon (Petitioner's Exhibit 2).

Dr. Taveau evaluated Petitioner on June 19, 2013. He examined Petitioner and reviewed the MRI scan. Dr. Taveau opined Petitioner had a disc herniation at L5-S1 and ordered additional physical therapy (Petitioner's Exhibit 26).

Petitioner was seen by Peggy Boyd, a Nurse Practitioner associated with Dr. Alexander on July 2, 2013, and July 22, 2013. On those occasions, NP Boyd administered epidural steroid injections (Petitioner's Exhibit 2).

Petitioner's condition did not improve and Dr. Taveau performed low back surgery on August 5, 2013. The procedure consisted of a L5 laminectomy and L5-S1 discectomy. Following surgery, Petitioner was seen by Robert Deaton, a Nurse Practitioner associated with Dr. Taveau, on August 20, 2013. At that time, NP Deaton authorized Petitioner to be off work, but she could continue nursing school with restrictions (Petitioner's Exhibit 26).

Dr. Taveau saw Petitioner on September 18, 2013, and authorized her to return to "unrestricted activity" on October 2, 2013. However, when Dr. Taveau subsequently saw Petitioner on October 24, 2013, November 25, 2013, and December 23, 2013, he authorized her to remain off work. When Dr. Taveau saw Petitioner on January 20, 2014, he authorized her to return to work on light duty with a limitation of 20 hours per week. On April 11, 2014, Dr. Taveau released Petitioner to return to work without restrictions (Petitioner's Exhibit 26). Following the surgery, Petitioner began nursing school to become an LPN.

In regard to the accident of May 2, 2014, Petitioner testified she returned to work approximately three weeks prior and had been working 12 hour shifts, three days per week. On May 2, 2014, Petitioner provided care to nine patients, four of which were "total lift" patients. Petitioner explained that a "total lift" patient required assistance doing virtually everything, such as going to the toilet, bathing, etc. It always required more than one person to assist these patients. The other five patients also required a significant amount of assistance. After working a portion of her shift, Petitioner began to experience low back pain with pain on the right side which she had not experienced with the prior injury. The accident was reported to Respondent the same day it occurred and an accident report was completed.

Following the accident, Respondent directed Petitioner to go to Dr. Steve Austin, who saw her that same day. According to Dr. Austin's record of that date, Petitioner "...does not feel that she has re-injured back but just took on too much work too fast." At that time, Petitioner completed and signed a form which noted she had been assisting four out of nine patients who required "total lifts/care" and her back was painful because of "activity and heavy lifting" (Petitioner's Exhibit 33).

Petitioner was subsequently seen by Dr. Alexander on May 6, 2014. According to his record of that date, Petitioner experienced a sudden onset of low back pain while at work on Friday, but there was no radiation of pain into the lower extremities. Dr. Alexander diagnosed Petitioner with a lumbar strain and authorized her to be off work (Petitioner's Exhibit 2).

Dr. Alexander again saw Petitioner on May 15, 2014, and Petitioner continued to have low back pain but with radicular pain into the right lower extremity. Because Petitioner's symptoms had worsened, Dr. Alexander ordered an MRI scan of the lumbar spine (Petitioner's Exhibit 2).

The MRI was performed on May 16, 2014. According to the radiologist, there was evidence of the previous laminectomy at L5-S1, scar tissue which may affect the descending S1 nerve roots and no evidence of recurrent disc protrusion (Petitioner's Exhibit 17).

Petitioner was subsequently seen by Dr. Taveau on May 19, 2014. Dr. Taveau noted Petitioner had symptoms of low back pain and right lower extremity radicular pain following a work-related injury of May 2, 2014. Dr. Taveau reviewed the MRI of May 16, 2014, and opined it revealed a recurrent disc herniation at L5-S1, paracentral right. He noted this was impinging on the right L5 and descending sacral nerve roots. He recommended conservative treatment including steroid injections, but that an L5-S1 fusion might be required (Petitioner's Exhibit 26).

When Dr. Taveau saw Petitioner on May 28, 2014, he noted she recently had been to the ER because of an exacerbation of her symptoms. He restated his opinion Petitioner had a recurrent disc herniation at L5-S1. When he saw Petitioner on June 6, 2014, he ordered an EMG study (Petitioner's Exhibit 26).

The EMG was performed on June 6, 2014. The study was consistent with right L5-S1 radiculopathy (Petitioner's Exhibit 26).

Petitioner returned to Dr. Alexander's office and received additional epidural steroid injections on June 9, 2014, October 27, 2014, and November 14, 2014. The injections were administered by Jennifer Alexander, a Physician Assistant (Petitioner's Exhibit 2).

Shortly after his last visit with Petitioner, Dr. Taveau made the decision to relocate his medical practice. He referred Petitioner to Dr. Matthew Gornet, an orthopedic surgeon.

On June 26, 2014, Petitioner was seen by Dr. Brent Newell, a pain management specialist. Petitioner complained of low back and leg pain, more on the right than left. Dr. Newell reviewed the MRI of May 16, 2014, and opined there was enhancing scar tissue in the L5-S1 disc affecting the S1 nerve roots, but no herniation. He recommended Petitioner undergo an epidural steroid injection. He administered bilateral epidural steroid injections at L5-S1 on July 2, 2014, and September 19, 2014 (Petitioner's Exhibit 13).

Petitioner received physical therapy from August 18, 2014, through October 30, 2014. When initially evaluated on August 18, 2014, Petitioner complained of low back and leg pain, right greater than left, but that the injections had given her some relief. When seen on October 30, 2014, the therapist noted Petitioner's complaints were in the right L4 dermatome and intermittently in the right L5-S1 dermatome (Petitioner's Exhibit 14).

At trial, Petitioner and Respondent stipulated Petitioner voluntarily resigned her employment with Respondent effective September 1, 2014. Petitioner testified she resigned because she had been accepted into nursing school (an RN program) and did not believe she could handle the physical and mental stress of working and going to school. At the time Petitioner resigned, Respondent was accommodating her light duty work/activity restrictions.

On October 30, 2014, Petitioner underwent another MRI of her lumbar spine. According the radiologist, post operative changes were noted at L5-S1, but no recurrent disc herniation (Petitioner's Exhibit 17).

Dr. Gornet initially evaluated Petitioner on November 20, 2014. At that time, Petitioner advised Dr. Gornet of both work-related accidents. Petitioner complained of low back and right leg pain with occasional left sided symptoms. Dr. Gornet reviewed all of the prior MRIs. He opined the MRI of May 16, 2014, and October 30, 2014, both revealed large annular tears at L5-S1. Dr. Gornet recommended Petitioner undergo a CT myelogram and another MRI. He imposed work/activity restrictions and opined Petitioner should undergo an anterior fusion at L5-S1 (Petitioner's Exhibit 23).

In regard to causality, Dr. Gornet opined Petitioner sustained a disc injury as a result of the work-related accident of May 13, 2013, and this condition was aggravated by the work-related accident of May 2, 2014. He noted the initial surgery which included the discectomy and removal of part of the structure of the spine weakened the structure, which can lead to pain and symptoms. He opined both injuries played a role in Petitioner's current need for treatment (Petitioner's Exhibit 23).

An MRI was performed on December 5, 2014. According to the radiologist, the MRI noted the prior disc surgery at L5-S1, moderate degenerative disc disease at L5-S1, but no evidence of recurrent disc herniation (Petitioner's Exhibit 17).

Dr. Gornet saw Petitioner on December 8, 2014, and reviewed the MRI of December 5, 2014. Dr. Gornet noted all of the discs appeared healthy with the exception of L5-S1. He did not specify what abnormalities were present at L5-S1 in his medical record of that date (Petitioner's Exhibit 23).

Dr. Taveau was deposed on December 15, 2014, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Taveau's testimony was consistent with his medical records and he reaffirmed the opinions contained therein. Dr. Taveau testified he performed disc surgery at L5-S1 on August 5, 2013, and the disc herniation was related to the accident of May 13, 2013 (Petitioner's Exhibit 34; pp 14-15).

In regard to his release for Petitioner to return to unrestricted activity as of October 2, 2013, and his subsequent note of October 24, 2013, wherein he authorized Petitioner to be off work, Dr. Taveau explained that he restricted Petitioner from returning to work as a CNA, but permitted her to perform her clinical tasks in nursing school. Dr. Taveau explained that Petitioner could be more protected and accommodated while performing her clinical duties in nursing school and not required to perform any tasks which could cause her to sustain an injury (Petitioner's Exhibit 34; pp 19-22).

In regard to the treatment Dr. Taveau provided to Petitioner after the accident of May 2, 2014, he noted Petitioner had radicular findings on the right that were not previously present as the prior findings were on the left. He testified this suggested a new condition and not just an exacerbation of the old condition. He opined the MRI performed on May 16, 2014, revealed a recurrent disc

herniation at L5-S1 paracentral right. He recommended Petitioner attempt conservative treatment, but that if it did not help her, then she should undergo a fusion at L5-S1 (Petitioner's Exhibit 34; pp 30-34).

On cross-examination, Dr. Taveau agreed he was not restricting Petitioner from any activities in nursing school, including the clinicals. This was based on his understanding that Petitioner's professors would allow her to have accommodations during the clinicals, but he had no verification of this. In regard to the radiologist's interpretation of the MRI of May 16, 2014, not revealing a recurrent disc herniation at L5-S1, he acknowledged the radiologist disagreed with his interpretation of it (Petitioner's Exhibit 34; pp 59-63, 70-71).

At the direction of Respondent, Petitioner was examined by Dr. Andrew Zelby, a neurosurgeon, on January 14, 2015. In connection with his examination of Petitioner, Dr. Zelby reviewed medical records and diagnostic studies provided to him by Respondent. Dr. Zelby opined the diagnostic studies performed after the accident of May 13, 2013, revealed a disc protrusion at L5-S1, but he opined there was no basis for Petitioner undergoing "urgent surgery," but he did not opine as to whether disc surgery was or was not appropriate. In regard to the diagnostic studies performed after the May, 2014, accident, Dr. Zelby opined there was no evidence of a recurrent herniated disc which was consistent with the opinion of the radiologist. In regard to the presence of an annular tear following surgery he opined this was meaningless and did not provide a basis to consider further surgery (Respondent's Exhibit 1).

Dr. Zelby's findings on examination of Petitioner were essentially normal and there were no objective findings to explain the persistence and severity of her symptoms. Dr. Zelby also noticed there were positive Waddell signs with significant symptom magnification. He opined there was no medical basis for Petitioner undergoing a fusion at L5-S1, Petitioner could work performing medium-heavy physical labor and Petitioner was at MMI as of January/February, 2014 (Respondent's Exhibit 1).

Petitioner was again seen by Dr. Gornet on March 19, 2015. Dr. Gornet also ordered a CT myelogram which was performed that same day (Petitioner's Exhibit 23). According to the radiologist, the study revealed an annular disc bulge and bilateral neural foraminal stenosis. The report did not address whether or not there was recurrent disc herniation (Petitioner's Exhibit 7).

When Dr. Gornet saw Petitioner on March 19, 2015, he reviewed Dr. Zelby's report. Dr. Gornet did note he had some concerns about symptom magnification on the part of Petitioner, but that the diagnostic studies proved that Petitioner had a large annular tear at L5-S1. He renewed his recommendation Petitioner undergo an anterior lumbar fusion at L5-S1. He did note Petitioner would have to cease taking all narcotic medications prior to his performing surgery (Petitioner's Exhibit 23).

Petitioner was subsequently evaluated by Michael Bryant, a Physician Assistant associated with Dr. Mark Fleming, a neurosurgeon (in the same office Dr. Taveau was previously associated with), on April 13, 2015. Petitioner advised she had been seen by Dr. Gornet who recommended she undergo lumbar fusion surgery. Petitioner complained of low back and right leg pain. PA Bryant reviewed the MRI scan from December, 2014, and opined it revealed no evidence of a

recurrent disc herniation. Petitioner was then referred to Dr. Gerson Criste, for evaluation/treatment which included a possible dorsal column stimulator (Petitioner's Exhibit 26).

Dr. Criste saw Petitioner on April 29, 2015, and noted there were differing medical opinions as to whether Petitioner should undergo surgery. Because Petitioner continued to complain of radicular right leg pain, Dr. Criste recommended Petitioner undergo epidural steroid injections (Petitioner's Exhibit 26).

Dr. Criste administered epidural steroid injections at L5 on the right side on May 4, 2015, and May 19, 2015. Petitioner subsequently advised Dr. Criste the injections had relieved her symptoms and she began another course of physical therapy (Petitioner's Exhibit 26).

Dr. Gornet was deposed on September 21, 2015, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Gornet's testimony was consistent with his medical records and he reaffirmed the opinions contained therein. Specifically, Dr. Gornet testified that both he and Dr. Taveau had opined Petitioner had a recurrent herniation and a structural annular tear at L5-S1. Both Dr. Gornet and Dr. Taveau recommended Petitioner undergo fusion surgery and Dr. Gornet attributed Petitioner's low back condition to her work-related injury (Petitioner's Exhibit 35; pp 9-10, 13-14).

On cross-examination, Dr. Gornet was questioned about Waddell findings and he noted Petitioner had undergone surgery at L5-S1 and Petitioner's marking on a pain diagram of her areas of complaint was in regard to both the L5 and S1 nerve roots. When questioned about Dr. Taveau's opinion that Petitioner had recurrent a disc herniation at L5-S1, Dr. Gornet testified Petitioner had more of a structural problem at L5-S1 because of her undergoing a prior discectomy and laminectomy at that level which caused a destabilization of her spine at L5-S1 as well as an annular tear. Dr. Gornet testified the only way to stabilize the spine was to perform a fusion (Petitioner's Exhibit 35; pp 22, 35-37).

Petitioner was again seen by Dr. Gornet on October 5, 2015. At that time, Petitioner was no longer taking narcotics and was doing better. Dr. Gornet opined Petitioner had discogenic pain with annular tear and a previous surgery at L5-S1 (Petitioner's Exhibit 23).

Dr. Zelby was deposed on December 2, 2015, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Zelby's testimony was consistent with his medical report of January 14, 2015, and he reaffirmed the opinions contained therein. Dr. Zelby testified that the need for original disc surgery at L5-S1 was questionable, and he opined that it was likely the condition would have resolved without the need for surgery. Dr. Zelby stated Petitioner's complaints did not correlate with her objective findings and there was no medical basis for performing an L5-S1 fusion because there was no instability (Respondent's Exhibit 2; pp 19-22).

On cross-examination, although Dr. Zelby questioned the need for disc surgery, he declined to state that Dr. Taveau committed medical malpractice by performing an unnecessary and unreasonable surgery. However, Dr. Zelby later commented that "Dr. Taveau seems plagued by a lack of detail in his notes." (Respondent's Exhibit 2; pp 33-34, 65-66).

Dr. Gornet saw Petitioner on January 4, 2016. At that time, Petitioner was in nursing school. Dr. Gornet's diagnosis continued to be discogenic pain at L5-S1. He attributed Petitioner's condition to the first accident (erroneously indicating it as "8/5/13", which was, in fact, the date the surgery was performed) and the surgery she underwent thereafter. He opined surgery caused destabilization of that segment of the spine. He ordered an MRI spectroscopy at L3-L4, L4-L5 and L5-S1 and noted if Petitioner continued to have symptoms then the anterior fusion surgery at L5-S1 would be appropriate (Petitioner's Exhibit 23).

During the time Petitioner was being seen by Dr. Gornet, she continued to seek treatment from PA Alexander. PA Alexander administered epidural steroid injections on January 9, 2015, January 25, 2016, April 5, 2016, September 27, 2016, October 14, 2016, and December 6, 2016 (Petitioner's Exhibit 2).

Dr. Gornet subsequently saw Petitioner on March 24, 2016, and noted the MRI spectroscopy was positive for the presence of painful chemicals at L5-S1 and L4-L5. Dr. Gornet described his examination as non-focal and he recommended Petitioner proceed with the anterior fusion at L5-S1 (Petitioner's Exhibit 23).

On March 27, 2016, Petitioner contacted Dr. Criste's office and advised her leg pain was returning and she wanted another injection. Dr. Criste administered an epidural steroid injection at L5 on the right on April 17, 2016 (Petitioner's Exhibit 26).

At the direction of Respondent, Dr. Michael Treister, an orthopedic surgeon, performed a utilization review on April 11, 2016, in regard to the L5-S1 anterior lumbar fusion that was recommended by Dr. Gornet. In connection with his evaluation, Dr. Treister reviewed medical records, which included Dr. Zelby's report, which were provided to him by Respondent. Dr. Treister opined that an anterior L5-S1 fusion was not medically reasonable and necessary. This conclusion was based, in part, on the lack of examination findings in several of Dr. Gornet's medical records, in particular, Dr. Gornet's records of October 5, 2015, January 4, 2016 and March 24, 2016. He also noted Dr. Gornet did not make any reference to Petitioner's response to the epidural steroid injections (Respondent's Exhibit 3).

Dr. Gornet again saw Petitioner on June 27, 2016, September 29, 2016, and January 5, 2017. Petitioner's condition remained essentially the same and Dr. Gornet noted he was awaiting approval to proceed with the fusion surgery (Petitioner's Exhibit 23).

On May 20, 2016, Petitioner contacted Dr. Criste's office and requested another injection. Dr. Criste subsequently administered epidural steroid injections at L5 on the right on July 6, 2016, and July 21, 2016 (Petitioner's Exhibit 26).

Dr. Treister was deposed on December 19, 2016, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Treister's testimony was consistent with his report and he reaffirmed the opinions contained therein. Specifically, he initially noted that when Dr. Gornet evaluated Petitioner on November 20, 2014, his findings correlated with nerve root pressure at the L4-L5 and not the L5-S1 level. In his review of Dr. Gornet's records subsequent to that date, Dr. Treister noted the lack of a description of Petitioner's subjective complaints and

any findings on examination. Dr. Treister also noted Petitioner's Waddell findings when examined by Dr. Zelby and that, after one of the epidural steroid injections, Petitioner's symptoms worsened (Respondent's Exhibit 4; pp 14-20).

Dr. Treister also noted Petitioner had been treated for anxiety and depression and that should be fully evaluated before proceeding to surgery. Dr. Treister also opined the use of MRI spectroscopy was not generally used to evaluate spinal conditions and a positive finding at L5-S1 was not supportive of Petitioner undergoing a fusion at that level. Dr. Trester testified an L5-S1 fusion surgical procedure was not indicated (Respondent's Exhibit 4; pp 31-40).

On cross-examination, Dr. Treister was questioned about his opinion regarding the use of the MRI spectroscopy. Dr. Treister testified the fact that the study revealed an abnormal chemical content was not of any significance because the disc was previously herniated and would have an abnormal chemical content (Respondent's Exhibit 4; pp 86-88).

Dr. Gornet was deposed for the second time on January 23, 2017, and his deposition testimony was received into evidence at trial. The primary reason Dr. Gornet was re-deposed was to rebut the opinions of Dr. Treister. Dr. Gornet testified he was treating an objective structural problem at L5-S1. In regard to the L5 nerve root, Dr. Gornet testified it was actually closer to L5-S1 than L4-L5. While the L5 nerve root can be irritated by pathology at L4-L5, it can also been irritated by pathology at L5-S1 (Petitioner's Exhibit 36; pp 7-9).

Dr. Gornet also reviewed the EMG study of June 6, 2014, and noted its findings of radiculopathy at L5-S1 and opined it was consistent with his findings. Dr. Gornet testified he did not record examination findings on every visit because there was no change as Petitioner's complaints remained essentially the same. In regard to Petitioner's depression, Dr. Gornet testified that patients who had appropriately selected pathology responded well to surgery. He specifically noted Petitioner was no longer on narcotics and had a treatable problem. Dr. Gornet also testified MRI spectroscopy was a reliable diagnostic tool to determine whether someone needed treatment or not (Petitioner's Exhibit 36; pp 17-23).

On cross-examination, Dr. Gornet agreed that were only three offices in the country that use spectroscopy to evaluate spinal patients. Dr. Gornet agreed that the presence of an annular tear, in and of itself, was not the basis for a surgical recommendation as many other factors needed to be considered (Petitioner's Exhibit 36; pp 28-31).

Petitioner began to experienced bilateral shoulder symptoms sometime in October, 2016. Petitioner initially sought medical treatment in December, 2016, at the office of Dr. Alexander, her family physician. On December 27, 2016, PA Alexander evaluated Petitioner and ordered x-rays and CT scans of both shoulders. The CT scans revealed the presence of avascular necrosis in both shoulders (Petitioner's Exhibits 2 and 6).

In regard to her shoulder condition, Petitioner was subsequently seen by Dr. George Paletta, an orthopedic surgeon, on January 18, 2017. At that time, Petitioner advised she had been diagnosed with avascular necrosis of both shoulders and had received steroids as part of her treatment for a back injury. Dr. Paletta ordered CT scans of both shoulders which also revealed avascular

necrosis of both shoulders. Dr. Paletta's diagnosis was humeral head avascular necrosis (Petitioner's Exhibit 23).

At trial, Petitioner testified she received at least 17 steroid injections as part of her treatment for her back injury. As noted herein, the medical records tendered at trial revealed Petitioner had, in fact, received 19 epidural steroid injections into her low back, from May 23, 2013, through December 6, 2016.

Dr. Paletta subsequently performed arthroscopic reconstructive surgery of the humeral heads on the left shoulder and right shoulder on April 25, 2017, and July 27, 2017, respectively. Dr. Paletta subsequently performed another right shoulder surgery on November 2, 2017, which consisted of an open repair of the subscapularis. He authorized Petitioner to be off work from April 25, 2017, through May 1, 2018 (Petitioner's Exhibit 23).

Dr. Paletta was deposed twice, on August 18, 2017, and again on April 25, 2018. In both depositions, Dr. Paletta noted Petitioner had undergone multiple steroid injections and he attributed the avascular necrosis as being secondary to steroid use (Petitioner's Exhibit 37; pp 11-12; Petitioner's Exhibit 38; pp 11-12).

At the direction of Respondent, Petitioner was examined for the second time by Dr. Zelby on April 23, 2018. In connection with his examination of Petitioner, Dr. Zelby reviewed medical records and diagnostic studies provided to him by Respondent. According to Dr. Zelby's report of that date, Petitioner advised him she sustained the injury of May 2, 2014, when she and two coworkers were attempting to lift a patient that weighed in excess of 300 pounds. She also advised him of having undergone 17 epidural steroid injections and the shoulder surgeries that were subsequently performed. Petitioner complained of low back and right leg pain (Respondent's Exhibit 5).

Dr. Zelby initially noted Petitioner provided a much different history of the accident of May 2, 2014, than what she previously told him. Dr. Zelby's findings on examination were objectively normal and he again noted the presence of symptom magnification. He also opined the numerous steroid injections were not medically necessary because she had no condition which would be treated with steroid injections. He opined the annular tear was no clinical significance and the use of MRI spectroscopy was not reasonable for determining treatment in spinal conditions. Dr. Zelby opined there was no objective evidence to support performing an L5-S1 fusion (Respondent's Exhibit 5).

When Dr. Gornet saw Petitioner on June 25, 2018, he renewed his recommendation Petitioner undergo a fusion at L5-S1. Petitioner continued to complain of low back and right leg pain. Dr. Gornet again noted Petitioner had structural back pain and an annular tear at L5-S1. Dr. Gornet reviewed Dr. Zelby's report of April 23, 2018, and noted Dr. Zelby had limited knowledge of the use of MRI spectroscopy. Dr. Gornet stated Rush Presbyterian Hospital had been in contact with him in regard to possibly using MRI spectroscopy (Petitioner's Exhibit 23).

Dr. Zelby was deposed on July 9, 2018, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Zelby's testimony was consistent with his report and he reaffirmed the opinions contained therein. He testified Petitioner had no residual recurrent disc issues or findings of radiculopathy. Dr. Zelby also noted that, in regard to the accident of May 2, 2014, Petitioner had previously advised she just sat down after work and experienced pain, but was now describing a specific accident (Respondent's Exhibit 6; pp 21-22).

On cross-examination, Dr. Zelby agreed that disc disruption at L5-S1 could cause L5 nerve irritation. In regard to the inconsistent history, Dr. Zelby agreed he did not have Petitioner complete any form as to how she sustained the injury, nor did he have any knowledge of what history Petitioner gave to the other medical providers (Respondent's Exhibit 6; pp 31-37).

Dr. Gornet was deposed for the third time on August 13, 2018, and his deposition testimony was received into evidence at trial. The primary reason for deposing Dr. Gornet at that time was so he could rebut Dr. Zelby's most recent report. Dr. Gornet testified Petitioner had objective findings which clearly showed on various MRIs scans and the MRI spectroscopy (Petitioner's Exhibit 39; pp 6-9).

On cross-examination, Dr. Gornet was asked about Petitioner's multiple steroid injections and whether they related to her avascular necrosis. He did not have an opinion regarding same (Petitioner's Exhibit 39; pp 16-17).

At the direction of Respondent, on September 21, 2018, Dr. Treister performed another utilization review regarding the medical reasonableness and necessity of the proposed L5-S1 fusion as well as the multiple steroid injections Petitioner had already undergone. Dr. Treister restated his opinion that there was no medical basis for an L5-S1 fusion. In regard to the epidural steroid injections, Dr. Treister opined the initial injections received on May 2, 2013, June 9, 2014, and July 2, 2014, were medically reasonable, but the injections received thereafter were not. Dr. Treister did not opine as to the medical reasonableness and necessity of the injections Petitioner received on July 2, 2013, and July 22, 2013. Among other things, Dr. Treister noted there was no consideration given to the cumulative effect of the steroid injections Petitioner had received. In respect to the diagnosis of avascular necrosis, Dr. Treister opined it was more likely than not referable to the cumulative effect of all the steroids (Respondent's Exhibit 7).

Dr. Treister was deposed on September 24, 2018, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Treister's testimony was consistent with his medical report and he reaffirmed the opinions contained therein. Specifically, Dr. Treister testified the injections Petitioner received on June 9, 2014, and July 2, 2014 (the first two subsequent to the May, 2014, accident) were reasonable and necessary, but all of the injections received thereafter were not medically reasonable and necessary. Dr. Treister was not questioned about the early injections Petitioner had received in May through July, 2013. Dr. Treister explained that there were no objective findings of radicular symptoms and Petitioner was not getting any better following the injections. He also testified the steroid injections contributed to the development of avascular necrosis and there was no medical basis to justify Petitioner having received 17 steroid injections (Respondent's Exhibit 8; pp 21-23, 26-28).

At trial, Petitioner testified she has continued to live with constant low back pain with radiation into both legs, more on the right than left. She wants to proceed with the fusion surgery recommended by Dr. Gornet. Petitioner has returned to work as an RN, but is careful at work, avoids lifting patients without assistance, gets help when needed, etc.

Conclusions of Law

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

The Arbitrator concludes Petitioner sustained an accidental injury arising out of and in the course of employment by Respondent on May 2, 2014.

In support of this conclusion the Arbitrator notes the following:

Petitioner testified she had just returned to work approximately three weeks prior and was taking care of nine patients, four of which were "total lift" patients. Petitioner's job assignment required a significant amount of lifting. After working a portion of her shift, Petitioner began to experience low back as well as right side pain which she had not experienced with the prior injury.

Petitioner reported the accident to Respondent that same day and a written report was prepared. The written report was not tendered into evidence and Respondent tendered no live witnesses at trial to rebut Petitioner's testimony about what occurred on May 2, 2014.

Respondent's position that Petitioner did not sustain a work-related accident on May 2, 2014, was based, in part, on the record of Dr. Austin in which Petitioner stated she did not sustain a re-injury, but had taken on too much work too fast. However, in that same record, Petitioner specifically referenced the number of patients she had to care for, doing total lifts and heavy lifting.

At trial, Petitioner was not cross-examined about any of the statements she made to Dr. Austin.

Respondent also relied on the history of the accident of May 2, 2014, contained in Dr. Zelby's report of April 23, 2018, wherein Petitioner purportedly informed him that she had sustained an accident when she and a coworker attempted to lift a patient who weighed in excess of 300 pounds. Dr. Zelby specifically noted that this was not the history Petitioner had given to him when he previously examined her on January 14, 2015.

At trial, Petitioner was not cross-examined about whether or not she provided such a history to Dr. Zelby when he examined her on April 23, 2018.

The Arbitrator finds Petitioner was a credible witness at trial. This was amplified by the fact that while Petitioner was undergoing extensive medical treatment, she completed nursing school and was subsequently certified as both an LPN and RN.

While Petitioner did not describe a specific lifting incident and immediate onset of pain, the Arbitrator finds Petitioner's description of her work activities and complaints afterward were descriptive of an accidental injury arising out of and in the course of her employment by Respondent.

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

The Arbitrator concludes Petitioner's current condition of ill-being is, in part, causally related to the accident of May 2, 2014. Specifically, the Arbitrator concludes Petitioner's current condition of ill-being in regard to her lumbar spine is causally related to the accident of May 2, 2014, but her bilateral shoulder condition is not related to the accident of May 2, 2014.

In support of this conclusion the Arbitrator notes the following:

At the time Petitioner sustained the accident on May 2, 2014, she experienced low back and right side pain and subsequently had right leg symptoms. When Petitioner sustained the prior work injury on May 13, 2013, she experienced low back and left leg pain.

When Petitioner was evaluated by Dr. Taveau (the physician who performed L5-S1 disc surgery on August 5, 2013), subsequent to the accident of May 2, 2014, Dr. Taveau noted Petitioner had low back pain and right lower extremity radicular pain. Dr. Taveau also opined Petitioner had sustained a recurrent disc herniation at L5-S1.

The fact Petitioner had pain in the right leg consistent with L5-S1 radiculopathy was confirmed by the EMG study performed on June 6, 2014.

In spite of the fact that the radiologist opined the MRI of May 16, 2014, did not reveal evidence of a recurrent disc herniation, Dr. Taveau opined there was a recurrent disc herniation and noted an L5-S1 fusion might be indicated.

Dr. Gornet opined the MRI studies revealed annular tears at L5-S1 and that Petitioner sustained a disc injury on May 13, 2013, which was aggravated by the accident of May 2, 2014.

Respondent's Section 12 examiner, Dr. Zelby, opined the diagnostic studies did not reveal a recurrent herniated disc at L5-S1 and Petitioner exhibited Waddell signs when he examined her on January 14, 2015. When Dr. Gornet reviewed Dr. Zelby's report, Dr. Gornet again noted the diagnostic studies revealed a large annular tear at L5-S1 and renewed his recommendation Petitioner undergo a fusion at that level.

The Arbitrator acknowledges that the radiologist who read various MRIs of Petitioner's lumbar spine opined there was not recurrent disc herniation; however, whether there was or was not a recurrent disc herniation is not the critical issue. When Dr. Gornet was deposed on September 21, 2015, he testified Petitioner had a structural problem which he described as destabilization of her spine at L5-S1 and that the only way to stabilize the spine was to perform a fusion.

Petitioner's prior treating physician, Dr. Taveau, has also recommended she undergo fusion surgery.

Respondent's utilization review physician, Dr. Treister, opined fusion surgery was not appropriate because, in part, Dr. Gornet's findings on examination correlated with nerve root pressure at L4-L5 and not L5-S1. However, Dr. Gornet testified the L5 nerve root can be irritated at L4-L5 as well as at L5-S1. Further, when he was deposed, Respondent's Section 12 examiner, Dr. Zelby, agreed that disc disruption at L5-S1 could irritate the L5 nerve root.

Based upon the preceding, the Arbitrator finds the opinions of Dr. Gornet and Dr. Taveau be more persuasive than those of Dr. Zelby and Dr. Treister.

In regard to Petitioner's bilateral shoulder condition, it was not caused by the accident of May 2, 2014, but by an excessive amount of steroid injections. As noted herein, the Arbitrator concluded that most of the steroid injections were medically unreasonable and unnecessary.

Petitioner's treating physician, Dr. Paletta, and Respondent's utilization review physician, Dr. Treister, both opined the avascular necrosis was related to Petitioner's steroid injections.

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

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

In regard to the epidural steroid injections, Respondent is liable for payment of the injections administered on June 9, 2014, and July 2, 2014 (steroid injections administered in May through July, 2013, were awarded in 13 WC 23310), but none of the steroid injections subsequent to July 2, 2014, because they were unreasonable and unnecessary. As aforestated, Petitioner's bilateral shoulder conditions are related to Petitioner's steroid injections.

Respondent is not liable for payment of medical treatment provided to Petitioner for her bilateral shoulder condition because it is related to the steroid injections, which the Arbitrator has determined to be medically unreasonable and unnecessary.

In regard to the MRI spectroscopy, Respondent is not liable for payment of the medical services incurred in connection with that diagnostic procedure because it was medically unreasonable and unnecessary.

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibit 1, except for all of the medical charges for epidural steroid injections administered to Petitioner subsequent to July 2, 2014, all of the medical charges for Petitioner's bilateral shoulder condition and the MRI spectroscopy, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule.

In support of this conclusion the Arbitrator notes the following:

As noted in disputed issue (F) the Arbitrator concludes Petitioner's current condition of ill-being in respect to her lumbar spine is causally related to the accident of May 2, 2014, for which Petitioner received significant medical treatment.

In regard to the epidural steroid injections administered to Petitioner, from May, 2013, through December, 2016, Petitioner underwent 19 steroid injections. Respondent's utilization review physician, Dr. Treister, opined that the first two injections administered subsequent to the accident of May 2, 2014 (June 9, 2014, and July 2, 2014) were medically reasonable and necessary, but the injections administered thereafter were not. He noted there was no consideration of the cumulative effect of these injections and he opined they contributed to the development of Petitioner's avascular necrosis. Petitioner's treating physician, Dr. Paletta, also opined the avascular necrosis was secondary to the steroid injections.

In regard to Dr. Gornet's use of the MRI spectroscopy, Respondent's utilization review physician, Dr. Treister, opined that measurement of the chemical content of the disc which has been operated upon has no significance. Dr. Gornet agreed it was only used as a diagnostic tool in spine cases in three offices in the country. The Arbitrator was not persuaded that this diagnostic procedure was medically reasonable and necessary.

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

The Arbitrator concludes Petitioner is entitled to prospective medical treatment including, but not limited to, the L5-S1 fusion surgery recommended by Dr. Gornet.

In support of this conclusion the Arbitrator notes the following:

As noted in the Arbitrator's conclusion of law in disputed issue (F), Dr. Gornet has opined Petitioner has a structural instability at L5-S1 and a fusion procedure is the only way to stabilize the spine.

The Arbitrator finds the opinions of Dr. Gornet and Dr. Taveau to be more persuasive than those of Dr. Zelby and Dr. Treister.

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

The Arbitrator concludes Petitioner is entitled to temporary total disability benefits of eight and three-sevenths (8 3/7) weeks commencing May 2, 2014, through June 30, 2014.

In support of this conclusion the Arbitrator notes the following:

Petitioner was receiving medical treatment and authorized to be off work for the aforestated period of time, until she returned to work on light duty.

The Arbitrator acknowledges Petitioner was authorized to be off work from April 27, 2017, through April 30, 2018, while being treated for bilateral shoulder condition. However, the Arbitrator found this shoulder condition was not work-related. Accordingly, Respondent does not owe temporary total disability benefits for that period of time.

William R. Gallagher, Arbitrator

SOIACC0013

STATE OF ILLINOIS

COUNTY OF
WILLIAMSON

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Stevie Lewis,

Petitioner,

vs.

NO: 14 WC 22576
20 IWCC 13

Southern Illinois Healthcare, Inc.,
d/b/a Memorial Hospital of Carbondale,

Respondent.

DISSENT

I respectfully dissent from the opinion of the majority and would reverse the Arbitrator's Decision in part. After considering the totality of the evidence, I would affirm the Arbitrator's award of the proposed lumbar fusion surgery, temporary total disability, and certain medical expenses relating to Petitioner's lumbar spine. However, I would reverse the Arbitrator's conclusion that Petitioner's diagnosis of avascular necrosis is not causally related to the May 2, 2014, work accident. Finally, I believe Petitioner met her burden of proving the bilateral shoulder surgeries performed by Dr. Paletta are causally related to the work accident.

The Arbitrator wrote an incredibly detailed and well-reasoned Decision in this matter. The credible evidence overwhelmingly supports the Arbitrator's conclusion that the work accident aggravated Petitioner's preexisting lumbar spine condition. This was not a temporary aggravation as Petitioner reported additional symptoms following the work accident. Petitioner testified credibly about her history of complaints and her treating physician, Dr. Gornet, was the most credible witness regarding the condition of Petitioner's lumbar spine. Dr. Gornet testified credibly that as a result of the work accident, Petitioner's spine is destabilized at L5-S1. According to Dr. Gornet, only a fusion surgery will stabilize Petitioner's spine. He thoroughly explained his opinions in his medical records and over the course of several evidence depositions. The opinions and testimony of Respondent's Section 12 examiners, Drs. Zelby and Treister, were less credible. For these reasons, I would affirm the Arbitrator's finding that Petitioner's lumbar spine condition

is causally related to the May 2, 2014, work accident and would affirm the Arbitrator's award of the requested prospective lumbar spine surgery.

The causal connection of Petitioner's diagnosis of bilateral shoulder avascular necrosis and the subsequent bilateral shoulder surgeries is a much more difficult issue. The evidence unquestionably supports the Arbitrator's conclusion that the vast majority of Petitioner's epidural injections were unreasonable and unrelated to the work accident. However, Petitioner's diagnosis of bilateral shoulder avascular necrosis is a direct result of her undergoing epidural injections. This does not automatically mean that Petitioner's bilateral shoulder surgeries are not causally related to the May 2, 2014, work accident. After all, even the majority agrees with the Arbitrator's finding that only the epidural steroid injections performed after July 2, 2014, are not causally related to Petitioner's work injury. Respondent's Section 12 examiner, Dr. Treister, opined that the cumulative effect of a patient undergoing multiple epidural steroid injections can cause avascular necrosis. Dr. Gornet credibly testified that a single steroid injection can cause avascular necrosis. After carefully weighing the relevant evidence, I believe it is probable that one of the steroid injections the Commission finds were reasonable and necessary caused Petitioner's avascular necrosis. Respondent provided no credible evidence that the steroid injections Petitioner underwent on June 9, 2014, and July 2, 2014, did not cause or contribute to Petitioner's development of avascular necrosis. Based primarily on Dr. Gornet's testimony regarding the connection between a single epidural steroid injection and the potential development of avascular necrosis, I would reverse the Arbitrator's denial of the bilateral shoulder surgeries. I would also reverse the Arbitrator's denial of reasonable and necessary medical expenses relating to Petitioner's diagnosis of avascular necrosis.

For the forgoing reasons, I would reverse the Arbitrator's Decision in part and find Petitioner's diagnosis of avascular necrosis and the related bilateral shoulder surgeries are causally related to the May 2, 2014, work accident. I would affirm the remainder of the Arbitrator's Decision.

JAN 6 – 2020

Thomas J. Tyrrell

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

YOAN MANDUJANO,

Petitioner,

vs. NO: 10 WC 46514

D'AGOSTINO LANDSCAPING/STEPHAN D'AGOSTINO/
ILLINOIS STATE TREASURER as *ex-officio* custodian of the
INJURED WORKERS' BENEFIT FUND,

Respondent.

20IWCC0014

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Respondent Injured Workers' Benefit Fund and notice given to all parties, the Commission, after considering the issues of notice of trial date and insurance coverage, and being advised of the facts and law, modifies the Decision of the Arbitrator as set forth below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Arbitrator awarded 5/7 weeks of Temporary Total Disability benefits, representing September 5, 2010 through September 9, 2010. This corresponds to Petitioner's in-patient stay at Advocate Lutheran General Hospital. PX5. Section 8(b) provides, in relevant part, "If the period of temporary total incapacity for work lasts more than 3 working days, weekly compensation as hereinafter provided shall be paid beginning on the 4th day of such temporary total incapacity and continuing as long as the total temporary incapacity lasts." *820 ILCS 305/8(b)*. Therefore, Petitioner is entitled to TTD for September 8, 2010 and September 9, 2010.

All else is affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 4, 2018, as modified above, is hereby affirmed and adopted.

501ACC0019

20IWCC0014

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay $16,966.49 in reasonable and necessary medical expenses as provided in §8(a) and subject to §8.2.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $320.00 per week for a period of 2/7 weeks, representing September 8, 2010 and September 9, 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 $288.00 per week for a period of 5 weeks, as provided in §8(d)2 of the Act, as the injuries sustained caused the 1% loss of use of the person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that the Illinois State Treasurer as *ex-officio* custodian of the Injured Workers' Benefit Fund was named as a co-Respondent in this matter. The Treasurer was represented by the Illinois Attorney General. This award hereby is entered against the Fund to the extent permitted and allowed under §4(d) of the Act, in the event of the failure of Respondent-Employer to pay the benefits due and owing the Petitioner. Respondent-Employer shall reimburse the Injured Workers' Benefit Fund for any compensation obligations of Respondent-Employer that are paid to the Petitioner from the Injured Workers' Benefit Fund. The Respondent-Employer's obligation to reimburse the Injured Workers' Benefit Fund, as set forth above, in no way limits or modifies its independent and separate liability for fines and penalties set forth in the Act for its failure to be properly insured.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $18,600.00. 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: JAN 6 - 2020

L. Elizabeth Coppoletti

LEC/mck

D: 12/18/19

Stephen Mathis

43

D. Douglas McCarthy

50IMCC0014

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MANDUJANO, YOAN Case# **10WC046514**

Employee/Petitioner

D'AGOSTINO LANDSCAPING/STEPHAN D'AGOSTINO/ILLINOIS STATE TREASURER AS EX-OFFICIO CUSTODIAN OF THE INJURED WORKERS' BENEFIT FUND

Employer/Respondent

20IWCC0014

On 6/4/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.03% 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.

0243 GUMBINER INJURY LAW GROUP
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180 N MICHIGAN AVE SUITE 2100
CHICAGO, IL 60601

0000 D'AGOSTINO LANDSCAPING
STEPHAN D'AGOSTINO
8300 WINONA ST
NORRIDGE, IL 60706

5875 ASSISTANT ATTORNEY GENERAL
STEPHANIE KEVIL
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

P100303W1 0S

STATE OF ILLINOIS)
)SS. 20IWCC0014
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

YOAN MANDUJANO,
Employee/Petitioner

v.

D'AGOSTINO LANDSCAPING/STEPHAN D'AGOSTINO/ ILLINOIS STATE TREASURER, AS EX-OFICIO CUSTODIAN OF THE INJURED WORKERS' BENEFIT FUND,
Employer/Respondent

Case # 10 WC 46514

Consolidated cases: N/A

20IWCC0014

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **MARIA S. BOCANEGRA**, Arbitrator of the Commission, in the city of **CHICAGO**, on **3/13/2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☒ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☒ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☒ What was the date of the accident?
E. ☒ 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 **Insurance, Notice of Trial**

20IWCC0014

FINDINGS

On **9/4/2010**, 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 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 **$24,960.00**; the average weekly wage was **$480.00**.

On the date of accident, Petitioner was **26** years of age, **single** with **0** dependent children.

Petitioner ***has*** received 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**.

ORDER

Respondent shall pay reasonable and necessary medical services of **$16,966.49**, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner temporary total disability benefits of **$320.00/week** for **5/7th weeks**, commencing **9/5/10** through **9/9/10**, as provided in Section 8(b) of the Act. Respondent shall pay Petitioner the temporary total disability benefits that have accrued from **9/5/10** through **9/9/10**, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall pay Petitioner permanent partial disability benefits of **$288.00/week** for **5 weeks**, because the injuries sustained caused the **1%** loss of the **man as a whole**, as provided in Section 8(d)2 of the Act.

The Illinois State Treasurer as ex-officio custodian of the Injured Workers' Benefit Fund was named as a co-Respondent in this matter. The Treasurer was represented by the Illinois Attorney General. This finding is hereby entered as to the Fund to the extent permitted and allowed under §4(d) of the Act. Should any recovery by Petitioner occur, Respondent-Employer shall reimburse the Injured Workers' Benefit Fund for any compensation obligations of Respondent-Employer that are paid to Petitioner from the Injured Workers' Benefit Fund, including but not limited to any full award in this matter, the amounts of any medical bills paid, temporary total disability paid or permanent partial disability paid. The Employer-Respondent's obligation to reimburse the IWBF, as set forth above, in no way limits or modifies its independent and separate liability for fines and penalties set forth in the Act for its failure to be properly insured.

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

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

6/4/20/18
Date

JUN 4 - 2018

FINDINGS OF FACT

Background

Yoan Mandujano ("Petitioner") alleged injuries arising out of and in the course of his alleged employment with D'Agostino Landscaping ("Respondent") occurring on 9/4/10. Ax1, Px3. Petitioner further alleged that on the date of accident, Respondent carried no workers' compensation insurance and amended his application for adjustment of claim to add the Injured Workers' Benefit Fund ("IWBF"). Ax1, Px3. On 3/13/18, by agreement between Petitioner and IWBF, along with notice to Respondent, this matter proceeded to hearing on all issues. Ax1. The IWBF challenged all issues, including whether notice of the trial date ws proper and whether Respondent lacked insurance. The following is a recitation of the facts adduced at trial.

Testimonial and Other Evidence

Petitioner testified that he was born in 1984 and was 34 years old at the time of trial with 5 children. On the alleged date of the accident, he had one child. Petitioner testified he worked for Respondent for 6 years, having been hired on the spot and that his dad also worked for Respondent. he testified that he was paid either with a personal check or in cash weekly. He worked Monday thru Saturday from 8am to 5pm. Petitioner testified that "he" decided what days were to be worked, that if Petitioner missed time, petitioner needed to tell him. He testified he worked approximately 48 hours per week. He testified that taxes were not taken out. Petitioner stated that there were some shirts with the company logo on it and that he usually wore a hat and boots.

Regarding duties, petitioner testified that his duties included cutting grass, trimming bushes, doing outdoor work, using equipment such as 5-speed lawn machines as provided by Stephan D'Agostino, using trimmers to trim bushes and using shovels. He testified that sometimes a supervisor would tell him what tool to use for what tasks but that other times, Petitioner already knew what to do. He testified they worked at several locations, did different routes every day. He said he would drive himself to a lot where they would all meet and from there they would drive the routes together, using company equipment to perform duties.

Petitioner testified that on 9/4/10, he worked for Respondent cutting grass with a lawnmower when he was stung by a bee in his stomach. He felt a burning sensation, stopped the machine and told his boss. He noticed a beehive and that the bees were "coming down like crazy" and that he ran. Petitioner said that Stephan D'Agostino told him to finish his shift or he would not get paid. After, he went to the emergency room.

Records show that on September 5, 2010, petitioner was admitted to Lutheran General Hospital. Px5. Diagnosis was abdominal cellulitis and secondary diagnoses included methicillin resistant staphylococcus aureus, toxic effect of venom, sting of hornets/wasps/bees causing poisoning and toxic reaction, all present on admission. Petitioner underwent drainage of the skin and subcutaneous tissue. The discharge summary indicated that petitioner presented with pain and swelling to the side of a bee sting one day prior. He was noted to have cellulitis and was started on empiric antibiotics. There was a small abscess noted and this was incised and drained. The wound culture revealed MRSA. He was discharged and advised to follow a 10-day course of antibiotics for MRSA. Petitioner was it eventually discharged on September 9, 2010.

On September 17, 2010, petitioner followed up with Dr. Patel, who discharge petition or with light duty work of no lifting more than 50 pounds. The doctor ordered these restrictions good until September 24, 2010.

Petitioner said he was released after 4 days with pain medications. Petitioner said he was told he could not lift over 50 pounds. Petitioner said he told him 2-3 weeks after surgery and that he responded he was not going to pay the bills. Currently, Petitioner testified he does not feel pain and was diagnosed with MRSA. He said he has no symptoms now because it's been 7 years.

CONCLUSIONS OF LAW

Arbitrator's Credibility Assessment

Petitioner was the only witness to testify at trial. The Arbitrator finds Petitioner to be truthful, candid and forthright regarding what he could recall surrounding the circumstances of his employment, the injury, his treatment and his current condition.

ISSUE (O) Arbitrator's Findings as Adequacy of Notice

No one purporting to be the representative Respondent Employer, D'Agostino, was present at the hearing. Petitioner provided one exhibit to support his contention that notice to Respondent Employer was proper. The record shows that on 2/12/18, Petitioner provided notice of a 3/13/18 trial date to Respondent's addresses, purportedly located at 4807 N. Crescent Ave., Harwood Heights, Illinois 60706. Px1. This letter states that it was sent via regular and certified mail. The bottom of the letter gives certified mail article number "7001 2510 0002 6388 1525." On 2/16/18, someone at the location in fact signed for the letter. The Arbitrator has considered the evidence presented, along with Petitioner's testimony and finds that notice of the hearing was sufficient.

ISSUE (O) Arbitrator's Findings as to Lack of Workers' Compensation Insurance

Regarding lack of insurance the Arbitrator finds that sufficient evidence was presented that Respondent did not carry workers' compensation insurance on the alleged date of accident. Px2.

ISSUE (A) Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
ISSUE (B) Was there an employee-employer relationship?

The Arbitrator finds that on 9/4/10, Respondent-Employer D'Agostino Landscaping was operating under and subject to the Illinois Workers' Compensation Act. Such evidence includes, but is not limited to, the unrebutted testimony of Petitioner that Respondent-Employer employed Petitioner to perform landscaping duties, which included the cutting of lawns and the using of gas powered machines such as a lawnmower, cutting tools such as a lawnmower and trimmer. Such actions result in Respondent being subject to the Act pursuant to Section 3(8) and (15).

Further, pursuant to the Act, Illinois may acquire jurisdiction over a claim (1) if the contract for hire was made in Illinois, (2) if the accident occurred in Illinois, or (3) if the claimant's employment was principally located in Illinois. 820 ILCS 305/1(b)(2). Petitioner's un-contradicted testimony shows that he was hired by Stephan D'Agostino, whose job site was located in Illinois. Petitioner credibly testified he was hired in Illinois.

Based upon the above, the Arbitrator finds that Respondent was operating under and subject to the Illinois Workers' Compensation Act on 9/4/10. The Arbitrator finds that Petitioner presented sufficient, credible evidence that on 9/4/10 an Employee-Employer Relationship existed. Such evidence includes, but is not limited to, the unrebutted testimony of Petitioner that she was hired by Respondent-Employer on the spot

and that he found this work thru his father, who already worked for Respondent-Employer, that he was paid $480.00 per week, that he worked up about 48 hours per week, that he was paid weekly by personal check or in cash and that no taxes were taken out, that Petitioner would wear a company shirt provided for by the Respondent-Employer, that he was directed where to meet, which routes to perform and what work was to be carried out. Such evidence demonstrates that Respondent exercised control over Petitioner's method and manner of work, that Respondent controlled the method of payment, that Respondent exercised the right to hire and therefore likely controlled the right to discharge Petitioner and that Respondent provided the tools, materials and/or equipment in Petitioner completing the work for which he was ultimately hired to do.

ISSUE (C) ***Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?***
ISSUE (D) ***What was the date of the accident?***
ISSUE (E) ***Was timely notice of the accident given to Respondent?***

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. Petitioner alleges that he injured himself while working Respondent-Employer on 9/4/10. Specifically, he stated that he was mowing a lawn and was stung by a bee. He noticed a bee nest nearby, felt a pain and notified his supervisor. He testified that Stephan D'Agostino was present that day, was aware he had been stung and directed him to continue working anyway.

Based on the foregoing, the Arbitrator finds that the date of the accident is 9/4/10 and that on that date, Petitioner was in the course of his employment as he was on the clock working for Respondent and a location where he was expected to be mowing a lawn. In addition, the Arbitrator finds that Petitioner's injury arises out of his employment with Respondent as he was performing duties directly related to his employment, namely, that of mowing a lawn when he was stung by a bee. Finally, the Arbitrator finds Petitioner gave proper notice when he notified his supervisor of the sting the same day.

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

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. Having found in favor of Petitioner on the foregoing issues, the Arbitrator finds that Petitioner's current condition of ill-being as it relates to the bee sting and resultant cellulitis and MRSA is causally related to his work accident. Petitioner was in a state of good health immediately before the accident and following the accident, he said he noticed a sting and burning sensation. Medical records corroborate this history and onset. Based upon a chain of events theory, the Arbitrator concludes that his condition of ill-being is causally related to the work accident.

ISSUE (G) ***What were Petitioner's earnings?***

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. Having found in favor of Petitioner on the foregoing issues, the Arbitrator concludes that Petitioner earned **$480.00** per week at the time of his injury. Petitioner's testimony is instrumental in this regard. Petitioner testified he made around $480.00 a week while working for Respondent-Employer. This arrangement was made when Petitioner was hired. No exhibits or evidence was introduced to dispute Petitioner's testimony. Therefore, the Arbitrator adopts Petitioner's testimony in this regard and concludes Petitioner earned **$480.00** per week.

ISSUE (H) What was Petitioner's age at the time of the accident?

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. Having found in favor of Petitioner on the foregoing issues, the Arbitrator concludes that Petitioner was 26 years old at the time of the accident. In so finding, the Arbitrator relies on Petitioner's undisputed testimony and on her medical records, which corroborate same.

ISSUE (I) What was Petitioner's marital status at the time of the accident?

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. Having found in favor of Petitioner on the foregoing issues, the Arbitrator concludes that Petitioner was single at the time of his accident. In so finding, the Arbitrator relies on Petitioner's undisputed testimony. Petitioner alleged he had one dependent and submitted evidence to corroborate same. Px4. The Arbitrator finds in favor of Petitioner for same.

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 incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. Having found in favor of Petitioner on the foregoing issues, the Arbitrator concludes that Respondent has not yet paid for reasonable and necessary medical services. At trial, Petitioner alleged outstanding bills due and owing as a result of this accident. Ax1. Petitioner testified none were paid. The Arbitrator concludes that Petitioner's medical treatment was reasonable and necessary to treat his cellulitis and MRSA. No contrary evidence was submitted to challenge the treatment from Lutheran, Access or Dr. Mauer. Therefore, Respondent shall pay reasonable and necessary medical services of **$16,966.49**, as provided in Sections 8(a) and 8.2 of the Act.

ISSUE (K) What temporary benefits are in dispute?

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. Having found in favor of Petitioner on the foregoing issues, the Arbitrator concludes that Petitioner has proven he was entitled to TTD from 9/5/10 thru 9/9/10, representing the time in which he was hospitalized inpatient for cellulitis and the MRSA as a result of the bee sting. Upon his discharge from Lutheran, petitioner was not issued any work restriction. Petitioner failed to provide evidence that after being discharged he could not work. There was no evidence he contacted his employer and attempted to return to work. Thereafter, Petitioner saw Dr. Patel, who placed him on light duty of no lifting greater than 50 pounds from 9/17/10 thru 9/24/10. Px6. However, petitioner did not testify that he attempted to return to work within these restrictions. Therefore, Respondent shall pay Petitioner temporary total disability benefits of **$320.00/week** for **5/7th weeks**, commencing **9/5/10** through **9/9/10**, as provided in Section 8(b) of the Act. Respondent shall pay Petitioner the temporary total disability benefits that have accrued from **9/5/10** through **9/9/10**, and shall pay the remainder of the award, if any, in weekly payments.

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

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. Having found in favor of Petitioner on the foregoing issues, the Arbitrator concludes that Petitioner has proven he is entitled to permanency for his injury. Petitioner's work accident resulted in a cellulitis and MRSA. He underwent inpatient hospitalization, irrigation and drainage and medications.

Petitioner last treated in 2010 and he has not treated since. Accordingly, his claim for any PPD is ripe for adjudication.

The Arbitrator finds that the nature and extent of the injury to be 1% man as a whole. The medical records and testimony of Petitioner are instrumental in this regard. Petitioner testified that he has no symptoms from this incident. Respondent shall pay Petitioner permanent partial disability benefits of **$288.00/week** for **5 weeks**, because the injuries sustained caused the **1%** loss of the **man as a whole**, as provided in Section 8(d)2 of the Act.

Signature of Arbitrator

6/4/18
Date

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JOHN RACHUY,

Petitioner,

vs. NO: 14 WC 42665

SERVICE STATION,

Respondent.

20IWCC0015

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 12, 2019 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 $69,600.00. 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: JAN 6 - 2020

D Douglas McCarthy
Douglas McCarthy

DDM/tdm
O: 12/18/19
052

Stephen J. Mathis
Stephen Mathis

SPECIAL CONCURRENCE/DISSENT

I concur with the majority in all aspects of its decision other than its order to compel Respondent to authorize medical treatment. This issue was previously addressed by the Court in *Hollywood Casino-Aurora, Inc. v. Illinois Workers' Compensation Commission*, 2012 IL App (2d) 110426WC, which is dispositive. The Court noted "Assuming for the sake of analysis that this provision of the Act [Section 8(a)] is sufficiently broad so as to include a requirement that an employer authorize medical treatment for an injured employee in advance of the services being rendered, the fact still remains that there is no provision in the Act authorizing the Commission to assess penalties against an employer that delays in giving such authorization." *Id.* at ¶ 19. Ordering Respondent to authorize medical treatment is meaningless where no enforcement mechanism exists under the Act. In accordance with Section 8(a) of the Act and the Court's holding in *Hollywood Casino*, I would order Respondent to provide and pay for the awarded medical expenses and/or treatment.

L Elizabeth Coppoletti
L. Elizabeth Coppoletti

SOIMCC0012

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

RACHUY, JOHN
Employee/Petitioner

Case# **14WC042665**

SERVICE SANITATION
Employer/Respondent

20IWCC0015

On 3/12/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.45% 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.

20IWCC0015

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

0274 HORWITZ HORWITZ & ASSOC LTD
TYLER BERBERICH
25 E WASHINGTON ST SUITE 900
CHICAGO, IL 60602

2965 KEEFE CAMPBELL BIERY & ASSOC
MATTHEW A WRIGLEY
118 N CLINTON ST SUITE 300
CHICAGO, IL 60661

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

20IWCC0015

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

John Rachuy
Employee/Petitioner

v.

Service Sanitation
Employer/Respondent

Case # **14** WC **42665**

Consolidated cases: **N/A**

20IWCC0015

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Stephen J. Friedman**, Arbitrator of the Commission, in the city of **Geneva**, on **January 11, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ 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 3, 2014**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$40,002.56**; the average weekly wage was **$769.28**.

On the date of accident, Petitioner was **34** years of age, ***married*** with **1** dependent child.

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

Respondent shall be given a credit of **$45,645.43** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$4,615.70** for other benefits, for a total credit of **$50,261.13**.

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 $512.85/week for 217 3/7 weeks, commencing November 12, 2014 through January 11, 2019, as provided in Section 8(b) of the Act. Respondent shall be given a credit of $45,645.43 for TTD and $4,615.70 for other benefits, for a total credit of $50,261.13.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $8,214.44 to ATI, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall receive credit for any additional payments made on the unpaid balances.

Respondent shall authorize and pay for additional reasonable and necessary treatment consistent the recommendations of Dr. Dewald including surgical intervention including an ALIF at L4-5 and L5-S1 with percutaneous instrumentation posteriorly, any postoperative treatment, physical therapy or other reasonable and necessary 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

March 6, 2019
Date

MAR 12 2019

ICArbDec19(b)

Statement of Facts

Petitioner John Rachuy testified that on July 3, 2014 he was employed by Respondent Service Sanitation as a pickup and delivery driver. He started with Respondent in April 2014. His duties were to drive to locations to deliver, pickup and service porta-potties. He testified that he was a one-man crew. He would go to the location and load or unload the porta-potties by hand. There was no lift gate on his truck. He would use a dolly to move them to the truck. He would lift them manually onto the truck. The porta-potties weighed about 70 to 100 pounds. If they contained waste, they would be heavier. The handicap and ADA handicap units weighed more. He testified that 10 to 12 porta-potties would fit on the truck. He would deliver 12 to 20 per day. If there was a special event, he could deliver or pick up 3 to 4 truckloads per day. The job description of a Service Technician was admitted at RX 4. It notes Petitioner would require the ability to lift 80 pounds regularly and repeatedly. Prior to his accident, Petitioner had no injuries, treatment, or lost time for his low back. Petitioner has a hearing loss. He wears two hearing aids and reads lips. He has difficulty with phone calls or in noisy environments.

Petitioner testified that on July 3, 2014, he went to pick up an ADA unit at a baseball field. It was 40 to 50 feet from the truck. He dragged it to the truck and emptied it. As he lifted it onto the truck, he felt a pop in his back and shooting pain down his left leg to his foot. He called dispatch to report he injured his back. He drove back to the yard. Petitioner prepared an Accident Report with a consistent description of the accident and pain in the back down the leg (PX 14). The dispatcher drove him to the doctor.

On July 3, 2014, Petitioner was seen at Comprehensive Care by Dr. David Foreit, DO (PX 4). Petitioner provided a consistent history of accident. He denied any previous injury or trauma to the back. He complained of back pain with a throbbing and tingling sensation down to his foot. Dr. Foreit diagnosed an acute low back injury, acute thoracic and lumbar strain and spasm, and left leg pain and paresthesia. He performed a decompression, prescribed medication, and took Petitioner off work (PX 4).

On July 7, 2014, Petitioner noted some improvement. He reported no leg pain but a tingling sensation that goes down to his foot. Petitioner appeared much more comfortable. Dr. Foreit performed decompression treatment on Petitioner's lumbar spine (PX 4). Petitioner continued treatment with Dr. Foreit who performed additional osteopathic manipulation for Petitioner's lower back pain. Dr. Foreit released Petitioner to work with light duty restrictions of lifting 5-10 pounds on July 14, 2014 (PX 4). Petitioner returned to work for Respondent. Petitioner testified that he drove the pickup and delivery truck and had a helper riding with him to do the lifting. On July 18, 2014, Petitioner was referred for physical therapy. On July 21, 2014, Petitioner began a course of physical therapy (PX 4).

On August 18, 2014, Petitioner sought emergency medical care at Franciscan Health. He reported left flank and groin pain since 5 AM and burning on urination. Petitioner reported he had not experienced this type of pain before. He noted a hernia repair three months ago. Urine analysis and CT of the abdomen/pelvis was normal. Dr. Hussain noted tenderness at the hernia surgical scar. He ordered blood work and a repeat CT scan with contrast for a possible bowel inflammation. The repeat CT scan was also unremarkable. Petitioner was discharged with an assessment of groin pain and back pain (PX 6).

Petitioner underwent physical therapy and treatment with Dr. Foreit through August and September 2014. He reported improvement of his pain levels and he was doing well working within his restrictions, On September 10, 2014 range of motion was 100%. Petitioner reported no low back pain and hoped to be released to return

to full duty. On September 11, 2014, Dr. Foreit recommended 2 more weeks of therapy and a full ergonomics test. He increased Petitioner's lifting restriction to 25 pounds. On September 24, 2014, Dr. Foreit noted that Petitioner was not experiencing pain down the leg, numbness or loss of function. Dr. Foreit cleared the Petitioner to work at full duty and recommended that he continue with decompression treatments once per week for 2-3 weeks (PX 4).

Petitioner testified that he attempted to work at full duty for Respondent. After one day of work, he experienced increased lower back and left leg pain and went back to light duty work. On October 8, 2014, Dr. Foreit noted that Petitioner had an exacerbation of his pain after one day of work and that he had been back to working light duty since that day. Dr. Foreit diagnosed a suspected disc herniation, recommended that Petitioner undergo an MRI, reinstated his light duty work restrictions and ordered physical therapy (PX 4). The October 14, 2014 lumbar MRI at Northwestern Medical Imaging found no evidence of disc herniation. There was an L4-5 mild posterior bulge and mild disc desiccation at L5-S1 with a mild disc bulge (PX 9).

Petitioner continued treatment with Dr. Foreit through October 2014. On October 29, 2014, Petitioner reported feeling the same with pain of 2-3/10. He was not complaining of any leg pain or numbness or tingling. Petitioner noted some discomfort with treatments, so they were put on hold by Dr. Foreit. Petitioner remained on light duty restrictions. On November 19, 2014, Dr. Foreit noted that Petitioner has not gained complete resolution of his injury and referred Petitioner for an orthopedic spine evaluation with either Dr. Khanna or Dr. Tyndall. He last saw Petitioner on December 3, 2014 and continued his 25-pound restriction (PX 4).

Petitioner testified that he was laid off from Respondent in November 2014. Petitioner testified that he was laid off with other workers. The work for Respondent was from spring through the fall. Petitioner and Respondent stipulated that temporary total disability benefits were due beginning on November 12, 2014 (Arb. Ex. 1).

On December 12, 2014, Petitioner was seen for a Section 12 examination by Dr. Charles Slack at Respondent's request. His report of the examination was admitted at RX 5. He testified by evidence deposition taken November 7, 2018 (RX 6). Dr. Slack performed a physical examination of Petitioner and reviewed his diagnostic films and medical records. He diagnosed Petitioner with a persistent symptomatic aggravation of degenerative lumbar disc and facet disease which has been ongoing since July 3, 2014 accident. He opined that this condition of ill-being is causally related to his incident on the job of July 2014. Dr. Slack did not feel that Petitioner had reached a healing plateau and recommended continued treatment including considering diagnostic lumbar facet blocks to determine if the facet spondylosis is causing the patient's ongoing pain. If indeed the diagnostic facet block does give some temporary relief, the patient would then be a candidate for radiofrequency lesioning of those facets. He suggested using medications such as Neurontin or Lyrica. If the patient's pain can then be better controlled, then he would suggest progressing to a functional capacity evaluation and possible work conditioning to determine his physical abilities. If the patient does not get any response with the additional medication or the facet assessment, the patient may then need to consider a lumbar discography to determine if the ongoing pain response has been emanating from a discogenic pain response. If that was the case, the patient then may possibly require a lumbar fusion type procedure. Dr. Slack recommended that Petitioner remain on light duty work restrictions (RX 5, RX 6).

On December 19, 2014, Petitioner was seen by Dr. Dwight Tyndall at Orthopaedic Specialists of Northwest Indiana upon the referral from Dr. Foreit. After examining the Petitioner and reviewing his MRI, Dr. Tyndall recommended that Petitioner undergo facet injections at L4-5 and L5-S1 bilaterally. Dr. Tyndall referred Petitioner to Dr. Christopher Dewald for treatment of his lower back pain (PX 3).

On January 30, 2015, Petitioner was seen by Dr. Dewald at Midwest Orthopedics at Rush. Dr. Dewald examined Petitioner and reviewed his MRI, which he felt showed disc degeneration at L5-S1 and some bulging and mild desiccation with no herniation. Dr. Dewald's impression was low back strain. He recommended that Petitioner undergo physical therapy and an epidural steroid injection. He did not recommend surgery at that time (PX 2).

On February 5, 2015, Petitioner began a course of physical therapy at ATI Physical Therapy through July 22, 2015 (PX 5). On March 6, 2015, Dr. Dewald noted Petitioner was trying to lose weight. Physical therapy had not helped significantly. He noted that Petitioner had lower back pain and left sided buttock pain. He diagnosed Petitioner with mechanical low back pain related to an injury at work. He provided an off-work slip (PX 2).

On April 24, 2015, Dr. Dewald drafted a letter in response to a Utilization Review from the Respondent's workers' compensation insurance carrier denying additional physical therapy. Dr. Dewald stated than Petitioner was undergoing treatment for low back pain sustained while lifting a heavy object while at work. Dr. Dewald stated that Petitioner was not a surgical candidate and recommended he follow up with a physiatrist or rehabilitation physician. On April 30, 2015, Dr. Dewald noted Petitioner was still significantly disabled by his pain. Physical examination was unchanged. He noted that the MRI did show an abnormal signal at L4 and L5 which could possibly be a spondylolysis. He prescribed diagnostic injections or facet blocks as recommended by Dr. Slack, a CT scan of the lumbar spine and continued physical therapy. Petitioner was advised to continue activity as tolerated (PX 2). A CT scan on May 4, 2105 noted no change since the October 2014 MRI. No pars defect was noted. The study was noted as limited (PX 2).

On May 11, 2015, Petitioner saw Dr. Shaun Kondamuri at Midwest Interventional Spine Specialists for lower back and left leg pain since his July 3, 2014 work accident. He recommended L4-5 transforaminal epidural steroid injections and continued physical therapy. Petitioner was to remain on light duty work restrictions with lifting up to 30 pounds (PX 7). On June 3, 2015, Petitioner underwent a L4-5 transforaminal epidural steroid injection. On June 22, 2015, Petitioner followed up with Dr. Kondamuri who indicated that neither the injection nor continued therapy had given Petitioner relief of his lower back or occasional leg pain. Dr. Kondamuri recommended L3, L4 and L5 medial nerve branch blocks and referred Petitioner to see Dr. Dewald to discuss this option (PX 7).

Petitioner saw Dr. Dewald on July 9, 2015. Dr. Dewald noted no relief from the injections and physical therapy. He assessed chronic low back pain and recommended that Petitioner see Dr. Cheng for pain management and one of his colleagues in Northwest Indiana, either Dr. Khanna or Dr. Thompkins, for a second surgical opinion. He stated that Petitioner's symptoms seemed to be discogenic in nature. His surgical options would be a L4-5 fusion, but he would like to avoid this at this time (PX 2).

On July 20, 2015, Petitioner saw Dr. Anton Thompkins at Lakeshore Bone and Joint Institute upon referral from Dr. Dewald. Dr. Thompkins reviewed Petitioner's MRI and CT scans. He stated the CT showed possible left sided foraminal stenosis due to a disc osteophyte complex on the left side which could correspond to his symptoms. The MRI did not show significant neural compromise, but was not an ideal study. Dr. Thompkins stated, "I have asked him to consider getting a new MRI to get a better understanding of soft tissue anatomy, but if it does show a structural problem in that particular area that is still there, I would recommend that Dr. Dewald consider just a discectomy. In knowing that, I told the patient that a discectomy will only help leg

symptoms. It will not help his back pain fully and he understands that. I think a discectomy is a far lateral approach. If that structural problem is there on a new MRI, would be a reasonable option to help this gentleman for his lumbar radiculopathy, but again, would not help his back pain" (PX 1). The impression of the July 31, 2015 MRI was very early degenerative disc disease, no evidence of disc herniation, spinal stenosis or significant neural foraminal stenosis (PX 1).

On August 11, 2015, Petitioner was seen by Dr. Cheng for low back pain and intermittent left leg pain. Dr. Cheng diagnosed an L4-5 disc bulge with no significant foraminal, lateral recess or central stenosis. He recommended light duty work, prescribed medications and recommended another epidural injection if Petitioner's symptoms continued. On August 26, 2015, Petitioner reported no improvement. Dr. Cheng noted that Petitioner's symptoms are more severe than he would anticipate for his condition. He recommended work conditioning (PX 2).

On August 17, 2015, Dr. Thompkins reviewed the MRI and went over it with the radiologist. He stated that the report is not ideal but agreed with the radiologist that Petitioner had foraminal narrowing at the left-hand side at L4-5, which corresponded to his clinical findings and history. Dr. Thompkins recommended that Petitioner undergo a repeat L4-5 left-sided transforaminal injection. If he does get benefit and his pain should come back, Dr. Thompkins indicated that a surgical decompression and discectomy would be appropriate (PX 1). On September 10, 2015, Petitioner underwent a L4-5 transforaminal epidural steroid injection L4-5 (PX 1).

On September 28, 2015, Dr. Thompkins noted that Petitioner did not have long term benefit from his latest injection but only had short term. Dr. Thompkins noted findings consistent with radiculopathy, foraminal stenosis on the left side at L4-5. He recommended a decompression foraminotomy surgery at L4-5 (PX 1). On October 7, 2015, Dr. Thompkins drafted a letter indicating his basis for recommending surgery. He stated that Petitioner's left sided radicular symptoms were consistent with the left sided neuroforaminal stenosis seen on Petitioner's MRI. In terms of his neurologic symptoms, he has a lumbar radiculopathy which is defined as pain, numbness and tingling down his leg on that left-hand side, which corresponds to his structural problems. It is, once again, recommended he undergo a decompression for the appropriate management of his symptoms. Otherwise, it would be considered negligence (PX 1). On October 30, 2015, Petitioner underwent a decompression laminectomy, partial facetectomy as well as foraminotomy on the left side with full neural element decompression at L4 and L5 (PX 1).

On November 9, 2015, Petitioner reported that his left leg symptoms had completely resolved. Dr. Thompkins provided Petitioner with 10-pound lifting restrictions on December 7, 2017 (PX 1). Petitioner underwent a course of post-surgical physical therapy at ATI beginning on December 11, 2015 (PX 5). On January 14, 2016, Petitioner complained of increased back achiness, stiffness and pain, but no true radicular symptoms. Dr. Thompkins stopped therapy. On February 22, 2016, Dr. Thompkins resumed physical therapy and to progress to work hardening. Dr. Thompkins stated that he realized that Petitioner would not be going back to his previous job but should maximize his nonoperative care (PX 1). Petitioner was discharged from physical therapy on March 23, 2016 (PX 5).

On March 21, 2016, Petitioner was seen by Dr. Thompkins who reported Petitioner was doing better. He does not have as much pain. He has some tightness in the morning which gets better. Petitioner did not do work hardening since he is no longer going to be doing that type of job. Petitioner was concerned that reinstating heavy lifting would create similar problems for him. Dr. Thompkins stated that if Petitioner does not have further worsening and does his home exercises, he can be seen as needed. Petitioner has reached maximum

medical improvement. Petitioner was released with permanent physical restrictions of no lifting over 20 pounds, no pushing or pulling over 40 pounds and no repetitive twisting (PX 1).

On May 16, 2016, Petitioner was examined by Dr. Andrew Zelby at Respondent's request (RX 1). Petitioner advanced complaints of pain in the back and left buttock, not extending into the left leg. Dr. Zelby notes non-organic findings of pain on superficial light touch, pain on simulation and diminished with distraction. He notes intermittent antalgic gait favoring the left. He finds no spasm. Strength, reflexes and sensation are normal. Dr. Zelby reviewed the diagnostic testing. He noted degenerative changes and an L4-5 disc bulge on the October 2014 MRI and May 2015 CT scan. In the July 31, 2015 MRI, he also noted a new broad based left sided L4-5 disc protrusion at L4-5 not seen in the early study with moderate left foraminal stenosis. Following review of the treating medical records, Dr. Zelby concluded that Petitioner's symptoms as of that date were due to symptom amplification and not due to any condition of his spine based upon the disparity between his subjective complaints and objective findings. He notes Petitioner has 3/5 positive Waddell signs. He further opined that Petitioner's surgery was not causally related to his work injury, as the October 2014 MRI did not show a herniated disc and "multiple surgeons" did not recommend surgery for more than a year after the accident. Dr. Zelby stated that Petitioner would have easily reached maximum medical improvement for his work injury by October or November 2014 at the latest and that he could return to work at full duty as of that date. Dr. Zelby stated that Petitioner was not in need of any further diagnostics or treatment for his low back. Dr. Zelby disagreed with the 20-pound lifting restriction but, based upon the fact that the Petitioner had undergone a single level hemilaminectomy and foraminotomy, he recommended that Petitioner remain on work restrictions of lifting 50-60 pounds occasionally and 25-30 pound frequently. Dr. Zelby did not feel that the need for those restrictions was related to Petitioner's work accident (RX 1).

Dr. Zelby testified by evidence deposition taken May 10, 2018 (RX 2). He testified to his findings on examination including the history taken, the physical examination, and the review of diagnostic testing and medical records. He provided opinions as contained in his report. He had not reviewed any updated records since March 2016. He agreed that Petitioner had initial complaints of left leg pain and after the surgery, the left leg pain resolved. Dr. Zelby testified that the herniated disc had nothing to do with his injury. He opined that the accident caused a temporary exacerbation of a preexisting degenerative condition. That condition was not aggravated or accelerated (RX 2).

On June 2, 2016, Petitioner followed up with Dr. Thompkins who noted that while Petitioner's left leg symptoms had resolved, he had increasing lower back pain. Physical examination showed Petitioner was neurologically intact. Dr. Thompkins stated that he believed Petitioner was developing discogenic pain for the disc injury he sustained and recommended an updated lumbar MRI (PX 1). The June 24, 2016 MRI impression was an overall unremarkable MRI with a left L4-5 disc bulge with minimal foraminal stenosis (PX 1). On June 24, 2016, Dr. Thompkins reviewed the lumbar MRI which showed some mild disc protrusion at L4-5, but Dr. Thompkins did not feel that was the source of Petitioner's back pain. He recommended a diskography to determine the source of Petitioner's discogenic pain (PX 1).

On July 13, 2016, Dr. Thompkins reviewed the Section 12 report from Dr. Zelby. Dr. Thompkins stated that Dr. Zelby "misrepresented" that Petitioner did not have a structural problem that required surgical intervention. Dr. Thompkins explained that Petitioner's July 2015 MRI showed severe left-sided neural foraminal stenosis with severe left subarticular zone narrowing, which correlated with Petitioner's lumbar radiculopathy. Dr. Thompkins stated that Petitioner had developed discogenic back pain post-surgery at the surgical site and it would require a discography to define his pain generator (PX 10).

On July 27, 2016, Petitioner underwent a discogram and post discogram CT scan of the lumbar spine at the L3-4, L4-5 and L5-S1 levels. The discogram impression was normal at L3-4 and recreated Petitioner's low back pain at L4-5 and L5-S1 (PX 1). The CT scan impression was abnormal morphologic appearance of L4-5 and L5-S1 with an annular tear at L4-5 with extravasation of contrast into the left side (PX 8).

On August 3, 2016, Dr. Thompkins noted Petitioner had a 2-level positive discogram at L4-5 and L5-S1. Dr. Thompkins offered the Petitioner the option of a 2-level fusion, a hybrid construct with a fusion at one level and an artificial disk at the other level. Dr. Thompkins recommended that he continue pain management with Dr. Roa and possibly physical therapy to avoid surgery due to his young age (PX 1).

Dr. Thompkins testified by evidence deposition taken January 29, 2018 (PX 11). He testified to his treatment of Petitioner including his reading of the July 31, 2015 MRI as showing significant narrowing in the foramen at L4-5 on the left-hand side which was causing nerve irritation. Dr. Thompkins believed that this finding was consistent with Petitioner's leg pain in the L4 nerve root distribution, his recommendation for injections and surgery. He testified to his post-operative care and his July 13, 2016 response to Dr. Zelby's report. Dr. Thompkins noted that Dr. Dewald had recommended a decompression and possible fusion prior to Petitioner seeing Dr. Thompkins. Dr. Thompkins performed a different surgery in order to try to avoid fusion in such a young patient. Dr. Thompkins stated that Petitioner developed post-surgical back pain with discogenic findings. Dr. Thompkins felt that a discography was reasonable to define Petitioner's pain generator. Dr. Thompkins testified that the discogram was positive at two levels. He stated that the outcomes for two level positive screens is not ideal. He discussed possible surgical options with Petitioner. Petitioner chose to continue pain management. Dr. Thompkins has not seen Petitioner since August 3, 2016 (PX 11).

Based upon his treatment of Petitioner, his review of medical imaging and the medical records he reviewed, Dr. Thompkins' opined that the current condition of ill-being in Petitioner's lumbar spine is causally related to his July 3, 2014 work accident. Dr. Thompkins opined that Petitioner had a structural issue in his spine that stemmed from his work accident, which was surgically treated and led to continued back pain. Dr. Thompkins opined that the surgery performed on Petitioner was causally related to his July 3, 2014 work accident and that all treatment to Petitioner's lumbar spine had been reasonable and necessary (PX 11). Dr. Thompkins confirmed that he knew of no injuries to or treatment of Petitioner's lumbar spine prior to his work injury. Dr. Thompkins testified that foraminal stenosis can be caused by a degenerative process. If Petitioner had any preexisting stenosis, it was asymptomatic until the work accident. A discogram requires the patient to tell the truth (PX 11).

Petitioner returned to Dr. Roa on August 25, 2016. She performed a lumbar medial branch nerve block on September 7, 2016 at L3-L5, injecting 6 facets. Petitioner indicated that these injections reduced his pain for approximately 4-5 hours. Dr. Roa suggested doing a second series of blocks (PX 1).

On September 15, 2016, Petitioner returned to Dr. Dewald. He noted Petitioner's leg pain has resolved but he still has significant back pain which is believed to be discogenic. He notes the diagnostic findings on MRI, CT scan and discogram. Dr. Dewald's assessment and plan states that the patient has exhausted nonoperative management of his chronic low back pain. Although he does not have radiculopathy complaints and significant signs of neurocompression posteriorly, his disk degeneration has proven to exhaust conservative management. We have thus discussed fusion of the L5-S1 level, which has the most apparent degeneration radiographically, but with inclusion of the L4-L5 level due to the positive findings on the discogram. Therefore,

we would like to plan an ALIF at these two levels with percutaneous instrumentation posteriorly. The patient understands the risks, benefits, and alternatives of the proposed procedure and would like to proceed (PX 2). On September 23, 2018, Dr. DeWald provided a note indication that he has not seen Petitioner since September 15, 2016 because of his workers compensation status which as delayed treatment (PX 12).

Petitioner testified that he has not seen Dr. Dewald since September 15, 2016. He has attempted to return to see Dr. Dewald, but has been unable due to non-approval by workers' compensation. Petitioner testified that he is in pain every day and cannot do a whole lot. When Petitioner attempts to do chores, his pain becomes so great that he has to rest the remainder of the day. Petitioner cannot sweep the floor or vacuum without pain. He is not doing his exercises. Petitioner wants to undergo the surgery he had previously discussed with Dr. Dewald. Petitioner has not contacted Respondent since his layoff for employment. He applied for unemployment compensation in Indiana. He has no resume or any job logs.

Lisa Helma prepared a vocational report (PX 16) and testified by evidence deposition taken January 3, 2019 (PX 17). She testified that she is a certified rehabilitation counselor who performed a vocational evaluation of Petitioner. Ms. Helma reviewed Petitioner's accident history, work restrictions, educational history and current functional status. In analyzing whether Petitioner is a candidate for vocational rehabilitation, Ms. Helma concluded that Petitioner would be a candidate for vocational rehabilitation, depending on which work restrictions were applied. Ms. Helma opined that if Dr. Dewald's restrictions were followed (currently recommending that Petitioner remain off work pending fusion surgery), then there would be no labor market available to Petitioner at this time. If the restrictions recommended by Dr. Thompkins were adopted, then Petitioner would be a candidate for vocational rehabilitation and could be expected to find a position earning approximately $9.00 to $12.00 per hour. If the restrictions recommended by Dr. Zelby were adopted and found to be related to Petitioner's work accident, then Petitioner again would be a candidate for vocational rehabilitation and would be able to earn approximately $10.00 to $15.00 per hour. Ms. Helma testified to her opinions regarding a proper training plan for Petitioner and her recommendations for a formal vocational rehabilitation under the restrictions of Dr. Thompkins or Dr. Zelby (PX 17).

Conclusions of Law

In support of the Arbitrator's decision with respect to (F) Causal Connection, the Arbitrator finds as follows:

A Workers' Compensation Claimant bears the burden of showing by a preponderance of credible evidence that his current condition of ill-being is causally related to the workplace injury. *Horath v. Industrial Commission*, 449 N.E.2d 1345, 1348 (Ill. 1983) citing *Rosenbaum v. Industrial Com.* (1982), 93 Ill.2d 381, 386, 67 Ill.Dec. 83, 444 N.E.2d 122). The accident need not be the sole or principal cause, as long as it was a causative factor in a claimant's condition of ill-being. *Lopez v. Ill. Workers' Comp. Comm'n*, 2014 IL App (3d) 130355WC-U, P25 (Ill. App. Ct. 3d Dist. 2014). Nothing in the statutory language requires proof of a direct causal connection. *Sperling v. Industrial Comm'n*, 129 Ill. 2d 416, 421, 544 N.E.2d 290, 292 (1989). A causal connection may be based on a medical expert's opinion that an accident "could have" or "might have" caused an injury. *Consolidation Coal Co. v. Industrial Comm'n*, 265 Ill. App. 3d 830, 839, 639 N.E.2d 886, 892 (1994). In addition, a chain of events suggesting a causal connection may suffice to prove causation even if the etiology of the disease is unknown. *Id.* Prior good health followed by a change immediately following an accident allows an inference that a subsequent condition of ill-being is the result of the accident. *Navistar International Transportation Co. v. Industrial Comm'n*, 315 Ill. App. 3d 1197, 1205 (2000).

Petitioner sustained an undisputed accident on July 3, 2014 in which he suffered an injury to his lower back. His unrebutted testimony and medical histories state that he had no prior low back injuries or treatment. Thereafter, he has been treated consistently for complaints of back pain and intermittent left leg pain. Petitioner had some initial improvement with treatment by Dr. Foreit sufficient to attempt a return to full duty work. But after suffering a return of symptoms after only one day, Dr. Foreit place Petitioner back on restrictions and referred his to an orthopedic surgeon. Although released to full duty work in September, Dr. Foreit had continued treatment and had not released Petitioner from further care.

On December 12, 2014, Petitioner was seen for a Section 12 examination by Dr. Charles Slack at the request of the Respondent. He diagnosed Petitioner with a persistent symptomatic aggravation of degenerative lumbar disc and facet disease causally related to his incident on the job of July 2014. Dr. Slack recommended continued treatment included considering diagnostic lumbar facet blocks to determine if the facet spondylosis is causing the patient's ongoing pain. If indeed the diagnostic facet block does give some temporary relief, the patient would then be a candidate for radiofrequency lesioning of those facets. If the patient does not get any response with the additional medication or the facet assessment, the patient may then need to consider a lumbar discography to determine if the ongoing pain response has been emanating from a discogenic pain response. If that was the case, the patient then may possibly require a lumbar fusion type procedure. Dr. Slack recommended that Petitioner remain on light duty work restrictions

Dr. Tyndall recommended that Petitioner undergo facet injections at L4-5 and L5-S1 bilaterally. Dr. Tyndall referred Petitioner to Dr. Christopher Dewald for treatment of his lower back pain. Dr. Dewald reviewed the MRI, which he felt showed disc degeneration at L5-S1 and some bulging and mild desiccation with no herniation. He recommended that Petitioner undergo physical therapy and an epidural steroid injection. He did not recommend surgery at that time.

On March 6, 2015, Dr. Dewald noted physical therapy had not helped significantly. He diagnosed Petitioner with mechanical low back pain related to an injury at work. On April 24, 2015, Dr. Dewald stated that Petitioner was not a surgical candidate and recommended he follow up with a physiatrist or rehabilitation physician. On April 30, 2015, Dr. Dewald noted Petitioner was still significantly disabled by his pain. Physical examination was unchanged. He noted that the MRI did show an abnormal signal at L4 and L5 which could possibly be a spondylolysis. He prescribed diagnostic injections or facet blocks as recommended by Dr. Slack, a CT scan of the lumbar spine and continued physical therapy. On May 11, 2015, Petitioner underwent a L4-5 transforaminal epidural steroid injection. On June 22, 2015, Dr. Kondamuri indicated that neither the injection nor continued therapy had given Petitioner relief of his lower back or occasional leg pain. On July 9, 2015. Dr. Dewald noted no relief from the injections and physical therapy. He assessed chronic low back pain and recommended that Petitioner see Dr. Cheng for pain management and either Dr. Khanna or Dr. Thompkins for a second surgical opinion. He stated that Petitioner's symptoms seemed to be discogenic in nature. His surgical options would be a L4-5 fusion, but he would like to avoid this at this time.

On July 20, 2015, Petitioner saw Dr. Thompkins who reviewed Petitioner's MRI and CT scans. He stated that the CT scan showed possible left sided foraminal stenosis due to a disc osteophyte complex on the left side which could correspond to his symptoms. Dr. Thompkins ordered a new MRI. Dr. Thompkins reviewed the July 31, 2015 MRI and went over it with the radiologist. He stated that Petitioner had foraminal narrowing at the left-hand side at L4-5, which corresponded to his clinical findings and history. Dr. Thompkins recommended that Petitioner undergo a repeat L4-5 left-sided transforaminal injection. If he does get benefit and his pain

should come back, Dr. Thompkins indicated that a surgical decompression and discectomy would be appropriate. On September 10, 2015, Petitioner underwent a L4-5 transforaminal epidural steroid injection L4-5. On September 28, 2015, Dr. Thompkins noted that Petitioner did not have long term benefit from his latest injection but only had short term. He notes findings consistent with radiculopathy, foraminal stenosis on the left side at L4-5. He recommended a decompression foraminotomy surgery at L4-5. On October 7, 2015, Dr. Thompkins drafted a letter indicating his basis for recommending surgery. He stated that Petitioner's left sided radicular symptoms were consistent with the left sided neuroforaminal stenosis seen on Petitioner's MRI. On October 30, 2015, Petitioner underwent a decompression laminectomy, partial facetectomy as well as foraminotomy on the left side with full neural element decompression at L4 and L5.

On November 9, 2015 Petitioner reported that his left leg symptoms had completely resolved. Dr. Thompkins provided Petitioner with 10-pound lifting restrictions on December 7, 2017. Petitioner underwent a course of post-surgical care. On March 21, 2016, Petitioner was seen by Dr. Thompkins. Petitioner was concerned that reinstating heavy lifting would create similar problems for him. Dr. Thompkins stated that if Petitioner does not have further worsening and does his home exercises he can be seen as needed. Petitioner has reached maximum medical improvement. Petitioner was released with permanent physical restrictions of no lifting over 20 pounds, no pushing or pulling over 40 pounds and no repetitive twisting.

On June 2, 2016, Petitioner followed up with Dr. Thompkins who noted that while Petitioner's left leg symptoms had resolved, he had increasing lower back pain. Dr. Thompkins stated he believed that Petitioner was developing discogenic pain for the disc injury he sustained and recommended an updated lumbar MRI. Dr. Thompkins reviewed the June 24, 2016 lumbar MRI which showed some mild disc protrusion at L4-5, but Dr. Thompkins did not feel that was the source of his back pain. He recommended a diskography to determine the source of Petitioner's discogenic pain. On July 27, 2016, Petitioner underwent a discogram and post discogram CT scan of the lumbar spine at the L3-4, L4-5 and L5-S1 levels. The discogram impression was normal at L3-4 and recreated Petitioner's slow back pain at L4-5 and L5-S1. The CT scan impression was abnormal morphologic appearance of L4-5 and L5-S1 with an annular tear at L4-5 with extravasation of contrast into the left side. On August 3, 2016, Dr. Thompkins noted Petitioner had a 2-level positive diskogram at L4-5 and L5-S1. Dr. Thompkins offered the Petitioner the option of a 2-level fusion, a hybrid construct, with a fusion at one level and an artificial disk at the other level. Dr. Thompkins recommended that he continue pain management with Dr. Roa and possibly physical therapy to avoid surgery due to his young age.

Dr. Roa performed a lumbar medial branch nerve block on September 7, 2016 at L3-L5. Petitioner indicated that these injections reduced his pain for approximately 4-5 hours. On September 15, 2016, Petitioner returned to Dr. Dewald who noted Petitioner's leg pain has resolved but he still has significant back pain which is believed to be discogenic. He notes the diagnostic findings on MRI, CT scan and discogram. Dr. Dewald's assessment and plan states that the patient has exhausted nonoperative management of his chronic low back pain. Although he does not have radiculopathy complaints and significant signs of neurocompression posteriorly, his disk degeneration has proven to exhaust conservative management. We have thus discussed fusion of the L5-S1 level, which has the most apparent degeneration radiographically, but with inclusion of the L4-L5 level due to the positive findings on the discogram. Therefore, we would like to plan an ALIF at these two levels with percutaneous instrumentation posteriorly.

Respondent has disputed causal connection based on the opinions of Dr. Zelby. Dr. Zelby concluded that Petitioner's symptoms were due to symptom amplification and not due to any condition of his spine based upon the disparity between his subjective complaints and objective findings. He notes Petitioner has 3/5

positive Waddell signs. He further opined that Petitioner's surgery was not causally related to his work injury, as the October 2014 MRI did not show a herniated disc and "multiple surgeons" did not recommend surgery for more than a year after the accident. Dr. Zelby stated that Petitioner would have "easily" reached maximum medical improvement for his work injury by October or November of 2014 at the latest and that he could return to work at full duty as of that date. Dr. Zelby stated that Petitioner was not in need of any further diagnostics or treatment for his low back. Dr. Zelby testified that the herniated disc had nothing to do with his injury. He opined that the accident caused a temporary exacerbation of a preexisting degenerative condition. That condition was not aggravated or accelerated.

Dr. Thompkins reviewed the report from Dr. Zelby. Dr. Thompkins stated that Dr. Zelby "misrepresented" that Petitioner did not have a structural problem that required surgical intervention. Dr. Thompkins explained that Petitioner's July 2015 MRI showed severe left-sided neural foraminal stenosis with severe left subarticular zone narrowing, which correlated with Petitioner's lumbar radiculopathy. Dr. Thompkins stated that Petitioner had developed discogenic back pain post-surgery at the surgical site and it would require a diskography. to define his pain generator. Dr. Thompkins' opined that the current condition of ill-being in Petitioner's lumbar spine is causally related to his July 3, 2014 work accident. Dr. Thompkins opined that Petitioner had a structural issue in his spine that stemmed from his work accident, which was surgically treated and lead to continued back pain. Dr. Thompkins opined that the surgery performed on Petitioner was causally related to his July 3, 2014 work accident.

It is the Commission's province to assess the credibility of witnesses, draw reasonable inferences from the evidence, determine what weight to give testimony, and resolve conflicts in the evidence, particularly medical opinion evidence. *Berry v. Industrial Comm'n*, 99 Ill. 2d 401, 406-07, 459 N.E.2d 963, 76 Ill. Dec. 828 (1984); *Hosteny v. Illinois Workers' Compensation Comm'n*, 397 Ill. App. 3d 665, 675, 928 N.E.2d 474, 340 Ill. Dec. 475 (2009); *Fickas v. Industrial Comm'n*, 308 Ill. App. 3d 1037, 1041, 721 N.E.2d 1165, 242 Ill. Dec. 634 (1999). Expert testimony shall be weighed like other evidence with its weight determined by the character, capacity, skill and opportunities for observation, as well as the state of mind of the expert and the nature of the case and its facts. *Madison Mining Company v. Industrial Commission*, 309 Ill. 91, 138 N.E. 211 (1923). The proponent of expert testimony must lay a foundation sufficient to establish the reliability of the bases for the expert's opinion. *Gross v. Illinois Workers' Compensation Comm'n*, 2011 IL App (4th) 100615WC, 960 N.E.2d 587, 355 Ill. Dec. 705. If the basis of an expert's opinion is grounded in guess or surmise, it is too speculative to be reliable. Expert opinions must be supported by facts and are only as valid as the facts underlying them. *In re Joseph S.*, 339 Ill. App. 3d 599, 607, 791 N.E.2d 80, 87, 274 Ill. Dec. 284 (2003). A finder of fact is not bound by an expert opinion on an ultimate issue, but may look 'behind' the opinion to examine the underlying facts. Not only may the Commission decide which medical view is to be accepted, it may attach greater weight to the opinion of the treating physician. *International Vermiculite Co. v. Industrial Comm'n*, 77 Ill.2d 1, 31 Ill.Dec. 789, 394 N.E.2d 1166 (1979); *ARA Services, Inc. v. Industrial Comm'n*, 226 Ill. App. 3d 225, 168 Ill. Dec. 756, 590 N.E. 2d 78 (1992).

Having heard the testimony and reviewed the exhibits, the Arbitrator finds the opinions of Dr. Zelby unpersuasive and finds the opinions of Dr. Thompkins and Dr. Dewald persuasive and supported by the Petitioner's credible testimony and symptoms, the diagnostic testing, physical examinations and the findings and opinions of Dr. Slack, Dr. Kondamuri, Dr. Tyndall, Dr. Foreit and Dr. Roa. The Arbitrator finds Dr. Zelby's statement that there was no surgical recommendation by multiple surgeons inaccurate. Dr. Dewald discussed surgical options. Dr. Slack discussed possible fusion. Dr. Thompkins performed surgery. All of the statements concerning Petitioner not being a surgical candidate were qualified by plans to first exhaust conservative

measures in light of Petitioner's young age. The Arbitrator also does not find Dr. Zelby's attribution of Petitioner's current symptoms to symptom amplification supported by the evidence. Petitioner returned to work with restrictions and, when released to full duty, made an attempt, although unsuccessful. There is no other evidence to support a claim of symptom magnification. The Petitioner's presentation at his medical treatment has been consistent. None of the multiple treating physicians has raised any question as to the validity of his complaints. The Arbitrator finds Petitioner a credible witness. The Arbitrator finds that the treatment provided to Petitioner was a cautious and measured attempt to address the symptoms and supported by the diagnostic testing and to avoid invasive surgery until other more conservative options were exhausted. The progression of physical therapy, injections, microsurgery, facet blocks and ultimately the recommendation for a fusion is the exact progression outlined by Dr. Slack if Petitioner did not obtain relief of his symptoms.

Based upon the record as a whole, including the credible testimony of Petitioner and the persuasive opinions of his treating medical providers, the Arbitrator finds that Petitioner has proven by a preponderance of the evidence that his current condition of ill-being in the lower back is causally connected to the accidental injuries sustained on July 3, 2014.

In support of the Arbitrator's decision with respect to (J) Medical, the Arbitrator finds as follows:

Under §8(a) of the Act, a claimant is entitled to recover reasonable medical expenses that are causally related to the accident and that are determined to be required to diagnose, relieve, or cure the effects of a claimant's injury. The claimant has the burden of proving that the medical services were necessary, and the expenses incurred were reasonable. *City of Chicago v. Illinois Workers ' Compensation Commission,* 409 Ill. App. 3d 258,267 (1st Dist., 2011). In weighing the reasonableness and necessity of treatment, the Commission considered the medical opinions presented. *Madison Mining Company v. Industrial Commission, 309 Ill. 591, 138 N.E. 211 (1923).* Based on the Arbitrator's finding with respect to Causal Connection, reasonable and necessary medical expenses related to Petitioner's low back condition would be causally connected to the accident. Petitioner has admitted unpaid medical bills claimed as PX 15. Respondent has admitted a payment log as RX 3.

The Arbitrator's review of these exhibits finds that the bills from Franciscan Alliance for treatment on August 18, 2014 claimed by Petitioner have not been paid by Respondent. The Arbitrator has reviewed the treatment records for this date contained in PX 6. Petitioner sought emergency medical care reporting left flank and groin pain since 5 AM and burning on urination. Petitioner reported he had not experienced this type of pain before. He noted a hernia repair three months ago. Urine analysis and CT of the abdomen/pelvis was normal. Dr. Hussain noted tenderness at the hernia surgical scar. He ordered blood work and a repeat CT scan with contrast for a possible bowel inflammation. The repeat CT scan was also unremarkable. Petitioner was discharged with an assessment of groin pain and back pain. The Arbitrator finds that this treatment for flank pain and vomiting was not related to Petitioner's injury to the low back. The testing and diagnosis focused solely on abdominal and pelvic issues. The bills for this treatment are denied.

With respect to the balance claimed to ATI, RX 5 contains the treatment records for this physical therapy from December 2015 through March 2016 as ordered by Petitioner's treating medical providers. This treatment was reasonable, necessary and causally related to the accident. RX 3 does show the claimed unpaid dates of treatment from December 2015 through March 2016 and the billing for these, but there are no headings on the columns shown on the exhibit. By comparing the amount on RX 3 to the payments documented on PX 15, it

appears that this figure is not the payment made but rather the charges received. The Arbitrator notes that there appear to be additional columns which have been cut off of the printed exhibit submitted which may indicate some payments made on these bills since the date of the preparation of the ATI statement included in PX 15, but the amount cannot be definitively established.

Based upon the record as a whole and the Arbitrator's finding with respect to Causal Connection, the Arbitrator finds that Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $8,214.44 to ATI as provided in Sections 8(a) and 8.2 of the Act. Respondent shall receive credit for any additional payments made on the unpaid balances.

In support of the Arbitrator's decision with respect to (K) Prospective Medical, the Arbitrator finds as follows:

Under §8(a) of the Act, a claimant is entitled to recover reasonable medical expenses that are causally related to the accident and that are determined to be required to diagnose, relieve, or cure the effects of a claimant's injury. The claimant has the burden of proving that the medical services were necessary, and the expenses incurred were reasonable. *City of Chicago v. Illinois Workers ' Compensation Commission,* 409 Ill. App. 3d 258,267 (1st Dist., 2011). In weighing the reasonableness and necessity of treatment, the Commission considered the medical opinions presented. *Madison Mining Company v. Industrial Commission, 309 Ill. 591, 138 N.E. 211 (1923).* Based on the Arbitrator's finding with respect to Causal Connection, reasonable and necessary prospective medical treatment related to Petitioner's low back condition would be causally connected to the accident.

As more fully addressed in the Arbitrator's finding with respect to Causal Connection above, the Arbitrator finds the opinions of Dr. Thompkins and Dr. Dewald persuasive. Dr. Dewald has recommended that Petitioner undergo another surgery including an ALIF at L4-5 and L5-S1 with percutaneous instrumentation posteriorly. Fusion surgery was discussed by Dr. Slack, Dr. Dewald and Dr. Thompkins as an option if Petitioner did not obtain relief from more conservative treatment. The evidence documents that he has not. Having heard the testimony and reviewed the evidence, the Arbitrator finds Dr. Dewald's recommendations reasonable, necessary and causally related.

Based upon the record as a whole and the Arbitrator's finding with respect to Causal Connection, the Arbitrator finds that Petitioner has proven by a preponderance of the evidence that Respondent shall authorize and pay for additional reasonable and necessary treatment consistent the recommendations of Dr. DeWald including surgical intervention including an ALIF at L4-5 and L5-S1 with percutaneous instrumentation posteriorly, any post-operative treatment, physical therapy or other reasonable and necessary care.

In support of the Arbitrator's decision with respect to (L) Temporary Compensation, the Arbitrator finds as follows:

Temporary compensation is provided for in Section 8(b) of the Workers' Compensation Act, which provides, weekly compensation shall be paid as long as the total temporary incapacity lasts, which has interpreted to mean that an employee is temporarily totally incapacitated from the time an injury incapacitates him for work until such time as he is as far recovered or restored as the permanent character of his injury will permit. It is a well-settled principle that when a claimant seeks TTD benefits, the dispositive inquiry is whether the claimant's

condition has stabilized, i.e., whether the claimant has reached maximum medical improvement. *Westin Hotel v. Industrial Comm'n,* 372 Ill. App. 3d 527, 542, 865 N.E.2d 342, 310 Ill. Dec. 18 (2007).

Petitioner worked light duty from the date of the accident through November 2014. The parties stipulated that Petitioner began missing work as of November 12, 2014. He has not returned to work thereafter. The parties stipulated that Petitioner received temporary compensation through July 19, 2016 totaling $45,645.43 and further stipulated that he received other benefits of $4,615.70.

Based upon the Arbitrator's findings with respect to Causal Connection and Prospective Medical, Petitioner is in need of additional treatment and has not yet reached maximum medical improvement. He would remain entitled to temporary compensation through the date of the hearing.

In cross examining Dr. Thompkins and Petitioner, Respondent raised questions concerning the exact physical nature of Petitioner's job and Petitioner's effort to return to work. The Act provides incentive for the injured employee to strive toward recovery and the goal of returning to gainful employment by providing that TTD benefits may be suspended or terminated if the employee if the employee refuses work falling within the physical restrictions prescribed by his doctor. See 820 ILCS 305/8(d) (West 2004); *Hartlein v. Illinois Power Co.*, 151 Ill. 2d 142, 166, 601 N.E.2d 720, 176 Ill. Dec. 22 (1992); *Hayden v. Industrial Comm'n*, 214 Ill. App. 3d 749, 574 N.E.2d 99, 158 Ill. Dec. 305 (1991). Based upon Petitioner's credible testimony and the job description admitted, the Arbitrator finds that Petitioner's regular job was more physical that the persuasive restrictions place upon him by his treating doctors or even the restrictions stated by Dr. Zelby. While Petitioner's November 2014 lay off was part of a seasonal force reduction, no evidence was admitted that Petitioner was offered the light duty driving job driving with a helper the next spring or any date after his layoff or that such work would have been available to him.

Based upon the record as a whole and the Arbitrator's findings with respect to Causal Connection and Prospective Medical, the Arbitrator finds that Petitioner has proved by a preponderance of the evidence that he is entitled to 217 3/7 weeks of temporary total disability benefits commencing November 12, 2014 through January 11, 2019, as provided in Section 8(b) of the Act. Respondent shall be given a credit of $45,645.43 for TTD and $4,615.70 for other benefits, for a total credit of $50,261.13.

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 Causal connection	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☒ Modify Medical; Permanent Disability	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JASON GLASS,

Petitioner,

vs. NO: 13 WC 39695

ADVANCED SERVICES, INC.,

Respondent.

20IWCC0016

DECISION AND OPINION ON REVIEW

Petitioner timely filed a Petition for Review of the Decision of the Arbitrator finding Petitioner sustained an accidental injury arising out of and in the course of his employment, and his condition of ill-being reached maximum medical improvement on August 9, 2013. Notice having been given to all parties, the Commission, after considering the issues of causation, wages, medical expenses, temporary disability, permanent disability, and credit, and being advised of the facts and law, adopts the Arbitrator's Findings of Fact, reverses the denial of causation in part, and modifies the awards of medical expenses and permanent disability.

CONCLUSIONS OF LAW:

I. Causation

The Arbitrator found Petitioner's second and third surgeries were not causally related to the work injury. The Commission views the evidence regarding Petitioner's second surgery differently.

The record reflects Petitioner was discharged from post-operative physical therapy on August 9, 2013; at that time, Petitioner reported ongoing pain at 3/10. PX13. Only three days later, on August 12, 2013 Petitioner presented for his next follow-up appointment with Dr. Li. At that re-evaluation, Dr. Li memorialized Petitioner had "continued" pain complaints, and Dr. Li

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documented objective physical examination findings of pain with palpation as well as decreased flexion. Diagnosing "residual medial pain" status post left knee arthroscopy with abrasion chondroplasty of the patella and repair of the patella tendon, Dr. Li administered a corticosteroid injection to ameliorate Petitioner's ongoing complaints and provided pain medication. PX11. When Petitioner returned to Dr. Li on October 11, 2013, Petitioner stated the injection provided only a week of relief and reported pain at 6/10. Dr. Li ordered an MRI to investigate the cause of Petitioner's pain. PX11. The prescribed MRI was performed on October 14, 2013, and the radiologist's report identified the following: 1) postoperative change along the course of the patellar tendon, which demonstrates diffuse thickening along its course; 2) probable small vertical tear of the anterior horn of the lateral meniscus reaching the inferior articular surface; 3) small joint effusion; and 4) intact cruciate and collaterals. PX7, PX11. Upon reviewing the MRI results on October 16, 2013, Dr. Li recommended arthroscopic repair, which was subsequently carried out on December 3, 2013. PX8. Post-operatively, Petitioner again underwent physical therapy. The February 24, 2014 discharge summary reflects Petitioner demonstrated "no significant objective or functional limitation at this time and has returned to full functional mobility"; the therapist further documented Petitioner met all therapy goals. PX12. On February 26, 2014, Dr. Li released Petitioner to advance activities as tolerated. PX11.

Dr. Li and Dr. Monaco provided conflicting opinions regarding causation. Dr. Li concluded the initial accident resulted in a patella tendon rupture which required surgery and subsequent therapy leading to a weakening of Petitioner's lateral meniscus. PX2, PX11. Dr. Monaco disagreed and opined no causal connection exists. In so doing, Dr. Monaco placed great significance on the fact neither the original MRI nor the March 8, 2013 operative report reveal evidence of meniscal injury or pathology:

> The first surgery involves a rupture of the patellar tendon appropriately treated with repair. At the time of that surgery there was no evidence of any other damage inside the joint, specifically no injury to the lateral meniscus. Subsequently, there was further complaints of pain leading to another MRI which showed signal changes consistent with a small possible, it looked like, vertical tear of the anterior portion of the lateral meniscus. This was not seen at the time of the previous surgery or at the time of the previous MRI. There was no history in the medical record to indicate any connection between that finding and his original injury. In fact, there was the disconnect of a normal MRI and a normal surgery in regards to the lateral meniscus prior to this tear showing up later on the second MRI. RX2, p. 21-22.

According to Dr. Monaco, since nothing in the medical record suggests a further incident which could cause the lateral meniscus tear subsequently shown on the October 2013 MRI, the injury could not be related to the original injury/surgery. The flaw in Dr. Monaco's opinion is there are in fact records evidencing such an incident in physical therapy: on June 14, 2013, the therapist memorialized, "Patient reported a 'pop' at knee during floor-waist lifts with some burning sensation following. He reports he has been feeling this occasionally. This exercise was stopped. No more complaints of popping were reported however some remaining burning remained." PX14. The Commission observes a "pop" and burning sensation in the knee while squatting with weights is consistent with a meniscal injury. See *Krantz v. Industrial Commission*, 289 Ill. App. 3d 447, 450-51, 681 N.E.2d 1100 (1997) (The Commission is an administrative tribunal that

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hears only workers' compensation cases and deals extensively with medical issues.); *Long v. Industrial Commission*, 76 Ill. 2d 561, 566, 394 N.E.2d 1192 (1979) (The Commission possesses inherent expertise regarding medical issues). The Commission finds it significant Dr. Monaco was not provided with and did not review these records, and as a result, we find Dr. Monaco's causation opinion as to the meniscal tear is entitled to little weight. *See, e.g., Sunny Hill of Will County v. Illinois Workers' Compensation Commission*, 2014 IL App (3d) 130028WC, ¶36, 14 N.E.3d 16 (Expert opinions must be supported by facts and are only as valid as the facts underlying them.)

Where the work injury itself causes a subsequent injury the chain of causation has not been broken: "In this context, the cases have applied a 'but for' test, basing compensability for an ultimate injury or disability upon a finding that it was caused by an Event which would not have occurred had it not been for the original injury...Clear illustrations of this chain of causation relationship are cases where a second injury occurs due to treatment for the first (Citations)...." *International Harvester v. Industrial Commission*, 46 Ill.2d 238, 245, 263 N.E.2d 49 (1970). Petitioner is a relatively young person with no prior history of left knee problems who sustained what Dr. Li described as a severe trauma to his knee. Following surgical repair of the ruptured patellar tendon, Petitioner commenced physical therapy. During one of the therapy modalities, he experienced a pop and burning of the knee which the Commission finds is consistent with a tear of his weakened meniscus. The Commission finds Petitioner's meniscal tear is a natural consequence flowing from the original injury.

However, while we conclude Petitioner's meniscal injury is causally related to the March 1, 2013 work injury, the Commission does not find Petitioner's 2015 complaints or treatment to be causally related. In denying causation, the Commission emphasizes the 19-month gap in treatment following the February 26, 2014 appointment with Dr. Li at which time Petitioner's knee condition had stabilized. PX11. The medical records from Petitioner's February 26, 2014 appointment memorialize that Petitioner's knee examination was entirely normal. No swelling, bruising, or redness was noted, and Petitioner's range of motion was normal and all ligaments stable. PX11. Dr. Li testified as of February 26, 2014 "Everything was looking good," and Dr. Li "released him to return to work, continue home exercise program, and see me only on an as-needed basis." PX1, p. 20.

Petitioner testified he returned to work full duty as of January 13, 2014 and worked without incident. T. 89. Petitioner further testified following the second surgery- "It went well" (T. 51) until he noticed a gradual onset of swelling in July or August of 2015 necessitating a consultation with Dr. Li on September 9, 2015. T. 52;54. Dr. Li's September 9, 2015 records memorialize the following history: "Patient stated that he has had increased pain in his Left knee for about 2 months with no knowns cause." PX11. We find it highly significant that on April 10, 2015, Petitioner advised Dr. Monaco that he "ha[d] had no problems since" April 2014, and in fact had recently traveled to Washington DC, and New York and walked approximately 40 miles over a five-day family vacation. RX1; T. 91-92.

The Commission finds Petitioner's subsequent development of pain complaints and re-initiation of treatment are not causally related to his work accident. To be clear, we are not persuaded by Dr. Li's assertion that Petitioner's accident caused an injury to the femoral trochlea

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given Dr. Li's testimony that the March 4, 2013 MRI evidenced intact cartilage in the femoral trochlea; therefore, no injury to this area. PX1, p. 41.

The Commission finds Petitioner's condition of ill-being reached maximum medical improvement as of February 26, 2014. The Commission observes Petitioner was authorized off work as of the December 3, 2013 surgery, and he returned to work on January 13, 2014. PX12; T. 89. Given our finding the December 3, 2013 surgery is causally related to the work injury, Petitioner is entitled to the associated 5 6/7 weeks of Temporary Total Disability benefits. This is consistent with the Request for Hearing, which reflects this period of Temporary Total Disability benefits was not in dispute, and Respondent was entitled to a credit for the Temporary Total Disability benefits paid.

II. Medical

Petitioner's Exhibit 16 contains medical bills associated with treatment of Petitioner's left knee. The Commission finds the charges incurred through February 26, 2014 are causally related to Petitioner's work injury and are reasonable and necessary as provided in Section 8(a).

III. Permanent Disability

As Petitioner's accident occurred after September 1, 2011, §8.1b applies. Section 8.1b(b) requires permanent partial disability be determined following consideration of five 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. *820 ILCS 305/8.1b(b).*

Section 8.1b(b)(i) – §8.1b(a) impairment report

Neither party submitted a §8.1b(a) impairment report. As an impairment report is not a prerequisite to an award of permanent partial disability benefits (*Corn Belt Energy Corp. v. Illinois Workers' Compensation Commission*, 2016 IL App (3d) 150311WC, ¶47, 56 N.E.3d 1101), the Commission will assess Petitioner's permanent disability based upon the remaining enumerated factors.

Section 8.1b(b)(ii) – occupation of the injured employee

Petitioner returned to his pre-injury job as a warehouse laborer/forklift operator. The Commission finds Petitioner's successful return to unrestricted work is significant and indicative of reduced permanent disability.

Section 8.1b(b)(iii) – age of the employee at the time of the injury

Petitioner was 38 years old on the date of his accidental injury. Petitioner is a relatively young man and will, therefore, have to live with his residual complaints for a longer period. The Commission finds this factor weighs in favor of increased permanent disability.

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Section 8.1b(b)(iv) - future earning capacity

No evidence was offered to suggest the injury had an adverse impact on Petitioner's future earning capacity. The Commission finds this indicative of reduced permanent disability.

Section 8.1b(b)(v) – evidence of disability corroborated by treating medical records

As noted above, Dr. Li explained Petitioner suffered a severe injury to his left knee. On March 8, 2013, Dr. Li performed left knee arthroscopy with abrasion chondroplasty of the patella and repair of patella tendon to address Petitioner's left patella tendon rupture and grade-2 chondral injury of the patella. On December 8, 2013, Dr. Li performed a second surgery: left knee arthroscopy with partial lateral meniscectomy; abrasion chondroplasty of the patella; and debridement of scar tissue of the patellar tendon. Post-operatively, Petitioner underwent physical therapy; the therapy records indicate Petitioner had mild residual complaints of weakness and stiffness, but no "significant objective or functional limitation" and had achieved all therapy goals. PX12. On February 26, 2014, Dr. Li released Petitioner to advance activities as tolerated. PX11. The record reflects Petitioner returned to full duty work and was able to successfully perform his job duties. Moreover, Petitioner confirmed he was able to engage in activities such as walking 40 miles while on a week-long family vacation. The Commission observes, however, Petitioner was not symptom-free: Petitioner described a constant sore, aching feeling; pain with changes in the weather, difficulty squatting and kneeling, and occasional giving way. RX1. The Commission finds these facts are mildly indicative of increased permanent disability.

Based on the above, the Commission finds Petitioner sustained permanent partial disability to the extent of 30% loss of use of the left leg under Section 8(e)12. The Commission notes the statutory minimum permanent partial disability rate under Section 8(b)2.1 is implicated. Petitioner's PPD award is to be paid at $319.00 per week. *820 ILCS 305/8(b)2.1.*

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner sustained an accidental injury arising out of and in the course of his employment on March 1, 2013, and his left knee condition of ill-being reached maximum medical improvement on February 26, 2014.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay the reasonable, necessary and causally related medical expenses incurred through February 26, 2014 pursuant to Sections 8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $319.00 per week for a period of 64.5 weeks, as provided in §8(e)12 of the Act, for the reason that the injuries sustained caused the 30% loss of use of the left leg.

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

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

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Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $18,000.00. 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: JAN 6 - 2020

L. Elizabeth Coppoletti

LEC/mck

D: 11/6/19

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L. Elizabeth Coppoletti

Stephen Mathis

Stephen Mathis

D. Douglas McCarthy

D. Douglas McCarthy

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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GLASS, JASON
Employee/Petitioner

Case# **13WC039695**

ADVANCED SERVICES INC
Employer/Respondent

20IWCC0016

On 2/26/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.45% 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:

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

2965 KEEFE CAMPBELL BIERY & ASSOC
NATHAN S BERNARD
118 N CLINTON ST SUITE 300
CHICAGO, IL 60661

STATE OF ILLINOIS)
)SS.
COUNTY OF McLean)

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

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ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Jason Glass
Employee/Petitioner

v.

Advanced Services, Inc.
Employer/Respondent

Case # **13** WC **39695**

Consolidated cases: **N/A**

20IWCC0016

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Bloomington**, on **January 22, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ 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 1, 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 **$25,503.40**; the average weekly wage was **$490.45**.

On the date of accident, Petitioner was **38** years of age, ***married*** with **2** dependent children.

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

Respondent shall be given a credit of **$4,680.26** for TTD, **$0** for TPD, **$0** for maintenance, **$0** in non-occupational indemnity disability benefits and **$68,830.16** for other benefits, for a total credit of **$73,510.42.**

Respondent is entitled to a credit for medical bills paid in the amount of **$65,382.36** through its group medical plan for which credit may be allowed under Section 8(j) of the Act.

ORDER

Respondent shall pay the reasonable and necessary medical services **for medical services rendered up to and including August 9, 2013 as contained in Petitioner's Exhibit 16** as provided in Sections 8(a) and 8.2 of the Act. Respondent is to hold Petitioner harmless for any claims for reimbursement from any health insurance provider and shall provide payment information to Petitioner relative to any credit due. Respondent is to pay unpaid balances with regard to said medical expenses **for medical services rendered up to and including August 9, 2013 as contained in Petitioner's Exhibit 16** directly to Petitioner. Respondent shall pay any unpaid, related medical expenses **for medical services rendered up to and including August 9, 2013 as contained in Petitioner's Exhibit 16** according to the fee schedule and shall provide documentation with regard to said fee schedule payment calculations to Petitioner. Respondent is entitled to a credit **for all benefits paid through group insurance** under Section 8(j) of the Act.

Respondent shall pay Petitioner the sum of **$319.00/week** for a period of **43 weeks**, as provided in **Section 8(e)** of the Act, because the injuries sustained caused **20% loss of use of the left leg.**

Respondent shall be given a credit of **$4,680.26** for temporary total disability benefits paid, which includes an overpayment of temporary total disability benefits following the second surgery from December 3, 2013 to January 12, 2014.

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

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

2/22/19
Date

FEB 26 2019

20IWCC0016

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Jason Glass
Employee/Petitioner

Case # **13** WC **39695**

v.

Consolidated cases: **N/A**

Advanced Services, Inc.
Employer/Respondent

20IWCC0016

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that on the date of accident he was working for Advanced Services but had been placed at Syngenta Seeds, and that his job was that of a warehouse laborer/forklift operator. He testified that on the date of accident, his job duties included moving pallets from cold storage to the warehouse, and that this was done with a forklift and pallet jack. He testified that at the time of the accident, he was lifting up a pallet with the jack, that he had jacked it 1-2 inches up off the floor and that when he pushed to get momentum, his left knee buckled and he fell. He testified that he felt a big pop and also heard a pop as well. He testified that he went straight to the floor and that he hit his knee when he hit the floor, as he fell directly on his kneecap. He testified that after he hit the ground, he was not able to move his leg. He testified that his co-workers helped him and set him up against a pallet and that after reporting the accident, he was ultimately taken to the hospital. He testified that he was ultimately seen and treated by Dr. Li.

Petitioner testified that he saw Dr. Li on the afternoon of March 4th and that he ordered an MRI. He testified that Dr. Li recommended surgery and that he underwent his first surgery on March 8, 2013. He testified that he returned to Dr. Li post-operatively and that he underwent post-operative physical therapy, among other forms of treatment. He testified that when he saw Dr. Li on June 11, 2013 his pain was a lot better, the swelling had subsided substantially, his mobility was a lot better and he was completely weighbearing without the aid of crutches or a cane. He testified that when he saw Dr. Li again on August 24, 2013, he still had some swelling but that it was not the extent of what it had been prior.

Petitioner testified that he had been getting better for a while and that he had been released to full duty work, but that he noticed slowly that it felt like his knee was catching and that he did not trust it. He testified that he was unable to bear weight all the time and that he would have to stop and rest, then continue walking. He testified that when he saw him on October 11th, Dr. Li recommended that another MRI be performed. He testified that the MRI revealed that he had a tear in the meniscus that needed to be repaired. He testified that after the second surgery was performed, he again underwent post-operative physical therapy and continued off work. He testified that he believed that he was released to full duty on or about February 26, 2014 and that when he saw Dr. Li on that date for his final visit, he had very little pain.

Petitioner testified that things went well after he was released that he still had pain if he stepped on uneven ground. He testified that he had decent motion in his knee but was unable to bend it all the way, that getting into a car was easier, that he had some instability and that he also had some weakness and loss of range of motion. He testified that in July or August 2015, he noticed that the swelling started to come back in his knee. He denied having had any falls, impacts, twists or other trauma to his left knee.

Petitioner testified that on September 9, 2015, he again saw Dr. Li and stated that he was having pain again and that he denied having had any trauma since the last surgery. He testified that he underwent another MRI and that Dr. Li recommended that he undergo additional physical therapy. He testified that he ultimately underwent a third surgery by Dr. Li on December 2, 2015. After outlining his post-operative treatment, Petitioner testified that he believed that he was released to full duty work again on or about March 22nd.

Petitioner testified that he still has some issues with his left knee, that it feels like his kneecap shifts occasionally and that he has to push it back. He testified that he still has weakness and that when he gets in a car, he occasionally has to lower himself while getting in using the frame of the car for assistance. He testified that he feels that his knee buckles from time to time.

Petitioner testified that he is currently performing similar duties with forklift operations for Respondent and that during the spring, he runs a planter on occasion. He testified that during the summer he walks bean fields which are uneven, and that he needs to make sure that he is not stepping into a hole.

Petitioner testified that he used to go hiking but that he no longer does so as it is extremely difficult. He testified that he is not as active as he used to be because his left knee hurts. He denied ever having been pain-free during the period when he underwent surgeries.

On cross examination, Petitioner testified that he had had issues with buckling of his right knee prior to the accident at issue.

On cross examination, Petitioner testified that when he raised the pallet up and when trying to get it to move he had to lean back a little bit in order to momentum, and that that was when his knee popped and buckled. He testified that the pallet likely weighed nearly 1,200 pounds.

The transcript of the deposition of Dr. Lawrence Li dated June 2, 2016 was entered into evidence at the time of arbitration as Petitioner's Exhibit 1. Dr. Li testified that his specialty is that of orthopedic surgery and that he is board-certified by the American Board of Orthopedic Surgery. (PX1).

Dr. Li testified that he first saw Petitioner on March 4, 2013, at which time he told him that he was moving a pallet at work and felt a pop in his knee, that his knee buckled, that he then fell directly over his kneecap and scraped it, and that he had been unable to bend or straighten his knee. He testified that he reviewed the x-rays which showed a high-riding patella suggestive of a patella tendon rupture, and that he recommended getting an MRI. He testified that the MRI showed a completely ruptured patella tendon and that he recommended arthroscopic surgery and open repair of the patella tendon. He testified that surgery was performed on March 8, 2013 and consisted of a left knee arthroscopy with abrasion chondroplasty of the patella and repair of the patella tendon. He testified that when he saw Petitioner on March 14, 2013, he was using the Game Ready vasopneumatic device to reduce post-operative pain, to reduce his narcotic use and to reduce the swelling. He testified that Petitioner was also using a CPM machine to help him with his range of motion. (PX1).

Dr. Li testified that when he saw Petitioner on April 4, 2013, his pain was better than before surgery, the therapy was progressing well and the Game Ready and CPM were both helping. He testified that he recommended that Petitioner continue the anti-inflammatory medications and that he return to work in two weeks with restrictions. He testified that when he saw him on May 2nd Petitioner's pain was improved but continued, and that he was still using the Game Ready system because he continued to have some swelling. He testified that he continued physical therapy on that date and recommended that Petitioner continue taking anti-inflammatory medications. He testified that when he saw him on June 11, 2013, he noted that therapy was improving but that Petitioner still could not squat, that he still had weakness with stairs and that he had mild pain with prolonged activities. He testified that things were improving but that Petitioner still at that

time had mild to moderate quad atrophy. He testified that he prescribed Mobic to decrease the inflammation, Dendracin to help with the pain and Prilosec to protect the GI system, as well as having prescribed continued physical therapy. (PX1).

Dr. Li testified that when he saw him on August 12, 2013, Petitioner's complaints were that he had continued medial pain with standing and walking, that his pain was aggravated with just daily activities and that it was also bothering him at night and interfered with his sleep. He testified that on physical examination, Petitioner had pain with palpation anterior to medially. He testified that he performed an injection on that date because of Petitioner's increased pain, and that he continued him on Mobic, Prilosec and Dendracin. He testified that when he saw him on October 11, 2013, Petitioner's pain was in the patella tendon, worse with use, and that he indicated that the injection had helped for a week. He testified that he recommended an MRI because he was concerned by possibly incomplete healing of the patella tendon or some other cause of the pain. He testified that he saw Petitioner in follow-up on October 16th, and that the MRI results were that the patella tendon looked appropriate and consistent for a post-operative tendon, that there was a small vertical tear on the anterior horn of the lateral meniscus, and that there was some swelling in the knee. He testified that he recommended that they proceed with left knee arthroscopy to address the lateral meniscus tear. He testified that the overall clinical picture supported the need for a surgical procedure, and that Petitioner had persistent pain and the inability to functional normally without pain and had been treated with injections, medications and extensive therapy. (PX1).

Dr. Li testified that Petitioner underwent surgery on December 3, 2013 and that the post-operative diagnosis was that of a lateral meniscus tear, chondral injury to the patella and scar tissue in the patella tendon. He testified that there was a causal relationship between the surgical procedure on December 3, 2013 and the original injury because Petitioner had a chondral injury of the patella from his original injury, that he had scar tissue in the patella tendon from the patella tendon repair and that he had altered knee mechanics. He testified that Petitioner had very weak quadriceps for a very long time and that that caused him to have abnormal biomechanics into the knee as he tried to progress and function, and that that would affect the kinematics of the knee and could cause a meniscal tear. (PX1).

Dr. Li testified that when he saw him on December 10, 2013, Petitioner had typical post-operative pain and that the Game Ready was definitely reducing the swelling and narcotic use, and that he had some redness around the portal incisions. He testified that he continued to prescribe the Game Ready system and physical therapy. He testified that the moderate swelling indicated that Petitioner still needed the Game Ready and that the quad atrophy and lack of range of motion indicated that Petitioner needed therapy. He testified that when he saw him on December 30, 2013 Petitioner's pain was better than before the surgery, that the Game Ready was working well and that the medications were helping his pain. He testified that when he saw him on January 29, 2014, Petitioner still had a significant strength deficit and that he continued to prescribe medications and physical therapy because of the quad atrophy. He testified that when he saw him on February 26, 2014, Petitioner had less pain and that his goals in therapy were achieved. He testified that Petitioner did not have any more swelling, that he had no bruising or redness, that he had full range of motion and that everything was looking good. He testified that he released Petitioner to return to work as of that date, and that he recommended that he continue his home exercise program and return as needed. (PX1).

Dr. Li testified that he saw Petitioner on September 9, 2015 when he indicated that over the last couple of months he had had increased pain in the left knee, that there was no known injury, and that he had complaints of popping, catching and giving out. He testified that he recommended an MRI and that he next saw Petitioner on September 15th when they discussed MRI results. He testified that the MRI showed that Petitioner had had previous lateral meniscectomy, no new lateral meniscus tear, a high-grade chondral defect along the femoral trochlea with underlying subchondral bone marrow edema that was new since the examination, and that he had some high-grade chondromalacia along the lateral femoral condyle that was new since the last MRI. He testified that the chondral defect on the femoral trochlea was the area right

opposite the patella and that when Petitioner fell and injured the patella tendon and the patella, he also injured the side opposite the side on the femur that the patella articulated with. He testified that at the time of the initial surgery they did not see anything, but that as time went on this area degenerated and became a high-grade chondral defect. He testified that the chondromalacia of the lateral femoral condyle was due to the abnormal kinematics of the knee and that the abnormal kinematics were due to the two prior surgical procedures, and that the quads were not as strong as they were initially. He testified that the physical examination performed on September 15th revealed moderate swelling, positive medial McMurray's and pain to palpation of the medial joint line and posteriorly. He further testified that range of motion was a little less than normal as well. He testified that he recommended a corticosteroid injection and physical therapy. (PX1).

Dr. Li testified that when he saw him on October 13, 2015 Petitioner reported that he was about 20% better after the injection but still had pain, and that he had pain over the lateral aspect of the knee. He testified that the findings on exam with pain of the patella compression correlated well with the femoral trochlea lesion, the positive medial and lateral McMurray's and the medial joint line tenderness consistent with the chondral injury on the lateral femoral condyle. He testified that he recommended continued therapy. He testified that when he saw him on November 10, 2015, Petitioner through additional therapy had no improvement, the injection wore off and the pain had gotten worse. He testified that he recommended a corticosteroid injection to relieve the pain and felt that Petitioner had failed non-operative treatment, so they were planning for a left knee arthroscopy. He testified that when he saw him on November 23, 2015, Petitioner complained of severe pain and could not tolerate it anymore. He testified that he recommended surgery. (PX1).

Dr. Li testified that surgery was performed on December 2, 2015 and consisted of a left knee arthroscopy with microfracture of the femoral trochlea and lateral femoral condyle, partial lateral meniscectomy and removal of loose bodies. He testified that the diagnosis was left knee chondral lesion of the femoral trochlea and lateral femoral condyle that were Grade 4 lesions, a lateral meniscus tear and multiple loose bodies of the left knee. When asked whether there was a causal relationship between this surgical procedure, the prior surgical procedures performed on Petitioner and the injury that he reported to him, Dr. Li responded in the affirmative. He testified that when Petitioner's knee buckled and he fell directly on the patella which then hit the femoral trochlea, this led to the Grade 4 lesion on the femoral trochlea. He testified that subsequent to the repair of the patella tendon Petitioner had abnormal kinematics that led to the lesion on the lateral femoral condyle, and that that led to the lesion on the lateral meniscus. He agreed that the first surgical procedure did not show the Grade 4 femoral trochlea injury as the original injury did not cause any "mackeral" damage to the cartilage. He testified that it was injured and only after rehabilitation and resumption of normal activities did it wear out a lot easier than the rest of the knee. He testified that subsequent to Petitioner resuming daily activities such as walking and climbing stairs, that area weakened and broke up. He testified that it took time for it to develop. When asked how the lateral meniscus tear that he repaired was causally related to the earlier surgical procedures, Dr. Li responded that Petitioner had had a lateral meniscus tear before in the second surgery that this would be related to and that it was related in the same way of the abnormal gait or kinematics of the knee. (PX1).

Dr. Li testified that when he saw him on December 9, 2015, Petitioner had swelling but the Game Ready was helping and he was progressing with therapy. He testified that he continued to prescribe the Game Ready system on that visit and that the lack of range of motion and swelling supported the need for that equipment. He testified that he also prescribed physical therapy and medications. He testified that when he saw him on January 7, 2016, Petitioner's pain was better than before surgery and that the Game Ready was reducing the swelling. He testified that he recommended continuing therapy and the anti-inflammatory medications. He testified that he did not have the exact date for when the Game Ready system was ended, but that he may have continued it for another week because Petitioner still had moderate swelling. He testified that when he saw him on February 4, 2010 [*sic*], Petitioner was progressing with

therapy but was still weak. He testified that he prescribed continued physical therapy. He testified that when he saw him on March 3, 2016, Petitioner was doing better with therapy, that he still needed Mobic to control his pain and that he had mild swelling, range of motion 0 - 110 and mild quad atrophy. He testified that he continued Petitioner on the Mobic because he needed it for his pain, that he continued him on a home exercise program and that he was to return to work full duty. (PX1).

Dr. Li testified that his diagnosis of Petitioner was that of a patella tendon injury and that he also had an associated patella chondral fracture. He testified that subsequent to that as Petitioner was recovering and dealing with the sequela of his patella tendon injury, he developed a lateral meniscus tear and that also as a result of hitting his patella he suffered an injury to the femoral trochlea that did not manifest from an arthroscopic-identifiable standpoint until later. He testified that he thought that there was a clear relationship between the injury and the development of the patella tendon rupture and the chondral injury of the patella, and that those injuries then contributed to the development of the lateral meniscus tear, to the chondral injury of the patella, and to the femoral trochlea and lateral femoral condyle. (PX1).

On cross examination, Dr. Li agreed that he kept an accurate history of all the complaints, treatment and recommendations in his records. He agreed that it was rare to see patella tendon tear. When asked whether he knew if Petitioner was pulling or pushing the pallet, Dr. Li responded that he did not know and that he assumed that he was pulling as it was more likely to be the mechanism of injury. He testified that the patella tendon rupture would cause Petitioner's knee to buckle. He testified that the fall itself only had a causal connection to the extent that when Petitioner hit his patella he caused a chondral fracture of the patella, and then the subsequent injury to the femoral trochlea that he was not aware of until the third surgery. He testified that he was not aware of any other specifics of the pallet that Petitioner was moving such as the size or weight. (PX1).

On cross examination, Dr. Li testified that the initial MRI of March 4, 2013 only showed a rupture of the patella tendon as well as small suprapatellar effusion. He testified that in terms of the patella cartilage it showed mild chondromalacia of the patella and that the femoral trochlea had intact cartilage. When asked whether anything in the MRI and his post-operative diagnosis in 2013 in the first surgery was inconsistent, Dr. Li responded that he thought that they were totally consistent. He agreed that when he was in surgery, he did not notice or see any other lateral meniscus or chondral issues and that that was consistent with the MRI he had reviewed. He testified that the MRI of March 2013 did not reflect any of the findings of the second and third surgery. (PX1).

On cross examination, Dr. Li testified that at the August 12, 2013 visit, Petitioner had persistent residual medial knee pain so he was given a cortisone injection but had been discharged from physical therapy. He agreed that this was inconsistent and testified that it was not the patella nor the patella tendon. He testified that he did not think that Petitioner was ever "done" with patella-type pain, but that it was manageable as of August 2013. He agreed that when Petitioner returned in October 2013 there was no new incident reported and that Petitioner just stated that he had pain over the patella tendon with use. He agreed that patella tendon complaints were the focus on that visit, not medial complaints. (PX1).

On cross examination, Dr. Li testified that the MRI in October 2013 was different than the first MRI and that it showed a patella tendon repair that had expected scar tissue, that there was an effusion in the knee, that there as an intact medial meniscus, that there was a lateral meniscus tear and that there was some damage along the inferior pole of the patella where the patella origin is located. He agreed that the patella tendon healed from the repair. (PX1).

On cross examination, Dr. Li agreed that on direct examination he did not mention anything about a disruption of blood supply causing the anterior horn lateral meniscus tear. He testified that the disrupted blood supply weakened the lateral meniscus, but that one needed to have some sort of kinetic movement in

order to get the tear. He agreed that the disruption of blood supply in and of itself did not cause the tear, but testified that it made it easier for the tear. (PX1).

On cross examination, Dr. Li agreed that he authored a report to Petitioner's counsel dated May 29, 2015 and that in that report he no longer talked about the disruption of blood flow but rather talked about a weakening of the knee. When asked why the change from November 2013 to 2015, Dr. Li responded that it was not really a change and that he was trying to give a brief answer to a non-medical person. (PX1).

On cross examination, Dr. Li agreed that following the second surgery and physical therapy Petitioner was discharged in February 2014. He agreed that Petitioner had had good results from the second surgery as well. He agreed that Petitioner was not only discharged from physical therapy but was also returned to work full duty and discharged from care. He agreed that when Petitioner returned in September 2015, he came back with ongoing pain. He agreed that in all three instances where Petitioner came back and in all three instances where he had surgery, he only ever related one specific incident to him of pulling a pallet and feeling a pop with his knee buckling and falling. (PX1).

On cross examination when asked how the MRI of 2015 was in any way inconsistent with the two prior MRIs, Dr. Li responded that there was a high-grade chondromalacia along the lateral femoral condyle and also a chondral injury along the femoral trochlea aside from the patella tendon rupture and repair. He agreed that there was no new lateral meniscus tear detected. He testified that the tear that was repaired in the third surgery was an extension of the previous tear. When asked where the pain was located in the knee prior to the third surgery, Dr. Li responded that the worst pain was still over the medial aspect of the knee, and that Petitioner also had some pain over the front part of the knee as well. He testified that the first surgery was for such a severe injury in the knee and that Petitioner had pain everywhere in the knee, and that it was impossible to pinpoint pain because it was painful "everywhere." (PX1).

On cross examination, Dr. Li testified that Petitioner had good results from the third and final surgery, and that they were able to successfully return him to work. He agreed that Petitioner was at maximum medical improvement and full duty. When asked what activities would cause the need for the two additional surgeries from the weakening of the first surgery, Dr. Li responded that with the femoral trochlea it would be activities like climbing stairs and activities where the knee bent and extended and that for the lateral lesion it would simply be walking, and that if one turned corners or pivoted, that would make things even worse. He testified that biking would do it if the seat was really low with aggravation of the femoral trochlea lesion. (PX1).

On redirect when asked whether simple walking, climbing stairs or riding a bicycle would likely cause the surgical procedures that he performed absent the initial trauma and surgical procedure, Dr. Li responded in the negative. He testified that normal biking, climbing stairs and walking in a healthy knee with normal kinematics was very unlikely to result in those injuries because the amount of sheer stress was not very much, and the amount of muscle support provided to the knee and shock absorption provided to the knee with good normal muscle support would not subject those structures such as the meniscus and the articular cartilage to the stresses necessary to cause tears. He testified that in a knee that was weakened that did not have good muscle support where the cartilage, meniscus and other structures had to absorb more of the stresses, then it was much more likely. (PX1).

On redirect when asked how the lack of blood supply, kinetics and biomechanical movement of the knee fit together to cause the lateral meniscus tear in the second surgery, Dr. Li responded that because of the weakened muscle and because of the abnormal kinematics parts of the knee were subjected to higher than normal stress doing things like walking, and that the uninjured knee would get less stress than the injured knee. When asked to explain how the left knee chondral injury Grade 4 femoral trochlea and lateral femoral condyle were related to the patella tendon tear, Dr. Li responded that when Petitioner ruptured his patella, he stated that he landed on his patella which overlay the femoral trochlea, and that it caused a force

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right directly on that area. He testified that in a chondral injury where the patella surface became abnormal, it rubbed against the femoral trochlea and caused abnormal stresses. He testified that it could be seen in the first surgical procedure but that it was not severe enough to cause changes right away, and that it broke away after Petitioner resumed normal activities. (PX1).

On redirect when asked why the tear of the lateral meniscus was not repaired the first time, Dr. Li responded that during the very first surgery Petitioner did not have a lateral meniscus tear. He testified that he did remove the torn portion of the meniscus but that meniscal tears had laminations, and that they did not remove every fragment that had a laminated tear because to do so would be to remove the entire meniscus and the patient would suffer even more. (PX1).

On further cross examination when asked if Petitioner had not fallen directly on the knee and whether that could or would change his opinion, Dr. Li responded that it would because he repaired the patella tendon and that it resulted in the abnormal kinematics of the patella femoral joint. (PX1).

The Letter of Dr. Li dated May 29, 2015 was entered into evidence at the time of arbitration as Petitioner's Exhibit 2. The letter reflects that Dr. Li opined that the March 1, 2013 injury at work caused a patella tendon rupture leading to the surgery of March 8, 2013 and subsequent therapy, and that it also lead to a weakening of Petitioner's lateral meniscus which lead him to require a second surgery on December 3, 2013. (PX2).

The medical records of OSF Occupational Health were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The records reflect that Petitioner was seen on March 1, 2013, at which time it was noted that he was complaining of pain in the left knee, that he leaned back on a pallet jack while moving a heavy pallet when his left knee popped/buckled and bent inwards, and that he landed with all weight on his left knee. It was noted that Petitioner had tried catching himself, that he had a cut on his left palm, and that his knee felt most comfortable when fully extended. The assessment was noted to be that of left knee pain/swelling. Petitioner was given a knee immobilizer, was given crutches, was given a prescription for Vicodin and was recommended to take over-the-counter Ibuprofen as needed and to return in 7-10 days. Petitioner was also issued work restrictions. (PX3).

The medical records of OSF St. Joseph Medical Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. The records reflect that Petitioner was seen in the emergency room on March 2, 2013, at which time it was noted that he fell onto his left knee the day before at work, that he had had increased swelling and pain on that date, and that he had had no other injuries. Petitioner underwent a CT of the left knee, which was interpreted as revealing soft tissue swelling, fluid and air in the soft tissues of the knee anteriorly and including intraarticular air and fluid; no fracture visualized. The final diagnosis was noted to be that of effusion of lower leg joint and fall from other slipping, tripping or stumbling. Petitioner was discharged to home. (PX4).

The records of OSF St. Joseph Medical Center reflect that Petitioner was seen in the emergency room on July 10, 2013, at which time he was seen for abdominal pain, nausea and vomiting. At the time of the December 10, 2015 emergency room visit, Petitioner was seen for shortness of breath. It was noted that Petitioner had had surgery about eight days ago and was going to physical therapy. (PX4).

The Interpretive Report for an MRI of the Left Knee dated March 4, 2013 was entered into evidence at the time of arbitration as Petitioner's Exhibit 5. The report reflects that the MRI films were interpreted as revealing (1) completely ruptured patellar tendon; (2) small suprapatellar effusion and fluid anterior to the patella and extending through the patellar tendon defect. (PX5).

The Operative Report dated March 8, 2013 from Ireland Grove Center for Surgery was entered into evidence at the time of arbitration as Petitioner's Exhibit 6. The records reflect that Petitioner underwent

(1) left knee arthroscopy with abrasion chondroplasty of the patella; (2) repair of patella tendon on that date by Dr. Li for a diagnosis of (1) left patella tendon rupture; (2) Grade 2 chondral injury of the patella. (PX6).

The Interpretive Report for an MRI of the Left Knee dated October 14, 2013 was entered into evidence at the time of arbitration as Petitioner's Exhibit 7. The report reflects that the MRI films were interpreted as revealing (1) post-operative change along the course of the patellar tendon, which demonstrates diffuse thickening along its course; (2) probable small vertical tear of the anterior horn of the lateral meniscus reaching the inferior articular surface; (3) small joint effusion; (4) intact cruciates and collaterals. (PX7).

The Operative Report dated December 3, 2013 from Ireland Grove Center for Surgery was entered into evidence at the time of arbitration as Petitioner's Exhibit 8. The report reflects that Petitioner underwent surgery by Dr. Li on that date, which consisted of (1) left knee arthroscopy with partial lateral meniscectomy; (2) abrasion chondroplasty of the patella; (3) debridement of scar tissue of the patella tendon for a diagnosis of (1) left knee lateral meniscus tear; (2) Grade 2 chondral injury of the patella; (3) scar tissue patella tendon. (PX8).

The Interpretive Report for an MRI of the Left Knee dated September 14, 2015 was entered into evidence at the time of arbitration as Petitioner's Exhibit 9. The report reflects that the MRI films were interpreted as revealing (1) status post partial lateral meniscectomy without new lateral meniscal tear detected; (2) focal high-grade chondral fissure/defect along the femoral trochlea with underlying subchondral bone marrow edema, new since prior exam; (3) focal region of moderate to high-grade chondromalacia along the lateral femoral condyle overlying the posterior horn of the lateral meniscus, new since the prior exam. (PX9).

The Operative Report dated December 2, 2015 from Ireland Grove Center for Surgery was entered into evidence at the time of arbitration as Petitioner's Exhibit 10. The report reflects that Petitioner underwent surgery by Dr. Li on that date, which consisted of (1) left knee arthroscopy with microfracture of the femoral trochlea and lateral femoral condyle; (2) partial lateral meniscectomy; (3) removal of loose bodies for a diagnosis of (1) left knee chondral injury, Grade 4 femoral trochlea and lateral femoral condyle; (2) tearing of anterior horn lateral meniscus. (PX10).

The medical records of Dr. Li were entered into evidence at the time of arbitration as Petitioner's Exhibit 11. The records reflect that Petitioner was seen on March 4, 2013, at which time it was noted that he was moving a pallet at work on Friday, that he felt a pop in his left knee and that the knee buckled, that he then fell directly onto the patella and had a scrape over it, that he had been unable to bend or extend the knee, that the pain over the patella tendon was worse and that he had no previous knee injury. The diagnosis was noted to be that of a left knee patella tendon rupture. Petitioner was recommended to undergo an MRI and was to follow-up to determine the treatment plan. Petitioner was also dispensed Mobic. At the time of the March 5, 2013 visit, Petitioner was recommended to undergo left arthroscopic knee surgery and patella tendon reconstruction. Petitioner was also dispensed Norco on that date. (PX11).

The records of Dr. Li reflect that Petitioner was seen on March 14, 2013, at which time it was noted that he had typical post-operative pain and that his pain was better than before surgery. It was noted that Game Ready Vasopneumatic compression therapy was helping to reduce swelling. Petitioner was dispensed Norco and was recommended to start physical therapy, to continue the CPM machine and Game Ready Vasopneumatic compression therapy, and to follow-up in four weeks. At the time of the April 4, 2013 visit it was noted that Petitioner's pain was better than before surgery, that therapy was progressing well, that Petitioner's pain was improving, that the Game Ready Vasopneumatic therapy was helping a lot, and that the CPM machine was helping with range of motion. Petitioner was dispensed Mobic and Dendracin, was allowed to return to work in two weeks with restrictions and was recommended to follow-up in four weeks. (PX11).

The records of Dr. Li reflect that Petitioner was seen on May 2, 2013, at which time it was noted that his pain was improving, that therapy was progressing well, that the Game Ready Vasopneumatic therapy was helping a lot and that his range of motion was much improved but that he was still weak. Petitioner was dispensed Mobic and Dendracin, was recommended to continue physical therapy and was to follow-up in four weeks. At the time of the June 11, 2013 visit, it was noted that Petitioner's therapy was progressing well, that his strength was improving but that he still could not squat and had weakness with stairs, and that he had mild pain with prolonged activities. Petitioner was dispensed Mobic and Dendracin, was recommended to continue physical therapy for strengthening and was to follow-up in two months. At the time of the August 12, 2013 visit, it was noted that Petitioner had had continual medial-side pain with standing and walking, that his pain was aggravated by activities of daily living and limited the lifestyle desired, and that pain also interfered with sleep and woke him up. It was also noted that Mobic and Dendracin helped reduce the pain. Petitioner was dispensed a two-month supply of Mobic and Dendracin and underwent a corticosteroid injection. (PX11).

The records of Dr. Li reflect that Petitioner was seen on October 11, 2013, at which time it was noted that he had pain in the patella tendon worse with use, that the corticosteroid injection helped for a week and that both Mobic and Dendracin reduced the pain. Petitioner was recommended to undergo an MRI and to follow-up to check for possible incomplete healing of the tendon or some other cause for pain. Petitioner was also dispensed Mobic and Dendracin. At the time of the October 16, 2013 visit, it was noted that Petitioner had pain in the patella tendon worse with use, that the corticosteroid injection helped for a week and that both Mobic and Dendracin reduced the pain. It was noted that Petitioner had a left knee anterior horn lateral meniscus tear causing pain in the repaired patella tendon, and that he was recommended to undergo left arthroscopic knee surgery. (PX11).

The records of Dr. Li reflect that Petitioner was seen on December 10, 2013, at which time it was noted that he had typical post-operative pain, that the Game Ready Vasopneumatic Cryotherapy was reducing swelling and narcotic use significantly, and that he had redness around the portal incisions. Petitioner was dispensed Keflex and Dendracin, was recommended to continue Game Ready Vasopneumatic compression therapy, was recommended to continue physical therapy and was to follow-up in three weeks. At the time of the December 30, 2013 visit, it was noted that Petitioner was dispensed Mobic and Dendracin, that he was to continue Game Ready Vasopneumatic compression therapy, was recommended to continue physical therapy and was to follow-up in four weeks. At the time of the January 29, 2014 visit, it was noted that Petitioner's pain was better than before surgery, that he was progressing well with therapy, that his strength was improved and that he still had a significant strength deficit. Petitioner was dispensed Mobic, was recommended to continue physical therapy and was to follow-up in four weeks. At the time of the February 26, 2014 visit, it was noted that Petitioner's pain was better than before surgery, that his goals in therapy had been achieved, and that the Mobic and Dendracin were reducing his pain significantly. Petitioner was dispensed a two-month supply of Mobic and Dendracin, was recommended to continue a home exercise program and was to advance activities as tolerated. (PX11).

The records of Dr. Li reflect that Petitioner was seen on September 9, 2015, at which time it was noted that he stated that he had had increased pain in his left knee for about two months with no known cause and that he reported no new injury but now complained of popping, catching and giving out. The diagnosis was noted to be that of left knee medial meniscus tear. Petitioner was dispensed Mobic, was recommended to undergo an MRI and was to follow-up to determine a treatment plan. At the time of the September 15, 2015 visit, it was noted that Petitioner had had increased pain in the left knee for about two months with no known cause, that he reported no new injury but now complained of popping, catching and giving out, and that the swelling had improved with Meloxicam. The assessment was noted to be that of left knee chondral injury femoral trochlea and lateral femoral chondral. Petitioner was given a Kenalog injection into the medial femoral condyle on that date, was referred to physical therapy and was recommended to follow-up in four weeks. (PX11).

The records of Dr. Li reflect that Petitioner was seen on October 13, 2015, at which time it was noted that he reported that his knee was about 20% better after the injection but that he still had pain, and that the pain was over the lateral aspect of the knee. The diagnosis was noted to be that of left knee chondral injury femoral trochlea and lateral femoral chondral. Petitioner was dispensed Mobic and Lido Pro, was recommended to continue physical therapy and was to follow-up in four weeks. At the time of the November 10, 2015 visit, it was noted that Petitioner had been through additional therapy without improvement, that his injection had worn off and that his pain was getting progressively worse. It was noted that Petitioner's pain was worse over the medial aspect and that he had pain anteriorly. Petitioner was dispensed Mobic and Dendracin and was given a Kenalog injection. It was noted that Petitioner had failed non-operative treatment and that the plan was for left arthroscopic knee surgery. At the time of the November 23, 2015 visit, it was noted that Petitioner's surgery had been denied but that his pain was too severe to tolerate. Petitioner was again recommended surgery. (PX11).

The records of Dr. Li reflect that Petitioner was seen on December 9, 2015, at which time it was noted that he had typical post-operative pain, that vasopneumatic compression therapy was helping reduce swelling and pain, and that he was progressing as expected with therapy. The diagnosis was noted to be that of left knee arthroscopy with microfracture of the femoral trochlea and lateral femoral condyle; partial lateral meniscectomy; removal of loose bodies. Petitioner was dispensed Norco, Dendracin and Ultram, and he was recommended to continue physical therapy and to follow-up in four weeks. At the time of the January 7, 2016 visit, it was noted that Petitioner's pain was better than before surgery, that he was progressing as expected with therapy, and that vasopneumatic compression therapy was helping reduce swelling and pain. Petitioner was dispensed Mobic and was recommended to continue physical therapy and to follow-up in four weeks. At the time of the February 4, 2016 visit, it was noted that Petitioner reported that his pain was better than before surgery and that he was progressing as expected with therapy but was still weak. Petitioner was dispensed Mobic and was recommended to continue therapy and to follow-up in four weeks. At the time of the March 3, 2016 visit, it was noted that Petitioner had done well with therapy but still needed Mobic to keep his pain under control. Petitioner was dispensed Mobic, was allowed to return to work full duty, was recommended to continue his home exercise program and was recommended to follow-up in four weeks. (PX11).

Physical Therapy Notes of Dr. Li were entered into evidence at the time of arbitration as Petitioner's Exhibit 12. The records reflect that a Discharge Summary was issued on February 24, 2014, at which time it was noted that Petitioner demonstrated no significant objective or functional limitation at that time and that he had returned to full functional mobility. It was noted that Petitioner had met all his goals of physical therapy. At the time of the Initial Evaluation on September 18, 2015, it was noted that Petitioner reported that he had been doing great, that about three weeks ago it (*i.e.*, his left knee) started hurting again and was really swollen, that it was doing a lot of popping and grinding, and that he did not recall an incident where he would have hurt or hit it. It was noted that Petitioner denied falling and that stairs, climbing in and out of the tractor at work and climbing ladders hurt. At the time of the November 4, 2015 physical therapy visit, it was noted that Petitioner reported that his knee pain seemed to have gotten worse over the last couple of weeks since he had been standing in one place more often at work, where he worked six days per week. At the time of the February 21, 2014 physical therapy visit, it was noted that Petitioner reported that his left knee was feeling better from the fall. (PX12).

The Physical Therapy Notes of Dr. Li reflect that Petitioner was seen on October 9, 2015, at which time it was noted that he reported that his knee was still bothering him and that he reported the whole knee hurt on that date, and that he got "popping" when he descended stairs. At the time of the October 23, 2015 physical therapy visit, it was noted that Petitioner reported that he had had to be standing most of the time at work on hard concrete and that it had been very painful to his knee. At the time of the October 30, 2015 physical therapy visit, it was noted that Petitioner reported that his knee was still sore and about the same overall, that he felt that he had less pain approximately two weeks ago but now was standing on concrete

most of the day which had made it worse again, and that he reported that the swelling was not quite as bad as it had been. At the time of the December 17, 2015 physical therapy visit, it was noted that Petitioner stated that he had been feeling some intermittent pain in the back center of his knee with exercises. At the time of the December 23, 2015 physical therapy visit, it was noted that Petitioner reported that he had some general soreness in the knee on that date and that he had some catching in the knee at times at the top of it. At the time of the January 5, 2016 physical therapy visit, it was noted that Petitioner reported that he started to experience popping in the knee a couple of days ago on the top of his knee but that there was no pain associated with it, and that he stated that it was more annoying than anything. (PX12).

Additional Physical Therapy Notes of Dr. Li were entered into evidence at the time of arbitration as Petitioner's Exhibit 13. At the time of the Initial Evaluation on March 14, 2013, it was noted that Petitioner was at work and lifting a pallet with a pallet jack and that as he leaned back, he heard and felt a loud pop and his left knee buckled under him. It was noted that Petitioner had undergone surgery on March 8, 2013 and had been referred for physical therapy. At the time of the April 10, 2013 physical therapy visit, it was noted that Petitioner had made excellent progress since beginning physical therapy and was progressing faster than would be expected. At the time of the May 10, 2013 physical therapy visit, it was noted that Petitioner's chief complaint was that his knee still gave out and felt weak, that he was unable to go hiking, camping or play sports with his son, and that he was unable to work full duty. At the time of the July 19, 2013 visit, it was noted that Petitioner had made significant progress with physical therapy thus far, that his pain was under control and the swelling had decreased, that his range of motion had improved to within normal limits and that his primary deficit at that time was decreased strength of the involved extremity which limited function, specifically that he was still unable to play sports with his children and climb down stairs easily as he had decreased eccentric control of his quads. It was noted that Petitioner was back to work full regular duty and was doing fine with it. The Discharge Note dated August 9, 2013 noted that Petitioner's chief complaint was that he was still unable to run and that he had not tried hiking. It was noted that Petitioner had made excellent progress with physical therapy, that he was able to perform all activities of daily living and work activities without difficulty, that he was able to jog around the gym and jump on a trampoline without pain but that he felt "funny" as he had not yet performed these types of activities, and that he had been educated in a home exercise program to be performed indefinitely. (PX13).

The Physical Therapy Notes of Dr. Li reflect that Petitioner underwent an Initial Evaluation on December 6, 2013, at which time it was noted that he was a return patient, that he had had a patellar tendon repair earlier that year, did well, was discharged from physical therapy and returned to work, and then had a meniscus tear that needed surgery. At the time of the January 31, 2014 physical therapy visit, it was noted that Petitioner's knee was really sore having to be up and down more, and that he reported some insulation fell on him and his neck was really itchy and was his main concern. At the time of the February 4, 2014 physical therapy visit, it was noted that Petitioner was progressing nicely, that he tolerated walking lunges with no pain, that he was ambulating with no deviations and reported no issues with work, and that he had no pain through or at the end of his session. The Discharge Note dated February 24, 2014 noted that Petitioner's chief complaint was that he just felt "weird" on that date and that he demonstrated no significant objective or functional limitation at that time and had returned to full functional mobility. It was noted that Petitioner was advised in a final home exercise program and that he had met all goals of physical therapy and was discharged. (PX13).

Additional Physical Therapy Notes of Dr. Li were entered into evidence at the time of arbitration as Petitioner's Exhibit 14. At the time of the March 27, 2013 physical therapy visit, it was noted that Petitioner stated that his knee was doing well, that his pain levels were under control and that he did fine after the last session. At the time of the April 1, 2013 physical therapy visit, it was noted that Petitioner stated that he did fine after his last therapy session, that he stated that he had a little soreness but stated it was from a busy day yesterday, and that he also stated that he had some mild tightness behind the knee. At the time of the April 5, 2013 physical therapy session, it was noted that Petitioner reported that he saw the

physician who felt that he was doing well and could return to work on April 22nd with restrictions of no more than three hours of standing. At the time of the April 12, 2013 physical therapy visit, it was noted that Petitioner reported that he thought his strength had improved since he would walk more normally. At the time of the April 24, 2013 physical therapy visit, it was noted that Petitioner reported that he was doing pretty good on that date as his knee felt good, but that he did feel lack of control at end range of knee extension in standing and walking. At the time of the April 29, 2013 physical therapy visit, it was noted that Petitioner stated that his knee was doing okay, that it was not 100% but better than two weeks ago, and that his pain was at a 2/10. (PX14).

The Physical Therapy Notes of Dr. Li reflect that Petitioner was seen on May 2, 2013, at which time it was noted that he reported that he just saw the doctor and was told to keep doing what he was doing, and that it looked good but was still weak. At the time of the May 13, 2013 physical therapy visit, it was noted that Petitioner reported that his knee was sore that morning and that he was not sure why. At the time of the May 17, 2013 physical therapy visit, it was noted that Petitioner reported that his knee was feeling a lot better that week and that he reported that he had been stretching and performing his home exercise program. At the time of the May 24, 2013 physical therapy visit, it was noted that Petitioner reported after feeling the sharp pain at the last session he was quite sore the next day and had difficulty walking correctly. At the time of the May 28, 2013 physical therapy visit, it was noted that Petitioner reported that he worked all weekend and so his knee was sore that morning but that he did wear a brace, and that he barely had time to do his home exercise program as he was so tired when he got done with work but that he tried. At the time of the May 31, 2013 physical therapy visit, it was noted that Petitioner reported that his knee was feeling really good. (PX14).

The Physical Therapy Notes of Dr. Li reflect that Petitioner was seen on June 4, 2013, at which time it was noted that he reported that his knee was stiff but not painful, that he stated that he did not do much over the weekend as far as stretching, and that he stated that he did fine after the last session and had been doing well overall with strengthening progression. At the time of the June 12, 2013 physical therapy visit, it was noted that Petitioner reported that his knee swelling continued to be present but that the doctor told him that it was normal at this stage, that the doctor released him to full duty and to continue therapy per therapist discretion, and that the most difficult tasks he would have to do at work was lifting 80# bags and carrying them across a field a range of distances. At the time of the June 14, 2013 physical therapy visit, it was noted that Petitioner reported a "pop" at the knee during floor-waist lifts with some burning sensation following, and that he reported he had been feeling this occasionally. (PX14).

The Physical Therapy Notes of Dr. Li reflect that Petitioner was seen on June 24, 2013, at which time it was noted that he reported that his knee had been feeling better but was still sore on the medial knee. At the time of the June 26, 2013 physical therapy visit, it was noted that Petitioner stated that his knee had been feeling good and had no complaints after the last session, that he stated that he had to do walking in the field on unlevel ground at work after the last session but did fine, and that he reported that his knee actually felt pain-free on that date. At the time of the July 15, 2013 physical therapy visit, it was noted that Petitioner had stiffness in the knee but only minimal soreness. At the time of the July 26, 2013 physical therapy visit, it was noted that Petitioner reported that his knee was sore from work. At the time of the July 30, 2013 physical therapy visit, it was noted that Petitioner reported that he was feeling better and that his knee was sore after walking around Springfield all day on Saturday, but that he had rested and the soreness went away. At the time of the August 2, 2013 physical therapy session, it was noted that Petitioner reported that he walked a total of 10 miles the day before, so his knee was somewhat sore. (PX14).

The Physical Therapy Notes of Dr. Li reflect that Petitioner was seen on December 12, 2013, at which time it was noted that he described his knee pain as "minimal." At the time of the December 18, 2013 physical therapy visit, it was noted that Petitioner stated that his knee was doing better and that he still had some soreness, but that it was mild and that stairs were the most challenging for him. At the time of the January 8, 2014 physical therapy visit, it was noted that Petitioner stated that his knee was doing

good, that he shoveled a little bit on Monday and that his knee tolerated it, and that he was no longer taking pain medications and had not for over three weeks. At the time of the January 15, 2014 physical therapy visit, it was noted that Petitioner reported that he had been working all that week, that he reported that it had been doing well but that he had had to do some kneeling, and that he reported the kneeling had made his knee sore some but overall was doing okay. At the time of the January 24, 2014 physical therapy visit, it was noted that Petitioner reported that his right calf had been cramping up lately and that he rated his knee pain at 2-3/10 but described it as sore and not painful. At the time of the January 29, 2014 physical therapy visit, it was noted that Petitioner stated that his knee was sore on that date but that he had been going up and down ladders at work that week and that his doctor had recommended three more weeks of therapy and then another follow-up to determine possible discharge. At the time of the February 12, 2014 physical therapy visit, it was noted that Petitioner reported that he was now able to kneel down as long as he was wearing knee pads for cushion. At the time of the February 17, 2014 physical therapy visit, it was noted that Petitioner reported that he had fallen last week at work twice due to ice patches and had been very sore since then. At the time of the February 21, 2014 physical therapy visit, it was noted that Petitioner reported that his left knee was feeling better from the fall. At the time of the February 19, 2014 physical therapy visit, it was noted that Petitioner reported that he still had a little soreness on his left knee where it hit the ground when he fell on the ice the other day, but other than that had no complaints. (PX14).

Pay Stubs were entered into evidence at the time of arbitration as Petitioner's Exhibit 15. The Medical Bills Exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibit 16. Additional Pay Stubs were entered into evidence at the time of arbitration as Petitioner's Exhibit 17.

The IME Report of Dr. Joseph Monaco dated April 20, 2015 was entered into evidence at the time of arbitration as Respondent's Exhibit 1. The report reflects that Petitioner was seen on April 10, 2015 for a Section 12 examination. It was noted that based on Dr. Monaco's review of the medical records and his evaluation, there was no evidence of any pre-existing condition involving the left knee. It was noted that Petitioner indicated that currently he was functioning well and did "tons of walking and hiking," and that he also just completed a trip to Washington, D.C. and New York City where he reported walking about 40 miles. It was noted that Petitioner noted that he could not run or play baseball but that he could jog lightly, and that he further indicated that he could not jump. (RX1).

The report reflects that Dr. Monaco opined that the ruptured left patellar tendon was the result of the work-related injury and not of any other pre-existing condition or activity, and that there was no evidence to indicate that Petitioner's subsequent surgery with arthroscopy for a tear of the lateral meniscus was related to the work-related incident of March 1, 2013. It was noted that review of the medical records indicated that there was no reported incident or injury following the initial injury and subsequent surgery with repair of the patellar tendon on March 8, 2013, and that Petitioner underwent an extensive course of physical therapy. It was noted that review of the therapy records did not reveal any indication of any subsequent incident or injury to Petitioner's left knee and that there was ongoing complaint of soreness, which would be expected following the rupture of the infrapatellar tendon. It was noted that Petitioner did go back to work to regular duty and did notice there was some discomfort and that he had had continued complaints of pain, but that he noted the pain was mostly in the area of the infrapatellar tendon, which would be completely expected in the post-operative period. It was noted that the only other complaint noted was that of "medial knee pain." It was noted that nowhere in the medical records did Petitioner indicate any complaints of pain in the anterolateral aspect of the left knee and that he had had a negative examination with McMurray's testing negative pre-operatively, that at the time of the initial MRI there was a normal-appearing lateral meniscus, that at the time of the initial surgery on March 8, 2013 there was a normal-appearing lateral meniscus, and that there was no indication of an occupational or non-occupational injury or incident in the post-operative period consistent with tearing of the lateral meniscus. (RX1).

The report reflects that Dr. Monaco opined that Petitioner had mild complaints of constant aching in the left knee which did not impair his functional activity other than as noted with certain activities such

as playing baseball and running, and that he was able to hike and walk and coached baseball and football. It was noted that when seen for evaluation Petitioner had an essentially normal examination of his left knee other than decreased sensation in an area over the anterior aspect of his knee lateral to the medial parapatellar scar, and that he also indicated that he recently had been using kneepads which had eliminated any difficulty or discomfort he was having when kneeling. The report further reflects that Dr. Li had cited a lack of circulation as a result of the original surgery as the cause of the tear of the lateral meniscus, and that Dr. Monaco was unable to find any medical evidence to support that theory. It was noted that Dr. Monaco opined that there were no clinical signs of a tear of the lateral meniscus, no evidence of any joint line tenderness or positive McMurray test, that subjectively the complaints were of pain in the patellar tendon as would be expected following repair of the ruptured patellar tendon, and that any other complaints involved the medial aspect of the knee, unrelated to any lateral compartment abnormalities. (RX1).

The report reflects that Dr. Monaco opined that Petitioner had very minor current subjective complaints with a normal physical examination, that it was his opinion that the current complaints were causally related to the initial injury of March 1, 2013 with rupture of the patellar tendon and that on exam, there were no objective signs of any further pathology involving the left knee other than decreased sensation lateral to the medial parapatellar scar, and that the complaint would be causally related to the work-related incident and subsequent surgery. It was noted that Dr. Monaco opined that Petitioner had reached maximum medical improvement and was able to work without restrictions in regard to the work-related incident of March 1, 2013, and that no further medical treatment was reasonable, necessary or indicated in reference to the March 1, 2013 work injury. (RX1).

The report reflects that Dr. Monaco further opined that the subsequent left knee arthroscopic surgery performed in December 2013 was unrelated to the work-related incident of March 1, 2013 and that based on his review of the medical records, he was unclear of the surgical indication other than the MRI finding of a small vertical tear of the lateral meniscus. It was noted that at the time of the surgery Petitioner was having problems mostly with pain over the patellar tendon which would be expected following the repair in March 2013, and that the only other complaints noted were of medial knee pain without any clinical signs of meniscus tear medially or laterally on examination noted in the medical records. It was noted that Dr. Monaco was unable to find any evidence to support Dr. Li's theory that the tear of the meniscus was related to the initial injury, that at the time of the initial injury the MRI showed no evidence of any tear of the lateral meniscus, that the operative note noted that there was an intact lateral femoral condyle, lateral tibial plateau and lateral meniscus, that there was no further injury subsequent to the surgery done in March of 2013, and that there were no clinical symptoms present prior to the December 2013 surgery to indicate a clinically-significant meniscal injury. (RX1).

The transcript of the deposition of Dr. Monaco dated December 8, 2016 was entered into evidence at the time of arbitration as Respondent's Exhibit 2. Dr. Monaco testified that he is an orthopedic surgeon and that he has been board-certified in orthopedic surgery since 1978. (RX2).

Dr. Monaco testified that he took a history from Petitioner as part of the IME that was performed and that it confirmed the history that had been found in the medical records of an injury at work where he was pushing a pallet when he backed up and his left knee gave out, and that he felt and heard a pop. He testified that this was the only mechanism of injury that Petitioner provided to him in his history. He testified that Petitioner indicated that he underwent surgery on March 8, 2013 and went through a course of physical therapy at Dr. Li's office which he completed in October of 2013, and that he returned to work full duty in June of 2013. He testified that in October 2013 Petitioner went back to see Dr. Li because the knee was hurting and swelling, and that a tear of the meniscus was found and surgically repaired by Dr. Li on December 3, 2013. He testified that Petitioner reported that he was released for full duty work without restrictions in April 2014, and that he indicated he had had no problems since. (RX2).

Dr. Monaco testified that Petitioner indicated to him that since he had returned to work he had been very active on his job and had done tons of walking and hiking, that two weeks prior to being examined he went on a four-day trip to Washington, D.C. and New York City with his family where he walked about 40 miles, that he indicated he currently could jog lightly but could not really jump, and that he also indicated that he just needed to be aware and cautious about walking in the field so that he did not step into a hole. He testified that Petitioner noted that there was an area of numbness which was lateral to his incision, that he was also complaining of a sore, achy feeling which was there almost constantly that he said felt like a stiffness, that he would use ice and take Naproxen periodically that seemed to help, and that he noticed sometimes the symptoms were worse with weather changes such as storms. He testified that Petitioner also indicated that he had some trouble squatting and kneeling although since he started using kneepads kneeling had been okay, that on occasion there was a popping sensation that caused a transient burning feeling, and that the knee on occasion gave way while walking, but that he had not actually fallen to the ground. (RX2).

Dr. Monaco testified that it was his opinion that as a result of the work-related incident of March 1, 2013, Petitioner incurred a rupture of his patellar tendon. He testified that it was his opinion that there was no evidence to indicate Petitioner's subsequent surgery with arthroscopy for the tear of the lateral meniscus was related to the work-related incident of March 1, 2013. He testified that according to the operative report, the diagnostic arthroscopy revealed no evidence of any pathology involving the medial or lateral meniscus, the medial or lateral tibiofemoral condyle or tibiofemoral compartments which included the tibial plateau and the femoral condyles, and that there was some mild chondromalacia of the patella and a normal-appearing trochlea. He testified that Petitioner had ongoing complaints which he felt were due to the patellar tendon injury and repair and that Dr. Li recommended an MRI, which looked unremarkable other than showing the post-operative changes of the patellar tendon and what looked like a vertical tear which reached the surface of the inferior surface of the lateral meniscus anteriorly. He testified that to him this was clinically insignificant as there had never been in the records any complaints of pain over the lateral meniscus area, and that the complaints were almost completely restricted to the patellar tendon with one mention of medial knee pain. He testified that there was nothing in the medical records to suggest that there had been any new injury to the knee that could explain the fact that there was no lateral meniscus injury seen on the first MRI, that there was no lateral meniscus injury seen at the time of surgery, that the lateral meniscus injury seen on the second MRI was minor in nature and not consistent with the clinical complaints, and there was no history of any further incident or trauma that would have potentially caused a meniscal tear. (RX2).

Dr. Monaco testified that even if there was some merit to the idea that doing a patellar tendon repair could cause some kind of vascular damage to the knee it would not cause any damage to the circulation to the lateral meniscus in areas where it already had no circulation, which was the area where the tendon was found in the "white zone." When asked whether, absent some type of disruption of the blood circulation, it was possible that there could just be a simple weakening of the knee from the first surgery to cause the need for the second surgery, Dr. Monaco responded in the negative and further testified that there was no medical evidence to support that the normal course of treatment such as physical therapy and ambulation was going to cause tearing of the meniscus. He testified that the first surgery involved a rupture of the patellar tendon appropriately treated with repair, that at the time of that surgery there was no evidence of any other damage inside the knee joint, specifically no injury to the lateral meniscus, that subsequently there were further complaints of pain leading to another MRI which showed signal changes consistent with a small vertical tear of the anterior portion of the lateral meniscus that was not seen at the time of the previous surgery or at the time of the previous MRI, and that there was no history in the medical records to indicate any connection between that finding and Petitioner's original injury. (RX2).

Dr. Monaco testified that the first surgery was consistent with the pre-operative evaluation, including clinical evaluation as well as MRI, in regard to the diagnosis and the treatment did not involve at all any treatment of the medial or lateral compartments, specifically no medical lateral meniscal pathology

or treatment was found or treatment given. He testified that with the second surgery it was noted at the time of the arthroscopy that that there was known to be some scar tissue around the patellar tendon which Dr. Li debrided, but that the main procedure that he performed was a partial lateral meniscectomy. He testified that the third procedure was completely intraarticular, that there was nothing to do with the patellar tendon injury which was the original injury, and that there were noted to be findings not consistent with the initial arthroscopy, including Grade 4 injury to the articular cartilage of the trochlea which was noted to be normal on the two previous surgeries, there was Grade 4 damage with loss of articular cartilage down to the bone or the lateral femoral condyle not present at either of the previous two surgeries, and that there were chondral loose bodies found which were not present in either of the prior two surgeries. (RX2).

Dr. Monaco testified that his review of the third surgery did not change his opinion at all on whether the treatment or restrictions for any condition other than the patella treatment were related to work at all. He testified that his opinion remained that the injury sustained by Petitioner on March 1, 2013 was clear and consistent with the clinical picture and the subsequent findings which was a rupture of the patellar tendon, that there was never any history of complaints involving the lateral meniscus, that there were never any findings of injury to the lateral meniscus at the time of the initial MRI and subsequent surgery, and the fact that there were further changes in the knee on the third surgery had nothing to do with the original injury to the patellar tendon. (RX2).

When asked whether he had formulated any opinions as to whether Petitioner could return to work or what his work restrictions at the time, Dr. Monaco responded that it was his opinion that Petitioner had reached maximum medical improvement and was able to work without restrictions regarding the work-related incident of March 1, 2013. He testified that he also opined that no further treatment was necessary. (RX2).

On cross examination, Dr. Monaco agreed that on the first procedure on March 8, 2013 Dr. Li performed a chondroplasty of the patella, and further testified that on the second procedure he did a debridement to remove scar tissue around the patella rupture. When asked whether that would be related to the first surgery, Dr. Monaco responded that one would never consider doing arthroscopic surgery to remove scar tissue just for itself. (RX2).

On cross examination when asked if someone had decreased range of motion in the knee and atrophy in the quad and whether that would suggest that they were having some kind of deficit or problems with the knee, Dr. Monaco responded that it would be normal to find that after having an injury of the patellar tendon and surgery. He testified that if it never got any better, it would be a deficit. He agreed that in 2015 Petitioner had swelling and decreased range of motion. When asked whether in 2013 and 2014 Petitioner had swelling, decreased range of motion and atrophy, Dr. Monaco responded that it was intermittent. (RX2).

On redirect, Dr. Monaco testified that at the time of the first surgery Dr. Li noted Grade 2 chondromalacia of the patellar facet and that the remainder of the articular cartilage was normal. He testified that in the second operation the findings by Dr. Li were similar with no chondromalacia of the medial or lateral tibia femoral compartments, including the femoral condyle and tibial plateau, and no chondromalacia of the trochlea and Grade 2 chondromalacia of the patellar. He testified that in the third operation Dr. Li indicated that the patellar cartilage looked okay, that there was a new area of damage involving the trochlea which was Grade 4, and that there was also a Grade 4 finding on the lateral femoral condyle with loss of articular cartilage on the bone. He testified that the areas of significant chondral injury were completely normal at the time of the first two surgeries but were now abnormal in a significant way, and that the chondromalacia of the patella, which was present the first two, was not really an issue. (RX2).

The November 4, 2013 Letter of Dr. Li was entered into evidence at the time of arbitration as Respondent's Exhibit 3. When asked if the recent findings on the MRI and the need for the recommended

left arthroscopic knee surgery was a direct result of the work-related condition for which he had been treating Petitioner, Dr. Li responded that the anterior horn lateral meniscus tear most likely resulted from the disruption of blood supply as a result of the patellar tendon rupture and subsequent surgery. (RX3).

The Payment Ledgers were entered into evidence at the time of arbitration as Respondent's Exhibit 4. The Wage Statement was entered into evidence at the time of arbitration as Respondent's Exhibit 5.

CONCLUSIONS OF LAW

With respect to disputed issue (C) pertaining to the issue of accident, the Arbitrator finds that Petitioner did sustain an accident that arose out of and in the course of employment with Respondent on March 1, 2013. The Arbitrator further finds that such work-related accident occurred to Petitioner's left patellar tendon on that date, as the initial medical records and exhibits taken as a whole document that there was no meniscal injury sustained in the accident of March 1, 2013. Furthermore, the Arbitrator finds that the evidence reveals that there were no other aggravations alleged to have worsened the condition, nor any other Applications for Adjustment of Claim filed related thereto, and that Petitioner further testified there were no other work-related incidents or intervening events involving the left knee.

With respect to disputed issue (F) pertaining to the issue of causation, the Arbitrator finds that Petitioner has met his burden of proving that his left patellar tendon injury is causally related to the accident of March 1, 2013, but that Petitioner has not met his burden of proving that his current condition of ill-being in the left knee is causally related to the accident of March 1, 2013.

At the outset, the Arbitrator notes that both Dr. Li and Dr. Monaco agreed that Petitioner's first knee surgery was causally related to the accident of March 1, 2013. (PX1; RX2). The causation dispute in the case, then, effectively surrounds the purported causal connection between Petitioner's second and third surgeries and the underlying work accident at issue.

Having considered and reviewed the entirety of the medical evidence, the Arbitrator finds that Petitioner's second and third surgeries were not natural consequences that flowed from the initial injury that arose out of and in the course of Petitioner's employment with Respondent on March 1, 2013, but rather that the second and third surgeries were entirely new and separate injuries - albeit to the same body part - but in separate compartments of the knee, *i.e.,* the patella versus the meniscus. That said, the Arbitrator finds that the chain of causation was broken following Petitioner's discharge from post-operative physical therapy on August 9, 2013.

In support of this finding, the Arbitrator finds to be significant the fact that Petitioner was able to work full duty and was discharged from physical therapy following the first surgery, the fact that there was a clear change in pathology following the first MRI and surgery as compared to the subsequent MRIs and surgeries, and the inconsistences between Dr. Li's rationale for the second surgery as indicated in the November 4, 2013 letter to Corvel as compared to the rationale as indicated in the narrative report authored on May 29, 2015. (PX11; PX5; PX7; RX3; PX2). As a result of the foregoing, the Arbitrator finds to be more persuasive the opinions of Dr. Monaco rather than those proffered by Dr. Li in this matter.

Dr. Monaco testified that it was his opinion that as a result of the work-related incident of March 1, 2013, Petitioner incurred a rupture of his patellar tendon. Dr. Monaco testified that it was his opinion that there was no evidence to indicate Petitioner's subsequent surgery with arthroscopy for the tear of the lateral meniscus was related to the work-related incident of March 1, 2013 and that, according to the operative report, the diagnostic arthroscopy revealed no evidence of any pathology involving the medial or

lateral meniscus, the medial or lateral tibiofemoral condyle or tibiofemoral compartments which included the tibial plateau and the femoral condyles, and that there was some mild chondromalacia of the patella and a normal-appearing trochlea. Dr. Monaco testified that Petitioner had ongoing complaints which he felt were due to the patellar tendon injury and repair and that Dr. Li recommended an MRI, which looked unremarkable other than showing the post-operative changes of the patellar tendon and what looked like a vertical tear which reached the surface of the inferior surface of the lateral meniscus anteriorly. Dr. Monaco testified that to him this was clinically insignificant as there had never been in the records any complaints of pain over the lateral meniscus area, and that the complaints were almost completely restricted to the patellar tendon with one mention of medial knee pain. Dr. Monaco further testified that there was nothing in the medical records to suggest that there had been any new injury to the knee that could explain the fact that there was no lateral meniscus injury seen on the first MRI, that there was no lateral meniscus injury seen at the time of surgery, that the lateral meniscus injury seen on the second MRI was minor in nature and not consistent with the clinical complaints, and there was no history of any further incident or trauma that would have potentially caused a meniscal tear. Dr. Monaco also testified that his review of the third surgery did not change his opinion at all on whether the treatment or restrictions for any condition other than the patella treatment were related to work at all, that his opinion remained that the injury sustained by Petitioner on March 1, 2013 was clear and consistent with the clinical picture and the subsequent findings which was a rupture of the patellar tendon, that there was never any history of complaints involving the lateral meniscus, that there were never any findings of injury to the lateral meniscus at the time of the initial MRI and subsequent surgery, and the fact that there were further changes in the knee on the third surgery had nothing to do with the original injury to the patellar tendon. (RX2).

Based upon the evidence in its entirety, the Arbitrator finds that Petitioner has met his burden of proving that his left patellar tendon injury is causally related to the accident of March 1, 2013, but that Petitioner has not met his burden of proving that his current condition of ill-being in the left knee is causally related to the accident of March 1, 2013. Related thereto, the Arbitrator further finds that Petitioner attained maximum medical improvement from the left patellar tendon injury as of his discharge from post-operative physical therapy on August 9, 2013, and that Petitioner's second and third surgeries were not natural consequences that flowed from the initial injury that arose out of and in the course of Petitioner's employment with Respondent on March 1, 2013, but rather that the second and third surgeries were entirely new and separate injuries - albeit to the same body part - but in separate compartments of the knee, *i.e.*, the patella versus the meniscus.

With respect to disputed issue (G) pertaining to the issue of Petitioner's earnings, having considered and reviewed the entirety of the testimony and documentation entered into evidence on the issue, the Arbitrator finds that in the year preceding the injury, Petitioner earned $25,503.40 and that the average weekly wage, calculated pursuant to Section 10 of the Act, was that of $490.45. Related thereto, the Arbitrator notes that Petitioner did not testify as to the existence of any mandatory overtime.

With respect to disputed issue (J) pertaining to necessary medical services, in light of the Arbitrator's aforementioned conclusions, the Arbitrator finds that Petitioner's care and treatment of the left patellar tendon injury was reasonable, necessary and causally related to his work accident of March 1, 2013. As a result, the Arbitrator finds that Respondent shall pay all reasonable and necessary medical services **for medical services rendered up to and including August 9, 2013 as set forth in Petitioner's Exhibit 16,** as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit for all medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

With respect to disputed issue (K) pertaining to the issue of temporary total disability benefits, the Arbitrator notes that Petitioner seeks the recovery of additional temporary total disability benefits for the

timeframe of December 2, 2015 through March 3, 2016, which pertains to the timeframe related to Petitioner's third surgery. (AX1). In light of the Arbitrator's findings as to the issue of causation, Petitioner's request for the recovery of such additional temporary total disability benefits is hereby denied. Respondent shall be given a credit of $4,680.26 for temporary total disability benefits already paid, which the Arbitrator notes includes an overpayment of temporary total disability benefits following the second surgery from December 3, 2013 to January 12, 2014.

With respect to disputed issue (L) pertaining to the nature and extent of Petitioner's injury, and consistent with 820 ILCS 305/8.1b, permanent partial disability shall be established using the following criteria: (i) the reported level of impairment pursuant to subsection (a) of Section 8.1b of the Act; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. 820 ILCS 305/8.1b. No single enumerated factor shall be the sole determinant of disability. *Id.*

With respect to Subsection (i) of Section 8.1b(b), the Arbitrator notes that neither party submitted an AMA rating. The Arbitrator places no weight on this factor when making the permanency determination.

With respect to Subsection (ii) of Section 8.1b(b), the Arbitrator notes that Petitioner testified that he continues to work for Respondent and is performing the same job tasks as prior to the March 1, 2013 accident. The Arbitrator places greater weight on this factor when making the permanency determination.

With respect to Subsection (iii) of Section 8.1b(b), Petitioner was 38 years old on his date of accident. Given the age of Petitioner and the fact that his treating physician has placed him under no restrictions, the Arbitrator places lesser weight on this factor when making the permanency determination.

With respect to Subsection (iv) of Section 8.1b(b), the Arbitrator notes that, following his work injury, Petitioner returned to work for Respondent in a full duty capacity. As there was no evidence of reduced earning capacity contained in the record, the Arbitrator places lesser weight on this factor when making the permanency determination.

With respect to Subsection (v) of Section 8.1b(b), the Arbitrator notes that Petitioner testified that he still has some issues with his left knee, that it feels like his kneecap shifts occasionally and that he has to push it back. Petitioner testified that he still has weakness and that when he gets in a car, he occasionally has to lower himself while getting in using the frame of the car for assistance. Petitioner further testified that he feels that his knee buckles from time to time. At the time of the March 3, 2016 visit with Dr. Li, it was noted that Petitioner had done well with therapy but still needed Mobic to keep his pain under control. Petitioner was dispensed Mobic, was allowed to return to work full duty, was recommended to continue his home exercise program and was recommended to follow-up in four weeks. (PX11). The Arbitrator concludes that Petitioner's evidence of disability at the time of arbitration, namely his continued complaints and limitations, were somewhat corroborated by his treating records at the conclusion of his treatment with Dr. Li. The Arbitrator accordingly places lesser weight on this factor in determining permanency.

The Arbitrator notes that the determination of permanent partial disability benefits is not simply a calculation, but an evaluation of all of the factors as stated in the Act in which consideration is not given to any single factor as the sole determinant. Based on the above factors and the record in its entirety, the Arbitrator concludes that Petitioner sustained permanent partial disability to the extent of **20% loss of use of the left leg** under Section 8(e) of the Act.

With respect to disputed issue (N) pertaining to the issue of credit for Respondent, the Arbitrator finds that Respondent is entitled to a credit of $4,680.26 for temporary total disability benefits already paid, which the Arbitrator notes includes an overpayment of temporary total disability benefits following the second surgery from December 3, 2013 to January 12, 2014; that Respondent is entitled to a credit in the

amount of $68,830.16 in medical payments made on Petitioner's behalf; and that Respondent is further entitled to a credit in the amount of $65,382.36 in medical bills through its group medical plan for which credit may be allowed under Section 8(j) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

- [x] 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

Illinois Workers' Compensation Commission,
Petitioner,

vs.

No. 14 INC 69,
19 WC 31015

Stefan N. Koev, individually and as owner and
d/b/a Koev Moving,
Respondent.

20IWCC0017

DECISION AND OPINION RE: INSURANCE NON-COMPLIANCE

Petitioner Illinois Workers' Compensation Commission brings this action by and through the Office of the Illinois Attorney General against the above-captioned Respondent. Petitioner alleges a violation of section 4(a) of the Illinois Workers' Compensation Act (the Act) for Respondent's failure to procure mandatory worker's compensation insurance. Proper and timely notice was given to all parties.

Petitioner alleges that Respondent knowingly and willfully lacked workers' compensation insurance for a total of 898 days between May 31, 2012 and November 14, 2014. A hearing was held before Commissioner Barbara N. Flores in Chicago, Illinois, on October 8, 2019. Petitioner appeared and presented the testimony of Investigator Antonio Smith. Respondent, Stefan N. Koev, failed to appear through counsel or *pro se*.

The Commission sought a fine under the Act of $429,000 for the 898 days Mr. Koev did business individually and as owner of Koev Moving and allegedly failed to provide coverage for his employees, plus $24,766.57 which the Injured Workers' Benefit Fund (IWBF) paid to Respondent's injured worker, for a total of $473,766.57.

20IWCC0017

The Commission, after considering the record in its entirety and being advised of the applicable law, finds that Respondent Stefan Koev did business individually and as owner of Koev Moving, and knowingly and willingly violated section 4(a) of the Act during the period in question. As a result, Respondent shall be held liable for non-compliance with the Act and shall pay a penalty in accordance with section 4(d) of the Act. The Commission hereby assesses the penalty of $400.00 per day for 898 days ($359,200.00), plus $24,766.57 for a total of $383,966.57.

FINDINGS OF FACT

The Commission's records show that the IWBF paid $24,766.57 to Respondent's injured worker, Charles Bauer, pursuant to the December 30, 2013 decision in claim 12 WC 33444. The decision in that claim found Respondent did not carry workers' compensation insurance on July 16, 2012, the date of Bauer's injury.

Investigator Smith testified he investigated Koev Moving. He stated that he believed Koev Moving was required to carry insurance under section 3 of the Act because it used electronic or gasoline powered equipment as a moving company.

On May 26, 2015, Investigator Smith sent Respondent a Notice of Insurance Compliance Hearing. The notice alleged Respondent was in non-compliance with the mandatory insurance coverage provisions of the Act during the period from July 20, 2005 to March 19, 2014, or during periods in business as applicable. The hearing was set for July 7, 2015. Investigator Smith received no response from Koev Moving.

Investigator Smith obtained records from the Illinois Secretary of State indicating the business was incorporated on May 31, 2012 and dissolved on November 14, 2014. The owners of the business were Koev Moving, LLC and Stefan Koev, individually. The records also indicate Koev was the sole member of the LLC.

Investigator Smith testified he conducted additional steps in his investigation of Respondent. He checked three different addresses with the Commission's Office of Self-Insurance and learned that Koev Moving was not self-insured. He submitted the three addresses to the National Council on Compensation Insurance (NCCI) and received signed certifications from an NCCI Proof of Coverage Analyst which indicated that Respondent was without workers' compensation insurance from July 20, 2005 to September 16, 2019. Records from the Illinois Department of Revenue indicated that Respondent filed no quarterly withholding tax returns from March 2009 through March 2014. Based on his investigation, Investigator Smith opined that Respondent did not carry workers' compensation insurance during the time requested.

Petitioner also submitted a number of exhibits in support of its case. Petitioner's Exhibit 1 was a copy of the Notice of Insurance Compliance Finding of Default and Scheduled Hearing

20IWCC0017

on the Merits for October 8, 2018. The notice refers to an Order of Default signed by Commissioner Flores on August 6, 2019. An unsigned copy of the order was attached to the exhibit.

Petitioner's Exhibits 2 and 3 were comprised of what Investigator Smith testified were true and accurate copies of the records he obtained from the Illinois Secretary of State. Petitioner's Exhibit 4 was a copy of the Notice of Insurance Compliance Hearing for July 7, 2015. Petitioner's Exhibit 5 was the Decision of the Arbitrator filed on December 30, 2013 regarding Bauer's claim against Respondent and the IWBF. Petitioner's Exhibit 6 contained the certifications provided by the Commission's Office of Self-Insurance. Petitioner's Exhibit 7 contained the certifications provided by the NCCI.

CONCLUSIONS OF LAW

Pursuant to section 3 of the Act, certain employers and their employees are automatically subject to the provisions of the Act if they engage in specific businesses, including "any business or enterprise in which electric, gasoline or other power driven equipment is used in the operation thereof." 820 ILCS 305/3(15) (West 2010).

The Commission finds that, based on the work performed by Koev Moving as disclosed in the unrebutted testimony of Investigator Smith, Respondent automatically falls under the provisions of section 3 of the Illinois Workers' Compensation Act and is required to carry workers' compensation insurance.

Regarding the issue of penalties, section 4(d) of the Act states in part:

> "Upon a finding by the Commission, after reasonable notice and hearing, of the knowing and willful failure or refusal of an employer to comply with any of the provisions of paragraph (a) of this Section or the failure or refusal to comply with any order of the Illinois Workers' Compensation Commission pursuant to paragraph (c) of this Section disqualifying him or her to operate as a self insurer and requiring him or her to insure his or her liability, the Commission may assess a civil penalty of up to $500 per day for each day of such failure or refusal after the effective date of this amendatory Act of 1989. The minimum penalty under this Section shall be the sum of $10,000. Each day of such failure or refusal shall constitute a separate offense." 820 ILCS 305/4(d) (West 2010).

Here, the records obtained from the Illinois Secretary of State establish that Mr. Koev was the owner of Koev Moving on May 31, 2012, signed the forms for Koev Moving's annual report on April 30, 2013, and remained the sole member of the LLC when it was involuntarily dissolved on November 14, 2014. The certifications from NCCI show that Respondent was without workers' compensation insurance from July 20, 2005 to September 16, 2019.

20IWCC0017

The Commission finds that Respondent is liable for a penalty for failure to comply with section 4(a) of the Act. Accordingly, the Commission turns to consider the amount of the penalty to be assessed. The Commission considers a number of factors in determining the amount of penalties to assess against an employer for such failure: "1) the length of time in which the employer had been violating the Act; 2) the number of settled/pending workers' compensation claims against the employer; 3) whether the employer had been made aware of his conduct in the past; 4) the number of employees working for the employer; 5) the employer's ability to secure and pay for future (or recently obtained) workers' compensation insurance premiums; 6) whether the employer has shown any mitigating circumstances, such as a willingness to cooperate, comply and settle; and 7) the ability of the company to pay the assessed penalty." *Illinois Workers' Compensation Comm'n v. EJC Engineering and Construction*, 98 INC 181.

In this case, the Commission finds that the length of time in which the Respondent had been violating the Act in failing to obtain worker's compensation insurance was significant. The Respondent failed to have insurance for 898 days. However, the Commission has before it only one underlying workers' compensation claim. Petitioner presented no evidence that Respondent was made aware of his conduct in the past. The Decision of the Arbitrator refers only to the claimant and one co-worker. The Commission does not find there are mitigating factors, as Mr. Koev failed to appear, let alone demonstrate a willingness to cooperate, comply and settle. There is also no evidence regarding Respondent's ability to secure and pay for future (or recently obtained) workers' compensation insurance premiums, or to pay for the assessed penalty.

The Commission finds that Petitioner has met its burden of proving that Respondent was operating a business in Illinois, and was properly served with notice, was legally required to maintain workers' compensation insurance, but conducted business for 898 days without workers' compensation insurance. The Commission also finds that Petitioner proved that such violation was willful given that Mr. Koev was warned previously that his failure to appear would result in a finding of knowing and willful non-compliance. Accordingly, the Commission finds that Respondent is liable for a penalty for failure to comply with section 4(a) of the Act. The Commission hereby assesses against Respondent a total fine of $383,966.57, representing the period of 898 days that Respondent was without workers' compensation insurance coverage ($359,200.00), plus the $24,766.57 paid by the IWBF.

IT IS THEREFORE ORDERED BY THE COMMISSION that Stefan N. Koev, individually and as owner of Koev Moving, pay to the Illinois Workers' Compensation Commission the sum of $383,966.57, as provided in section 4(d) of the Act.

Pursuant to Commission Rule 9100.90, once the Commission assesses a penalty against an employer in accordance with section 4(d) of the Act, payment shall be made according to the following procedure: 1) payment of the penalty shall be made by certified check or money order

20IWCC0017

made payable to the Illinois Workers' Compensation Commission; 2) payment shall be mailed or presented within 30 days after the final Order of the Commission or the order of the court on review after final adjudication to:

Workers Compensation Commission,
Insurance Compliance Division
100 West Randolph Street
Suite 8-328
Chicago, Illinois 60601

3) or as otherwise directed by www.iwcc.il.gov.

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 the Circuit Court.

DATED: JAN 9 - 2020
r: 10/08/19
BNF/kcb
045

Barbara N. Flores

Deborah L. Simpson

Marc Parker

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

RENARD EDWARDS,

Petitioner,

vs. NO: 17 WC 36522

RANDSTAD MANUFARCTURING,
N/K/A RANDSTAD NORTH AMERICA, INC.,

Respondent.

20IWCC0018

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §§19(b) and 8(a) 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, prospective medical care, temporary disability benefits, penalties or fees, and chain of referrals, and being advised of the facts and law, affirms and modifies 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 (1980).

I. Evidentiary Issues

In this case, Respondent objected to the admission of Petitioner's §19(b)/8(a) petition as untimely filed. The Commission agrees with the Arbitrator in overruling this objection to the extent that the original version of the petition was timely filed. However, the Commission sustains Respondent's objection to the admission of Petitioner's subsequent petition for penalties and fees, which was initially included in an amended petition and untimely. Accordingly, the Arbitrator's denial of penalties and fees is rendered moot.

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Respondent also objected on hearsay grounds to the admission of Dr. Wingate's notes dated August 17, 2018 and Dr. Koutsky's notes dated November 6, 2018. Both sets of notes were included in Petitioner's Exhibit 5. Respondent argues these notes were prepared for use in litigation and therefore not admissible under §16 of the Act.

The Commission agrees with the Arbitrator's decision to overrule this objection. Although Dr. Wingate's notes referred to Dr. Bernstein's IME report, when read in their entirety and in context of the chronology of Petitioner's treatment, the Commission concludes that these notes were prepared in the course of treatment and not for use in litigation. Thus, Dr. Wingate's notes were admissible pursuant to §16 of the Act. Similarly, Dr. Koutsky's surgical recommendation was based on the diagnostic records, physical examination and subjective complaints of Petitioner and not solely for use in litigation as Respondent asserts. Moreover, the Commission concludes Dr. Koutsky's notes were not created solely to cure defects that would exist if Respondent's objection to Dr. Wingate's notes had been sustained. Accordingly, Dr. Koutsky's notes also were admissible pursuant to §16 of the Act.

II. The Merits

The Commission further affirms the rulings of the Arbitrator on the merits of Petitioner's claims of accident, causal connection, medical expenses, prospective medical care, temporary disability benefits, and chain of referrals. The Commission adds that it places greater weight on the opinions of Dr. Koutsky than those of Dr. Bernstein. It is the function of the Commission to resolve conflicts in medical testimony; greater weight may be attached to the opinion of the treating physician. See *ARA Services, Inc. v. Industrial Comm'n*, 226 Ill. App. 3d 225, 232 (1992) (citing *International Vermiculite Co. v. Industrial Comm'n*, 77 Ill. 2d 1, 4 (1979)).

In this case, as noted above and in the Arbitrator's decision, the opinions and recommendations of Petitioner's treating physicians were clearly supported by objective findings and Petitioner's medical records as a whole. Even Dr. Bernstein noted Petitioner's history of accident and indicated that Petitioner may have suffered an aggravation of a preexisting degenerative condition.

Excepting the modifications stated above, the Decision of the Arbitrator is affirmed and adopted in all other respects.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 22, 2019, is hereby affirmed and adopted with the modifications noted above.

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20IWCC0018

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 $52,400.00. 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: 11/21/19
JAN 9 - 2020
BNF/kcb
045

Barbara N. Flores

Deborah L. Simpson

Marc Parker

30 LCC0018

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

EDWARDS, RENARD
Employee/Petitioner

Case# **17WC036522**

RANDSTAD MANUFACTURING
Employer/Respondent

20IWCC0018

On 2/22/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.45% 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:

0243 GUMBINER INJURY LAW GROUP
CHRISTOPHER COOPER
180 N MICHIGAN AVE SUITE 2100
CHICAGO, IL 60601

1505 SLAVIN & SLAVIN LLC
KATHARINE J BARNES GAINER
100 N LASALLE ST 25TH 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
19(b)

18IWCC0018

Renard Edwards
Employee/Petitioner

v.

Randstad Manufacturing
Employer/Respondent

Case # 17 WC 36522

Consolidated cases: _____

20IWCC0018

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gregory Dollison**, Arbitrator of the Commission, in the city of **Chicago, Illinois**, on **January 3, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ 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 **Chain of referral**

FINDINGS

On the date of accident, **November 30, 2017**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**26, 877.76**; the average weekly wage was $**516.88**.

On the date of accident, Petitioner was **52** years of age, ***single*** with 0 dependent children.

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

Respondent shall be given a credit of $**0** for TTD, $**0** for TPD, $**0** for maintenance, and $**1,240.52** for other benefits, for a total credit of $**1,240.52**.

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 **$31,198.03,** as provided in Sections 8(a) and 8.2 of the Act.

Respondents shall pay Petitioner temporary total disability benefits of **$344.58**/week, for **56-1/7** weeks, commencing **December 7, 2017 through January 3, 2019**, pursuant to §8(b) of the Act.

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

2/21/19
Date

ICArbDec19(b)

FEB 22 2019

STATEMENT OF FACTS:

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Petitioner testified that as of November 30, 2017, he had been working for Respondent for approximately 2 ½ months and was assigned to work at a client of Respondent, DHL Supply Chain, in the position of an inventory specialist/forklift driver. Petitioner testified that he was tasked with locating inventory material that could not be found throughout the warehouse, driving a forklift to take incoming materials from the receiving dock to racked space or to their locations. Petitioner provided that in essence, he would bring materials into the warehouse, rack it and find lost inventory. Petitioner explained that while racking (putting it away), he had to manually lift the materials. Petitioner testified that November 30, 2017 was a particularly busy day. The type of material that came in that particular day included "a lot of iron parts, a lot of motors, actuators, a lot of heavy equipment." Petitioner testified that he was tasked with racking drill bits. He had to lift the drill bits, bend underneath racks and transfer the materials into three or four-foot crates. Petitioner provided that the bending placed him in awkward positions and the materials could weigh between 15 to 20 pounds. Petitioner testified that while performing this function, he began to experience lower back pain. Petitioner stated, "it was really taxing on my back; and toward the end of the night, I felt it got to be excruciating." Petitioner testified that he was in a lot of pain and decided that he should let someone know that he was hurt. Petitioner indicated that since his immediate supervisor had already left for the day, he talked to the lead worker who informed him to go to the Shipping Department and tell Ricky who was the highest-ranking manager that evening. Petitioner stated that Ricky instructed him to write out an injury statement on a blank sheet of paper and sign it. Thereafter, "he gave me the okay to go ahead and clock out." Petitioner testified that he went home, soaked his back with Epsom Salt, and took a couple pain pills.

Petitioner testified that he returned to work the following day, December 1, 2017. Petitioner stated that he did not do much and stayed on the forklift and lifted whatever that could be lifted by the forklift. Petitioner also testified that he informed his immediate supervisor, at the beginning of his shift, that "...yesterday evening was kind of taxing. I hurt myself, so I'm going to be taking it easy today." Petitioner testified that his supervisor responded "okay, just keep me posted." Petitioner testified that he was not asked to fill out any official paperwork nor was he offered any medical attention.

Petitioner testified that after working his full regular shift on December 1, 2017, he was asked to turn-in his badge and key card. Petitioner testified that in the ensuing days, he attempted to contact Respondent to inquire about the status of his work assignment at DHL Supply Chain to which he received no response. Petitioner testified that thereafter on December 7, 2017, he received a telephone call from a representative of Respondent who advised him of his termination from DHL Supply Chain.

Petitioner testified that he did not seek immediate medical attention until he saw Dr. Sajjad Murtaza at Illinois Orthopedic Network (ION) on December 7, 2017. Petitioner testified that between November 30 and December 7, 2017, he attempted soaking, stretching, and taking ibuprofen. He indicated the pain would not abate. Records submitted show Petitioner presented to Dr. Murtaza and reported that he developed low back pain with radiating pain to the right lower extremity while doing heavy lifting at work. Dr. Murtaza noted that his clinic had treated Petitioner for a low back injury two years prior for which Petitioner underwent two epidural steroid injections. The doctor noted that Petitioner "...had no___ after that." Upon physical examination, Petitioner had a mildly antalgic gait; 40 degrees of flexion, 10 degrees of extension, 20 degrees of right and left lateral bending. He had negative straight leg raises bilaterally but the doctor noted Petitioner 45 plantar and dorsiflexion weakness. Dr. Murtaza recommended a lumbar spine MRI, physical therapy, and prescribed Naproxen and Flexeril refills. Petitioner was also kept off work. (PX 5)

The MRI was completed on December 12, 2017. The study demonstrated a diffuse disk bulge and large right paracentral/lateral-recess extrusion measuring 8-9 mm thick and extruded 17 mm cranially at L4-5. There was moderate to severe foraminal narrowing, mild to moderate on the left. The spinal canal was mildly narrowed. The impression was right sided herniation L4-5 with underlying bulge narrowing the foramina right worse than left. (PX 5)

Records submitted show Petitioner then sought treatment with Dr. Bialon-Wnek at Bone & Joint Clinic on December 13, 2017. At that time, Dr. Bialin-Wnek wrote, "[Petitioner] was involved in a work-related incident on Thursday, November 30, 2017. At the time of the incident, Mr. Edwards was working for Randstad. Mr. Edwards works as a forklift operator and was moving heavy load from one destination to another. Once the item got to the other destination it is his job to lift and adjust the product to place on shelves. After doing this all shift he began to feel a pain in his back which radiated down the right leg." Petitioner reported that he immediately reported the incident to his operations supervisor who did not send him to a doctor. According to the doctor, Petitioner also reported that he was hurt in the same area previously. Dr. Bialon-Wnek performed an examination observing moderate inflammation and moderate trigger points in the lower back. Lumbar flexion measured 40 degrees with pain, extension was at 10 degrees with pain, lateral flexion was at 20 degrees with pain and 20 degrees with pain during right lateral flexion. Chiropractic treatment was recommended for diagnoses of low back pain and right leg pain. (PX 6)

Petitioner commenced the recommended therapy sessions on December 14, 2017. By January 10, 2018, he had completed eleven sessions. Dr. Bialon-Wnek noted that although Petitioner was responding well to his care, he continued with symptoms of lower back and right leg pain. According to Dr. Bialon-Wnek, Petitioner described lower back pain that was sharp, shooting with motion and throbbing. His right leg pain was described as shooting with motion. (PX 6)

Petitioner returned to Dr. Murtaza on January 11, 2018. Dr. Murtaza reviewed the MRI of Petitioner's lumbar spine and opined Petitioner had a large disk herniation. Dr. Murtaza recommended Petitioner undergo steroid injections, which Petitioner wanted some time to consider. Dr. Murtaza also recommended an EMG to correlate with Petitioner's MRI and continued him off work completely. (PX 5)

On January 16, 2018, Petitioner returned to Dr. Bialon-Wnek and reported his current back pain level and right leg pain level were 1/10. Dr. Bialon-Wnek performed another physical examination and noted significant improvement since the last visit. (PX 6)

Petitioner commenced another round of physical therapy on January 16, 2018. By February 23, 2018 he had undergone twelve (12) sessions. Therapy records noted that Petitioner reported he was doing better and rated his low back pain at 2/10 and right leg pain at 0/10. He reported that his low back pain was sharp and throbbing. (PX 6)

Petitioner returned to ION on March 1, 2018. At that time, he saw Dr. Krishna Chunduri with complaints of low back pain and right leg numbness, tingling, weakness down to his foot. Petitioner rated his pain at 5/10. According to Dr. Chunduri, Petitioner reported that his symptoms started as a result of a work injury that occurred on 11/30/2017. Dr. Chunduri wrote, "[o]n the day of the injury he works as a forklift operator. He is transporting and moving motors that weigh up to 80-90 pounds and he states after he moves them, he has to place the motors on shelves and he has to lift them manually in a bent over position, lifting up, placing them and adjusting them. These are all 80-90 pounds or greater. He states as a result of this, he notices the pain in his lower back…" The doctor also noted that Petitioner reported a prior facet joint injury in 2015 which had been treated and subsequently resolved. The doctor noted that Petitioner "…is now here with what appears to be a different problem." After performing an examination and reviewing the previously taken MRI, Dr. Chunduri felt Petitioner was "…suffering from a large disk herniation with extrusion that is resulting in his

current symptoms, which is the result of the severe nerve compression." The doctor stated that Petitioner's symptoms were "...a very different injury compared to his 2015 injury, which was a facet sprain. It does appear to me this is a new injury as the result of his current injury..." Dr. Chunduri recommended a right L4-L5 transforaminal epidural injection. Petitioner was continued off work and an additional round of therapy was ordered. (PX 5, PX 6)

Petitioner began participating in the ordered therapy sessions on March 2, 2018. At that time, Petitioner reported low back pain was at 3/10 and his right leg complaint was at 1/10. By March 22, 2018, he had completed five (5) therapy sessions. At that time, he reported that his symptoms were about the same, i.e., low back at 3/10 and right leg at 1/10. (PX 6)

Petitioner returned to Dr. Chunduri on March 22, 2018. The doctor noted Petitioner had undergone the previously prescribed injection (The Arbitrator notes the medical bills submitted show the injection was carried out on March 8, 2018) and reported significant improvement. Petitioner indicated that his pain waxed and waned, depending on activity, and could be as high as 5/10 with radiation down his right leg. Dr. Chunduri recommended a repeat injection noting that if same did not provide further improvement, a surgical evaluation was likely. (PX 5)

At Respondent's request, Petitioner underwent a Section 12 examination with Dr. Avi Bernstein on May 7, 2018. Dr. Bernstein performed an examination and reviewed medical records of Dr. Murtaza and Dr. Bialon-Wnek through January 16, 2018. The doctor also reviewed the December 12, 2017 MRI and a CT scan report dated May 19, 2015. Dr. Bernstein provided the MRI scan was of poor quality but nevertheless demonstrated degenerative changes from L4-S1. The doctor indicated he was unable to identify a distinct disc herniation in the lumbar spine or evidence of nerve root compression. He noted the report described an extruded right lateral disc herniation, but he felt same was an artifact. Dr. Bernstein also noted that he reviewed a CT scan report dated May 19, 2015. The doctor stated the report described facet arthrosis at L4-5 with a moderate diffused disc bulge. Endplate spurs were also identified on the right side. Dr. Bernstein assessed continued right-sided low back pain and radiating leg pain of unclear etiology. The doctor stated "[Petitioner] has a degenerative condition of the lumbar spine from L4-S1 and he has a pre-existing history of low back pain and right-sided radiating leg pain for which he was treated in 2015." The doctor opined that it was possible Petitioner suffered an aggravation of his degenerative condition as a result of the work incident. The doctor stated Petitioner had improvement in his condition "to a 1/10 level" by mid-January which strongly supported his position that Petitioner had a temporary duration. Dr. Bernstein opined that Petitioner was at maximum medical improvement and required no further therapeutic modalities or diagnostic workups. He felt Petitioner could return to work full duty work as a forklift driver. (RX 2)

Dr. Chunduri performed the repeat injection on May 10, 2018. (PX 5) Petitioner testified that the injections did not provide lasting relief.

Petitioner returned to Dr. Chunduri on June 28, 2018. Petitioner reported that the injection provided temporary relief and rated his pain at 6/10. Petitioner also reported that his right leg symptoms continued but were more intermittent. Dr. Chunduri recommended a spine surgery evaluation. (PX 5)

On August 17, 2018, Petitioner presented to Dr. Jeffrey K. Wingate for a surgical consultation. Dr. Wingate documented that Petitioner reported with a chief complaint of 5/10 low back pain and bilateral leg pain. Petitioner conveyed that on November 20, 2017, he experienced increasing low back pain after a particularly heavy day of bending and twisting in a confined space. Petitioner also reported to a self-limited episode of low back pain in 2015 which was treated conservatively and "...completely putting all of his back pain behind him and returning to full employment status." Dr. Wingate noted that he reviewed the December 2017 MRI scan as well as the report. The doctor felt same demonstrated a very large right paracentral extrusion

of disk material that had migrated cephalad up under the right L4 pedicle. The doctor stated that he concurred with the report transcribed by the radiologist, Dr. Eugene Pai. After performing an examination, Dr. Wingate's impression was right L4-5extruded HNP with radiculopathy. Dr. Wingate felt that the "..single best option for [Petitioner was] a hemilaminectomy with discectomy and decompression of the neural elements." The doctor noted that he had not seen an EMG study but speculated same would likely be positive and would nevertheless change the findings on the MRI scan. Dr. Wingate also commented that he had the opportunity to review Dr. Bernstein's IME report. Dr. Wingate wrote, "My opinion differs dramatically from that of Dr. Bernstein. None of these records nor any of these images, in my opinion, indicate any canal lesions or any extruded disk fragments, nor is the patient having clinical symptoms at the time leading up to the injury on 11/30/2017…I would like to proceed with a ___ standing MRI scan including flexion, extension studies to help resolve the issue of canal-encroaching lesion at L4-5 which is the central issue here and to which I find no reference from information provided to me." Dr. Wingate felt that the lifting on November 30, 2017 was "causally related to the work-derived injury…" (PX 5)

Petitioner underwent an EMG/NCV study on September 12, 2018. The study was deemed abnormal demonstrating evidence of a bilateral L5 lumbar spine radiculopathy. There was no evidence of a distal right or left lower extremity peripheral neuropathy. (PX 5)

Petitioner returned to ION on November 6, 2018 where he was seen by Dr. Kevin Koutsky for an orthopedic evaluation. The doctor recorded Petitioner's complaints of lower back pain that radiated down both lower extremities, right more than left. Petitioner reported that his symptoms began on November 30, 2017 after lifting motors, actuators and digging equipment which weighed between 75 and 200 pounds. Dr. Koutsky performed a physical examination and reviewed the MRI and EMG studies. He noted the MRI revealed a large right paracentral disk extrusion with cranial migration. Also noted was that the EMG revealed bilateral L5 radiculopathy with no evidence of any peripheral neuropathy. Dr. Koutsky felt Petitioner had a right L4-5 disk extrusion after sustaining a work-related injury on November 30, 2017. The doctor recommended a lumbar decompression. (PX 5)

Mr. Adrian Ortiz was called to testify on behalf of Respondent. Mr. Ortiz testified that he had been employed by Respondent as a Senior Staffing Manager for 1 ½ years prior to the hearing. Mr. Ortiz testified that as a Senior Staffing Manager, he was familiar with the procedures that take place when an employee of Respondent reports that he had a work-related injury on assignment at a client location. Specifically, Mr. Ortiz testified that after Respondent is notified of a work injury by either the employee or borrowing employer, Respondent then interviews the employee about the nature of the injury and whether the employee wants/needs to seek immediate medical treatment, and if the employee does not, then the employee is asked to come into the office to fill out and file an injury report. Mr. Ortiz testified that when the employee comes into the office to fill out the employer's injury report, Mr. Ortiz gathers as much information as possible from the employee for his report, and then also instructs the employee to fill out his own report using the same internal computer system. Mr. Ortiz testified that thereafter, the employee is scheduled for a medical evaluation and drug screening. Mr. Ortiz testified that after all of the initial investigation reports are prepared and completed, Respondent then maintains a file containing all of the reports that were completed during that investigation process.

Mr. Ortiz testified that prior to the hearing, he personally reviewed all of the investigation reports and documents in Petitioner's file that was prepared after Petitioner reported he sustained an injury while working for Respondent. Mr. Ortiz testified that based upon his personal review of that file, Petitioner called the branch office on December 7, 2017 to inquire about why his assignment had ended with DHL Supply Chain at which time he was informed that he had been terminated from his employment position due to poor performance related issues. Mr. Ortiz testified that after Petitioner was informed that he had been terminated for poor performance related issues, Petitioner then alleged that he had sustained a work-related injury on November 30, 2017. Mr. Ortiz further testified that investigation report specifically documented that during that telephone

conversation on December 7, 2017, Petitioner initially reported that he had bumped his head on November 30, 2017 and then subsequently reported that his back started to hurt on November 30, 2017.

Mr. Ortiz testified that there was no documentation that Petitioner reported a work injury to anyone on November 30, 2017. Mr. Ortiz testified that based upon his review of the supervisor's report, Petitioner was observed on November 30, 2017 holding his back and was subsequently questioned by the supervisor. Mr. Ortiz testified that the supervisor's report did not document that Petitioner reported a work-related incident or injury at that time.

Petitioner testified that he never complained or treated for a head injury. Petitioner testified that he did injure his back in 2015 for which he filed a workers' compensation claim (15 WC 23202). That matter ultimately settled on April 1, 2016. According to the settlement contract, the nature of the injury was "lumbar sprain/strain with facet pain and dysfunction." Medical records submitted show Petitioner received facet joint injections on June 25, 2015 and July 23, 2015. He was released to return to full duty work without restrictions on August 21, 2015. (PX 3)

Petitioner testified that he continues to experience lower back pain. Petitioner stated the pain "doesn't allow me to do the normal things that I would do on a daily basis." Petitioner provided that he has difficulty standing for long periods. He no longer jogs, household chores can be difficult and he has trouble sleeping at night. Petitioner related that he experiences radiating pain down his leg. He rated his pain level at 6/10 or 7/10 depending on activity. Petitioner also testified that he has not worked since the accident. He has looked for work, but the only job that called him back violated his restrictions set by his doctor.

In support of the Arbitrator's decision regarding C.) Whether an accident occurred that arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds as follows:

Petitioner testified that he was tasked with locating inventory material that could not be found throughout the warehouse, driving a forklift to take incoming materials from the receiving dock to racked space or to their locations. Petitioner explained that while racking (putting it away), he had to manually lift the materials. Petitioner testified that November 30, 2017 was a particularly busy day. Petitioner testified that he was tasked with racking drill bits. He had to lift the drill bits, bend underneath racks and transfer the materials into three or four-foot crates. Petitioner provided that the bending placed him in awkward positions and the materials could weigh between 15 to 20 pounds. Petitioner testified that while performing this function, he began to experience lower back pain. Petitioner stated, "it was really taxing on my back; and toward the end of the night, I felt it got to be excruciating." Petitioner testified that because his immediate supervisor had already left for the day, he informed "Ricky" who was the highest-ranking manager that evening. Petitioner stated that "Ricky" instructed him to write out an injury statement on a blank sheet of paper and sign it. The Arbitrator notes that "Ricky" was not called to testify.

Petitioner testified that he returned to work the following day, December 1, 2017. Petitioner testified that he informed his immediate supervisor, that "...yesterday evening was kind of taxing. I hurt myself, so I'm going to be taking it easy today." Petitioner testified that his supervisor responded "okay, just keep me posted." Petitioner testified that he was not asked to fill out any official paperwork nor was he offered any medical attention.

Petitioner's account of the events is consistent with his representations to the medical professionals who treated him in this matter. On December 7, 2017, Petitioner presented to Dr. Murtaza and reported that he developed low back pain with radiating pain to the right lower extremity while doing heavy lifting at work. On December 13, 2017, Petitioner saw Dr. Bialon-Wnek at Bone & Joint Clinic. At that time, Dr. Bialin-Wnek wrote, "[Petitioner] was involved in a work-related incident on Thursday, November 30, 2017. At the time of

the incident, Mr. Edwards was working for Randstad. Mr. Edwards works as a forklift operator and was moving heavy load from one destination to another. Once the item got to the other destination it is his job to lift and adjust the product to place on shelves. After doing this all shift he began to feel a pain in his back which radiated down the right leg." Petitioner reported that he immediately reported the incident to his operations supervisor who did not send him to a doctor. On March 1, 2018, Petitioner saw Dr. Krishna Chunduri. According to Dr. Chunduri, Petitioner reported that his symptoms started as a result of a work injury that occurred on 11/30/2017. Dr. Chunduri wrote, "[o]n the day of the injury he works as a forklift operator. He is transporting and moving motors that weigh up to 80-90 pounds and he states after he moves them, he has to place the motors on shelves and he has to lift them manually in a bent over position, lifting up, placing them and adjusting them. These are all 80-90 pounds or greater. He states as a result of this, he notices the pain in his lower back..." On August 17, 2018, Petitioner presented to Dr. Jeffrey K. Wingate for a surgical consultation. Dr. Wingate documented that Petitioner conveyed that on November 20, 2017, he experienced increasing low back pain after a particularly heavy day of bending and twisting in a confined space. Lastly, Petitioner saw Dr. Kevin Koutsky for an orthopedic evaluation on November 6, 2018. The doctor recorded Petitioner's symptoms began on November 30, 2017 after lifting motors, actuators and digging equipment.

Respondent suggests Petitioner designed that he sustained an injury only after he was terminated. Respondent presented the testimony of Mr. Adrian Ortiz, Respondent's Senior Manager, to support its position. According to Mr. Ortiz, he reviewed investigative materials and documents related to this claim. Mr. Ortiz indicated the materials show Petitioner called the branch office on December 7, 2017 to inquire as to why his assignment ended with DHL Supply Chain. At that time, Petitioner was informed that he had been terminated from his employment position due to poor performance related issues. Mr. Ortiz testified Petitioner then conveyed that he had sustained a work-related injury on November 30, 2017, reporting that he bumped his head and that his back started hurting on November 30, 2017. Mr. Ortiz also testified that based upon his review of the supervisor's report, Petitioner was observed on November 30, 2017 holding his back and was subsequently questioned by the supervisor. Mr. Ortiz testified that the supervisor's report did not document that Petitioner specifically reported a work-related incident or injury at that time. The Arbitrator notes that the supervisor's report was not introduced at trial. The Arbitrator further notes Petitioner's testimony that he never complained or treated for a head injury. His testimony is buttressed by the medical documentation that does not reference any complaint or treatment for a head injury.

Relying on Petitioner's credible testimony, the consistent medical records, and Mr. Ortiz's testimony that Petitioner was observed on November 30, 2017 holding his back, the Arbitrator finds that Petitioner sustained an accident that arose out of and in the course of his employment with Respondent on November 30, 2017.

In support of the Arbitrator's decision regarding F.) Whether the Petitioner's current condition of ill-being is causally related to a work injury, the Arbitrator finds as follows:

The Arbitrator finds that Petitioner established a causal connection between the onset of pain in his lower back to the bending and lifting heavy items and an awkward position. Petitioner credibly testified that prior to the accident he was not experiencing any back pain. It is undisputed that Petitioner suffered a previous back injury in 2015. Medical records show Petitioner was treated for diagnoses of facet syndrome and lumbar spondylosis. He received two injections and was released to full duty without any restrictions on October 15, 2015.

Subsequent to the present accident, Petitioner primarily treated with physicians at Illinois Orthopedic Network. On December 7, 2017, Petitioner saw Dr. Murtaza. Petitioner testified that between November 30 and December 7, 2017, he attempted soaking, stretching, and taking ibuprofen. He indicated the pain would not abate. Petitioner presented to Dr. Murtaza and reported that he developed low back pain with radiating pain to

the right lower extremity while doing heavy lifting at work. Dr. Murtaza noted that his clinic had treated Petitioner for a low back injury two years prior for which Petitioner underwent two epidural steroid injections. The doctor noted that Petitioner "...had no___ after that." After obtaining an MRI, which demonstrated a diffuse disk bulge and large right paracentral/lateral-recess extrusion measuring 8-9 mm thick and extruded 17 mm cranially at L4-5, Dr. Murtaza diagnosed Petitioner with a large disk herniation. Petitioner next saw Dr. Chunduri with complaints of low back pain and right leg numbness, tingling, weakness down to his foot. In addition to recording a history of accident, the doctor also noted that Petitioner reported a prior facet joint injury in 2015 which had been treated and subsequently resolved. The doctor noted that Petitioner "...is now here with what appears to be a different problem." After performing an examination and reviewing the previously taken MRI, Dr. Chunduri felt Petitioner was "...suffering from a large disk herniation with extrusion that is resulting in his current symptoms, which is the result of the severe nerve compression." The doctor stated that Petitioner's symptoms were "...a very different injury compared to his 2015 injury, which was a facet sprain. It does appear to me this is a new injury as the result of his current injury..." Dr. Chunduri treated Petitioner conservatively with injections, medication and physical therapy referrals. By March 22, 2018, Dr. Chunduri reported that Petitioner's symptoms continued indicating his pain waxed and waned, depending on activity. Ultimately, Dr. Chunduri recommended a spine surgery evaluation.

Petitioner presented to Dr. Wingate for a surgical consultation on August 17, 2018. Dr. Wingate documented that Petitioner experienced increasing low back pain after a particularly heavy day of bending and twisting in a confined space on November 30, 2017. The doctor also noted that Petitioner had a self-limited episode of low back pain in 2015 which was treated conservatively and "...completely putting all of his back pain behind him and returning to full employment status." Dr. Wingate reviewed the December 2017 MRI scan feeling same demonstrated a very large right paracentral extrusion of disk material that had migrated cephalad up under the right L4 pedicle. After performing an examination, Dr. Wingate's impression was right L4-5 extruded HNP with radiculopathy. Dr. Wingate felt that the "..single best option for [Petitioner was] a hemilaminectomy with discectomy and decompression of the neural elements." Dr. Wingate felt that the lifting on November 30, 2017 was "causally related to the work-derived injury..."

Petitioner returned to ION on November 6, 2018 where he was seen by Dr. Kevin Koutsky for an orthopedic evaluation. The doctor recorded Petitioner's complaints of lower back pain that radiated down both lower extremities, right more than left. Petitioner reported that his symptoms began on November 30, 2017 after lifting motors, actuators and digging equipment. Dr. Koutsky reviewed the MRI and a subsequent EMG study. He noted the MRI revealed a large right paracentral disk extrusion with cranial migration. Also noted was that the EMG revealed bilateral L5 radiculopathy with no evidence of any peripheral neuropathy. Dr. Koutsky felt Petitioner had a right L4-5 disk extrusion after sustaining a work-related injury on November 30, 2017. The doctor recommended a lumbar decompression.

At Respondent's request, Petitioner underwent a Section 12 examination with Dr. Avi Bernstein on May 7, 2018. Dr. Bernstein reviewed Petitioner's medical records through January 16, 2018. The doctor reviewed the December 12, 2017 MRI and a CT scan report dated May 19, 2015. Dr. Bernstein provided the MRI scan was of poor quality but nevertheless demonstrated degenerative changes from L4-S1. The doctor indicated he was unable to identify a distinct disc herniation in the lumbar spine or evidence of nerve root compression. He noted the report described an extruded right lateral disc herniation, but he felt same was an artifact. Dr. Bernstein also noted that he reviewed a CT scan report dated May 19, 2015. The doctor stated the report described facet arthrosis at L4-5 with a moderate diffused disc bulge. Endplate spurs were also identified on the right side. Dr. Bernstein assessed continued right-sided low back pain and radiating leg pain of unclear etiology. The doctor stated "[Petitioner] has a degenerative condition of the lumbar spine from L4-S1 and he has a pre-existing history of low back pain and right-sided radiating leg pain for which he was treated in 2015." The doctor opined that it was possible Petitioner suffered an aggravation of his degenerative condition as a result of the work incident. The doctor stated Petitioner had improvement in his condition "to a 1/10 level" by mid-January which

strongly supported his position that Petitioner had a temporary duration. Dr. Bernstein opined that Petitioner was at maximum medical improvement and required no further therapeutic modalities or diagnostic workups. He felt Petitioner could return to work full duty work as a forklift driver.

The Arbitrator notes that at the hearing, Respondent raised an evidentiary objection to the submission of the medical reports contained within Petitioner's Exhibit 5 namely the notes authored by Dr. Wingate on August 17, 2018. Respondent contended the medical report of said physician was made for the purposes of litigation, and as such, the medical report is hearsay and not admissible. The Arbitrator overruled Respondent's objection but reserved the right to change said ruling after reviewing the totality of the records. After reviewing the records, the Arbitrator stands by the initial ruling. In doing so, the Arbitrator notes the records demonstrate that on March 22, 2018, Dr. Chunduri recommended a repeat injection noting that if same did not provide further improvement, a surgical evaluation was likely. Prior to undergoing the recommended repeat injection Respondent procured a Section 12 examination with Dr. Bernstein which took place on May 7, 2018. As noted above, Dr. Bernstein expressed his opinion regarding the MRI scan findings as well as his opinion regarding Petitioner's diagnosis and his ability to return to work. Subsequent to the Section 12 examination, Dr. Chunduri performed the repeat injection, on May 10, 2018, which provided no lasting relief. Thereafter, Dr. Chunduri specifically recommended a spine surgery evaluation. Petitioner then presented to Dr. Wingate for the recommended surgical consultation on August 17, 2018. In his notes dated same, Dr. Wingate not only documents Petitioner's history, his review of diagnostics, examination findings, and ultimate conclusions, the doctor also references his disagreements with the diagnostic interpretations and opinions of Dr. Bernstein. Dr. Wingate's notes and/or comments do not appear to be prompted or elicited from an outside source, i.e. narrative request, but was noted to support his treatment recommendation.

Based on all the above, the Arbitrator finds that a causal relationship exists between Petitioner's present condition of ill-being and the accident sustained on November 30, 2017. The Arbitrator is persuaded by the opinions of Petitioner's treating physicians over those of Dr. Bernstein. The Arbitrator notes that notwithstanding the Arbitrator ruling on Dr. Wingate's notes, the remaining records are sufficient enough to find in favor of Petitioner.

In support of the Arbitrator's decision regarding J.) Whether the medical services that were provided to Petitioner reasonable and necessary. Has Respondent paid all appropriate charges for all reasonable and necessary medical services; and K.) Is Petitioner entitled to any prospective medical care, the Arbitrator finds as follows:

Petitioner submitted the following medical bills into evidence:

Illinois Orthopedic Network:	$16,846.73
Il bone & Joint:	$8,360.71
Midwest Specialty Pharmacy:	$2,330.90
Preferred Open MRI	$1,500
Midwest Ann.	$2,159.69

Having found the requisite causal relationship, the Arbitrator finds that Respondent shall pay the above referenced reasonable and necessary medical bills in the amount of $31,198.03, as provided in sections 8(a) and 8.2 of the Act.

With respect to prospective medical care, Dr. Wingate diagnosed right L4-5 extruded HNP with radiculopathy. Dr. Wingate felt that the "...single best option for [Petitioner was] a hemilaminectomy with discectomy and decompression of the neural elements." The doctor noted that he had not seen an EMG study but speculated same would likely be positive and would nevertheless change the findings on the MRI scan.

Thereafter, an EMG/NCV study was completed and was deemed abnormal demonstrating evidence of a bilateral L5 lumbar spine radiculopathy. Petitioner next saw Dr. Koutsky for an orthopedic evaluation. The doctor reviewed the MRI and EMG studies. He noted the MRI revealed a large right paracentral disk extrusion with cranial migration. Also noted was that the EMG revealed bilateral L5 radiculopathy with no evidence of any peripheral neuropathy. Dr. Koutsky felt Petitioner had a right L4-5 disk extrusion and recommended a lumbar decompression.

Based on the above, the Arbitrator finds that Respondent shall authorize and pay for the surgical recommendation as prescribed.

In support of the Arbitrator's decision regarding L.) What temporary benefits (TTD) are in dispute, the Arbitrator finds as follows:

Records submitted show the initial authorization for an off-work status was prescribed by Dr. Mutaza on December 7, 2017. Petitioner has been kept off work since that time by his treating physicians. As noted in paragraph F.), the Arbitrator is not persuaded by Dr. Bernstein opinion and relies on the opinions of his treating physicians.

Based upon the evidence presented, Arbitrator finds that Petitioner is entitled to temporary total disability for the period of December 7, 2017 through January 3, 2019, a period of 56-1/7

In support of the Arbitrator's decision regarding M.) Should penalties or fees should be imposed upon Respondent, the Arbitrator finds as follows:

Respondent's accident dispute was not unreasonable. As such, Petitioner's request for penalties and fees are denied.

In support of the Arbitrator's decision regarding O.) Chain of referrals under Section 8(a) of the Act, the Arbitrator finds as follows:

The Arbitrator finds that all treatment rendered was carried out by multiple physicians at Illinois Orthopedic Network. All of the physical therapy sessions were prescribed by his treating physicians. As such the Arbitrator finds Petitioner did not exceed his choice of doctors with the confines of Section 8(a) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Cherry Bell,
Petitioner,

vs. No: 17 WC 02772

Automobile Club of Southern California,
Respondent.

ORDER

This cause comes before the Commission on Respondent's Motion to Dismiss Petitioner's Petition for Review of the Arbitration Decision. A hearing was held before Commissioner Marc Parker in Collinsville, IL, on November 12, 2019. Both parties were present, and a record of the hearing was taken.

Petitioner's underlying claim was tried before an Arbitrator at the Commission on October 26, 2017, and on December 4, 2017, proofs were closed. On February 25, 2019, the Arbitrator issued his decision. On March 26, 2019, Petitioner filed a pro-se Petition for Review. On that date, Petitioner also filed a Notice of Motion for a hearing to have her fees waived as a poor person under Section 20, along with a document setting forth her reasons. At the time of that filing, no hearing date was requested. For reasons unknown, the Commission's mainframe computer did not reflect that Petitioner had filed a Section 20 Petition.

On August 2, 2019, the pro-se Petitioner appeared before an Arbitrator sitting at the Collinsville Commission and presented her Section 20 Petition. That Arbitrator signed an order purporting to grant the Petition to allow Petitioner's fees to be waived. On September 27, 2019, Respondent filed its Motion to Dismiss Petitioner's Petition for Review.

The Commission finds that Petitioner's Section 20 Petition was timely filed on March 26, 2019, and that it effectively tolled the deadline for perfecting her Petition for Review of the Arbitration Decision; and specifically, Petitioner's deadline to file an agreed statement of the facts or transcript of evidence in connection with her Petition for Review. The Commission also finds that the Arbitrator who signed the August 2, 2019 order purportedly granting Petitioner's Section

20 Petition, was without jurisdiction to do so. Accordingly, the Commission finds that August 2, 2019 order void, and that Petitioner's Section 20 Petition remains pending.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent's Motion to Dismiss Petitioner's Petition for Review is hereby denied.

IT IS FURTHER ORDERED BY THE COMMISSION that the Arbitrator's August 2, 2019 order granting Petitioner's Section 20 Petition, is hereby vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's Section 20 Petition filed March 26, 2019 is hereby set for hearing before Commissioner Marc Parker at the Workers' Compensation Commission, Collinsville, IL, at 10:30 am on January 28, 2020.

DATED: JAN 7 - 2020

Marc Parker

r-11/12/19
mp/mcp
68

Deborah L. Simpson

Barbara N. Flores

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Ramon Gonzalez,

Petitioner,

vs. No. 08 WC 42208

Jorge Gonzalez and Lucia Gonzalez d/b/a
Grasshoppers Lawn Maintenance,

Respondents.

ORDER

This matter comes before the Commission on Petitioner's petition for penalties and attorney fees, with proper notice given. Having carefully considered the entire record, the Commission finds and orders as follows:

On April 16, 2014, an Arbitrator approved a settlement contract in this matter, which provides in pertinent part that Respondents would pay, pursuant to the fee schedule, certain medical bills. On February 19, 2016, Petitioner filed a petition for penalties and attorney fees alleging that Respondents failed to pay outstanding medical bills in the sum of $13,507.21[1] from Franciscan/St. James health system. The matter was continued while Respondents were making installment payments on the outstanding medical bills. However, Respondents stopped paying the installments in February of 2019.

On September 12, 2019, Commissioner Stephen Mathis held a hearing on the petition. Petitioner appeared through counsel. Respondents did not appear despite receiving notice of the hearing. At the time of the hearing, the outstanding amount was $5,508.63, the last payment having been made on January 25, 2019.

The Commission finds Respondents liable to pay to Petitioner section 19(k) penalties of $2,754.32, section 19(l) penalties of $6,930.00 (from January 25 through September 12, 2019) and section 16 attorney fees of $550.86.

IT IS THEREFORE ORDERED BY THE COMMISSION that the petition for penalties and attorney fees is granted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondents shall pay to

[1] Fee schedule amount.

Petitioner section 19(k) penalties of $2,754.32, section 19(l) penalties of $6,930.00 and section 16 attorney fees of $550.86.

Bond for the removal of this cause to the Circuit Court by Respondents is hereby fixed at the sum of $10,300.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JAN 10 2020
SM/sk
44

Stephen Mathis

Douglas McCarthy

L. Elizabeth Coppoletti

Collection

ILLINOIS WORKERS' COMPENSATION COMMISSION

Illinois Workers' Compensation Commission, Insurance Compliance Division,	)	
Petitioner,	)	No. 16 INC 67
		18WC028055
v.	)	
Grand Medical Clinic, Inc.,	)	
Respondent.	)	

ORDER

This matter, after oral request by the Petitioner, The Illinois Workers' Compensation Commission – Insurance Compliance Division, by and through its attorney, the Office of the Illinois Attorney General, is dismissed. The Office of the Attorney General has advised this Commission it no longer seeks to proceed in this matter against Respondents.

S J Mathis

Commissioner Stephen Mathis

JAN 10 2020

Dated: 9-12-19

ILLINOIS WORKERS' COMPENSATION COMMISSION

Illinois Workers' Compensation Commission, Insurance Compliance Division,	)	
Petitioner,	)	No. 08 INC 420
	)	19WC020213
v.	)	
JEM Traffic Control Services,	)	
Respondent.	)	

ORDER

This matter, after oral request by the Petitioner, The Illinois Workers' Compensation Commission – Insurance Compliance Division, by and through its attorney, the Office of the Illinois Attorney General, is dismissed. The Office of the Attorney General has advised this Commission it no longer seeks to proceed in this matter against Respondents.

Commissioner Mathis

JAN 10 2020

Dated: 12/19/19

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

DEC 19 2019

By: Stephen J. Mathis, Commissioner

12 WC 013080

Before the Illinois Workers' Compensation Commission

Page 1

STATE OF ILLINOIS)SS.

COUNTY OF JEFFERSON

GALE MATHUS, as Grandfather and next Friend of AUSTIN MICHAEL INZERMA, a minor,

Petitioner,

v.

CONTINENTAL TIRE,

Respondent.

12 WC 013080

ORDER

On March 14, 2018 an Arbitration Decision was filed in the above-entitled matter making an award of benefits under various sections of the Act. This matter comes before the Commission on the Motion to Substitute Representative Petitioner which was filed during pendency of the Petition for Review filed by Respondent.

David Mathus, now deceased, suffered grievous injuries in a work-related accident that occurred on December 23, 2010. On April 14, 2012 the original Application for Adjustment of Claim was filed bearing the signature of David Mathus. David Mathus died on December 20, 2014 of causes unrelated to his injuries. David Mathus is survived by his minor son, Austin Michael Izerma, date of birth March 14, 2007.

At hearing, Petitioner presented documentary evidence which established that David Mathus was Austin's biological father and a copy of the Uniform Order of Support entered in the Circuit Court of the Second Judicial District Circuit, Jefferson County reflecting decedent's child support obligation in the amount of $434.00 per month. The order references Evelyn Izerma as Austin Michael Izerma's legal representative.

An Amended Application for Adjustment of Claim was filed on February 15, 2017 by Gale Mathus, the father of decedent, captioned:

Gale Mathus, as Grandfather and Next Best Friend of Austin Michael Izerma, a minor,

Petitioner,

v. 12 WC 013080

Continental Tires/ The Americas, LLC.

Respondent.

The Amended Application was signed by Gale Mathus. The attorney of record was Brian T. Morrow. The filing was not accompanied by any documentation identifying Gale Mathus as the duly appointed legal guardian of Austin Michael Izerma the minor, who was the lineal heir of decedent, David Mathus.

The matter proceeded to hearing on June 8, 2017 before Arbitrator Hemenway. No evidence was elicited at hearing regarding the guardianship of the minor or any legal authority vested in Gale Mathus to act on the minor's behalf. Further, there was no evidence that Petitioner's attorney, Mr. Morrow had been properly retained as counsel to represent the interests of the minor. No objection was ever raised by Respondent to the authority of Gale Mathus to represent the interests of the minor or the representation by Mr. Morrow nor was the issue raised by the Arbitrator.

Gale Mathus died during the pendency of review. On November 6, 2019 a motion was filed by attorney Brian T. Morrow to Substitute Representative Petitioner seeking to substitute Austin's grandmother, Elizabeth Mathus. The motion was not accompanied by any documentation demonstrating that Elizabeth Mathus was the duly appointed representative of Austin Michael Izerma.

IT IS THERFORE ORDERED BY THE COMMISSION that the matter is entered and continued generally pending presentation of evidence of proper appointment of a legal representative to retain counsel and represent the interests of the minor, AUSTIN MICHAEL IZERMA in the prosecution of this matter.

IT IS THERFORE ORDERED BY THE COMMISSION that the matter is entered and continued generally pending presentation of evidence of proper appointment of a legal representative to retain counsel and represent the interests of the minor, AUSTIN MICHAEL IZERMA in the prosecution of this matter.

Dated: DEC 3 1 2019

11/6/19
SJM/msb
44

Stephen J. Mathis

Douglas McCarthy

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION

Illinois Workers' Compensation Commission, Insurance Compliance Division, Petitioner, v. George Tompoe individually and as President of Super T. Plumbing, Inc. Respondent.	)	No. 15 INC 118

ORDER

Upon the oral request by the Petitioner, The Illinois Workers' Compensation Commission – Insurance Compliance Division, by and through its attorney, the Office of the Illinois Attorney General, this matter is dismissed. The Office of the Attorney General has advised this Commission it no longer seeks to proceed in this matter against Respondent.

DEC 1 0 2019

Commissioner Barbara Flores

Dated: JAN 7 - 2020

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

ERASMO SUAREZ,

Petitioner,

vs.

20IWCC0019

NO: 15 WC 33777

ARCH FLOORING CO. AND
ILLINOIS STATE TREASURER AS
EX-OFFICIO CUSTODIAN OF THE
INJURED WORKERS' BENEFIT FUND,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issue of nature and extent, and being advised of the facts and law, 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 initially notes that Respondent's Petition for Review also listed "Maintenance – Duration" as an issue on Review. However, maintenance benefits were never an issue in this case and Respondent's brief only argued the issue of nature and extent.

We hereby modify the Arbitrator's decision and find that Petitioner sustained permanent partial disability to the extent of 15% loss of use of the left thumb, which we analyze pursuant to §8.1b(b) of the Act as follows:

i) Neither party submitted an AMA Rating, so this is given no weight.

S01ACC0018

ii) Occupation: We agree with the Arbitrator's finding that "Petitioner's installer job with Respondent involved manual labor, as does his current job for a different flooring contractor. Petitioner credibly testified to having difficulty using his left thumb to grasp small items such as nails. Petitioner also testified to a lack of sensation in the tip of the thumb. His records show he lost the fat pad of the thumb secondary to the injury." *Dec. at 7.* We find that this factor deserves the greatest weight. Petitioner's testimony regarding the loss of sensation and difficulty grasping small items is credible and consistent with the medical records indicating that a portion of Petitioner's fat pad was gone.

iii) Age: We give this factor minimal weight. Although Petitioner could potentially remain in the workforce for another 35 to 40 years, we have already considered his difficulty manipulating small objects under the occupation factor above.

iv) Future Earning Capacity: Petitioner eventually returned to work full duty in the same occupation as a flooring installer but for a different employer. Although he testified that he now earns "around half" of what he previously earned, there is no evidence that this loss of income is related to his injury. The Commission, therefore, gives this factor no weight since there is no evidence that Petitioner's injury has caused a diminution of his future earning capacity.

v) Evidence of Disability Corroborated by the Treating Records: The Commission gives this factor some weight but notes that the partial loss of the fat pad on Petitioner's left thumb was already considered and given weight under the "occupation" factor. Petitioner never followed up with a physician after the emergency room visit so there are no medical records to corroborate Petitioner's current complaints and there is no medical evidence of any nerve damage caused by the laceration. However, we find that his testimony is consistent with the partial loss of the fat pad.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $600.00 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.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $540.00 per week for a period of 11.4 weeks, as provided in §8(e)1 of the Act, for the reason that the injuries sustained caused the loss of use of 15% of Petitioner's left thumb.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $2,577.00 for medical expenses under §8(a) of the Act.

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

SOINCC0018

20IWCC0019

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

The Illinois State Treasurer as *ex-officio* custodian of the Injured Workers' Benefit Fund was named as a co-Respondent in this matter. The Treasurer was represented by the Illinois Attorney General. This award is hereby entered against the Fund to the extent permitted and allowed under §4(d) of the Act, in the event of the failure of Respondent-Employer to pay the benefits due and owing the Petitioner. Respondent-Employer shall reimburse the Injured Workers' Benefit Fund for any compensation obligations of Respondent-Employer that are paid to the Petitioner from the Injured Workers' Benefit Fund.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $11,000.00. 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: JAN 10 2020

Maria Elena Portela

Maria E. Portela

Kathryn A. Doerries

Kathryn A. Doerries

SE/
O: 12/10/19
49

DISSENT

I believe the Arbitrator's award of 25% loss of use of the left thumb pursuant to §8(e)1 was entirely justified under the circumstances.

The record shows that on the date of the accident Petitioner suffered a soft tissue amputation of his left thumb while using a table saw and working for an uninsured employer. Lake Zurich paramedics arrived and noted a 1" laceration to the mid thumb, down to the bone. Mr. Suarez was taken to the Advocate Good Shepherd Hospital Emergency Department where it was noted that he sustained an avulsion type wound of the thumb pad with some tissue loss, specifically of the fat pad. Mild debridement of the necrotic skin was performed and the wound was closed, at which time sagging of the volar pad was noted due to loss of the subcutaneous tissues. Petitioner was advised to see orthopedic surgeon Dr. Mo, given the complexity of the laceration. However, he indicated that he did not seek follow-up care thereafter.

Petitioner attempted to return to work for Respondent but, not surprisingly, was told by his supervisor he was not needed anymore. He never returned to work for Respondent. He indicated that he worked light duty for a friend for about three months before obtaining full duty work for another employer earning half the salary that he was making while working for Respondent.

SOIMCC0018

20IWCC0019

Currently, Petitioner testified that he lacks sensitivity in the tip of his left thumb and that he cannot control the thumb the way he could before the accident. He noted the thumb feels weak and that it is difficult for him to grasp small objects. In addition, he indicated that when he uses a hammer he cannot use his left thumb to grip the nail and that he has to position the nail between his left index and middle fingers. He also stated his left thumb feels numb when it is cold outside and that he experiences cramping when he tries to grip something. Petitioner is right handed.

Furthermore, the Arbitrator viewed the injured appendage, which we did not, and noted "... the lack of a fat pad and a horizontal, suture-related scar on the tip of the left thumb" as well as the fact that "[t]he tip of the left thumb was noticeably thinner than the tip of the right thumb." (Arb.Dec., p.3). The Arbitrator also found Petitioner to be very credible and his account of the injury consistent with the records. (Id., p.4).

Based on the above, particularly the impact this injury has had on Petitioner's occupation and future earning capacity as a manual laborer, not to mention his young age and his credible complaints of diminished sensation and grip strength, I believe the Arbitrator's award of 25% loss of use of the left thumb was more than warranted.

Therefore, I respectfully dissent.

Thomas J. Tyrrell

S0IACC007 8

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SUAREZ, ERASMO
Employee/Petitioner

Case# **15WC033777**

ARCH FLOORING COMPANY AND THE ILLINOIS INJURED WORKERS' BENEFIT FUND
Employer/Respondent

20IWCC0019

On 6/26/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.03% 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:

1922 STEVEN B SALK & ASSOC LTD
FRANK I GAUGHAN
150 N WACKER DR SUITE 2570
CHICAGO, IL 60606

0000 ARCH FLOORING COMPANY
3420 W IRVING PARK RD
CHICAGO, IL 60618

0000 ARCH FLOORING COMPANY
3366 N KEDZIE AVE
CHICAGO, IL 60618

0000 ASSISTANT ATTORNEY GENERAL
NDUBUISI VINCENT OBAH
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

SOIACC0013

20IWCC0019

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

Erasmo Suarez
Employee/Petitioner

Case # **15** WC **33777**

v.

Consolidated cases: **D/N/A**

Arch Flooring Company and the Illinois Injured Workers' Benefit Fund
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Molly Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **June 11 and 18, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **4/1/2015**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did*** 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 left thumb condition of ill-being ***is*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**46,800.00**; the average weekly wage was $**900.00**.

On the date of accident, Petitioner was **28** years of age, ***single*** with **1** dependent child.

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

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

Respondent shall be given a credit of $**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

Medical benefits

Respondent shall pay reasonable and necessary medical services of $2,577.00, as provided in Sections 8(a) and 8.2 of the Act. PX 2-3.

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $600.00/week for 3 4/7 weeks, commencing 4/2/2015 through 4/26/2015, as provided in Section 8(b) of the Act.

Permanent Partial Disability: Schedule injury (For injuries before 9/1/11)

Respondent shall pay Petitioner permanent partial disability benefits of $540/week for 19 weeks, because the injuries sustained caused the 25% loss of the left thumb, as provided in Section 8(e)(l) of the Act.

Injured Workers' Benefit Fund

The Illinois State Treasurer, ex-officio custodian of the Injured Workers' Benefit Fund, was named as a co-respondent in this matter. The Treasurer was represented by the Illinois Attorney General. .This award is hereby entered against the Fund to the extent permitted and allowed under Section 4(d) of this Act. In the event the Respondent/Employer/Owner/Officer fails to pay the benefits, the Injured Workers' Benefit Fund has the right to recover the benefits paid due and owing the Petitioner pursuant to Section 5(b) and 4(d) of this Act. Respondent/Employer/Owner/Officer shall reimburse the Injured Workers' Benefit Fund for any compensation obligations of Respondent/Employer/Owner/Officer that are paid to the Petitioner from the Injured Workers' Benefit Fund.

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

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

Molly C Mason

Signature of Arbitrator

6/26/19
Date

JUN 26 2019

SOIMC0018

Erasmo Suarez v. Arch Flooring Company and
Illinois State Treasurer as ex officio custodian of the
Injured Workers' Benefit Fund
15 WC 33777

Summary of Disputed Issues

Petitioner claims he began working as an installer for Respondent Arch Flooring Company about 2 or 2 ½ years before his claimed accident. He testified his job involved using electrical saws to cut wood. He lacerated his left thumb while using a saw on April 1, 2015. He testified that Daniel, Respondent's owner, was at the jobsite where the injury occurred and came to his aid immediately afterward.

Petitioner was transported via ambulance to an Emergency Room shortly after the accident. He underwent X-rays and closure of the wound. The Emergency Room physician noted the loss of the fat pad from the thumb. He recommended that Petitioner seek follow-up care with an orthopedic surgeon but Petitioner did not do so. Petitioner attempted to return to work for Arch Flooring but was not taken back. He testified he was off work through April 26, 2015 and began performing light duty for a friend on April 27, 2015. He eventually returned to full duty, albeit at a significantly reduced rate of pay.

All issues other than penalties and fees are in dispute.

Arbitrator's Findings Concerning Notice of Hearing and Insurance Coverage

Petitioner filed his original Application for Adjustment of Claim, naming Arch Flooring Company as Respondent, on October 21, 2015. Petitioner subsequently amended the Application to name the Injured Workers' Benefit Fund [hereafter "the Fund"] as an additional Respondent. At no time did Respondent Arch Flooring Company file an appearance.

In March 2019, the Arbitrator set a trial date of June 11, 2019, with Petitioner's counsel and counsel for the Fund agreeing to this setting. The hearing began at 10::30 AM on June 11th. At no time between 8:30 AM and 10:30 AM did any individual purporting to represent Arch Flooring Company check in with the Arbitrator. During the hearing, counsel for Petitioner and the Fund denied having any prior contact with anyone purporting to represent Arch Flooring Company. Petitioner's counsel offered into evidence, with no objection from the Fund, copies of a letter he sent to Arch Flooring Company (using two different Chicago addresses and one Wilmette address) on March 15, 2019. In the letter, he advised Arch Flooring Company of the hearing scheduled for 9:00 AM on June 11, 2019. He sent each letter via regular and certified mail. He indicated he obtained the Chicago addresses from Petitioner. All three envelopes are marked "return to sender." Two indicate the addressee was unknown and left no forwarding information. PX 4A-B. The third reflects the mailing was unclaimed. PX 4C.

Based on the foregoing, the Arbitrator finds that Petitioner made an adequate attempt to notify Arch Flooring Company of the hearing.

Petitioner also offered into evidence, with no objection from the Fund, a Certification dated March 7, 2019 signed by Roguens Loriston, an employee of NCCI. In this document, Loriston affirmed that NCCI's database showed no workers' compensation insurance coverage information for Arch Flooring Company, at an address on Kedzie in Chicago, as of April 1, 2015. PX 5. By agreement, the

parties re-opened proofs on June 18, 2019. On that date, Petitioner offered into evidence, with no objection from the Fund, a Certification dated January 21, 2016, signed by Lain Hines, an employee of NCCI. In this document, Hines affirmed that NCCI's database showed the cancellation of workers' compensation insurance coverage for Arch Flooring, at a location in Wilmette, Illinois, effective December 13, 2014. PX 6.

Based on PX 5 and PX 6, the Arbitrator finds that Respondent Arch Flooring Company lacked workers' compensation coverage as of Petitioner's alleged injury on April 1, 2015.

Arbitrator's Findings of Fact

Petitioner testified through a Spanish-speaking interpreter.

Petitioner testified he was born on April 13, 1986. As of April 1, 2015, he was single and had one dependent child. As of the hearing, that child was eleven years old.

Petitioner testified he began working for Respondent Arch Flooring Company two or two and a half years before the accident of April 1, 2015. His job for Respondent involved installing wooden floors in apartments that were being renovated. He used two types of electrical circular saws to cut the wood that was used for the flooring. He used his hands to feed the pieces of wood into the saws.

Petitioner testified that Arch Flooring Company provided all of the tools and materials he used on the job.

Petitioner testified that, prior to the accident, he worked for Arch Flooring Company from Monday through Saturday. He was paid $150 per day. He received his weekly pay in cash each Saturday.

Petitioner testified he typically began his workday at 7:30 AM. Each morning he met his supervisor Daniel at a storage facility located at Kedzie and Belmont in Chicago. Arch Flooring Company stored its tools at this facility. Daniel would then give him a ride to the jobsite. Daniel supervised the work he did at the jobsites. Daniel was typically present at those sites. At the end of each workday, Daniel would drive him back to the storage facility and he would go home from there.

Petitioner testified he is right-handed. He denied injuring his left thumb before or after the accident of April 1, 2015.

Petitioner testified he worked at a jobsite in Barrington, Illinois, on April 1, 2015. At about 1:00 PM that day, he using a circular table saw to cut a piece of wood when he cut his left thumb. He felt pain and saw blood right after the accident. His co-worker, Juvenal, witnessed the accident. Daniel was present at the site and came to the scene within minutes of the accident. Daniel observed the condition of his left thumb. Daniel called 911.

Petitioner testified he was transported via ambulance to the Emergency Room at Advocate Good Shepherd Hospital shortly after the accident. At the hospital, he underwent X-rays. His wound was sutured and he was given medicine. The doctor recommended he seek follow-up care but he did not do so.

The certified Emergency Room records (PX 1) contain a seven-page report from the Lake Zurich Fire/Rescue Department. The report reflects that paramedics encountered Petitioner at a residence in Barrington, Illinois at about 2:33 PM on April 1, 2015. The report also reflects that Petitioner reported cutting his left thumb while using a table saw. The paramedics noted a 1-inch laceration to "mid thumb, down to the bone." They indicated there was no apparent alcohol or drug use. They provided wound care and administered pain medication. PX 1, pp. 9-11 of 64.

The Emergency Room records identified Arch Flooring Company as Petitioner's employer. PX 1, p. 3 of 64. The history reflects that Petitioner "was at work today, using a power saw and actually cut his left thumb." The examining physician, Robert Romolo, D.O., noted a "stellate avulsion laceration of the volar thumb paid of the left hand." He described the laceration as 3 centimeters long. Left thumb X-rays showed no foreign body or fracture. PX 1, pp. 33 and 51 of 64. Dr. Romolo explored the wound, noting that the fad pad was missing. He did not visualize bones or tendons. He debrided necrotic skin and "approximated the wound as best as possible." He noted "some sagging of the volar pad due to loss of the subcutaneous tissues." He noted "good motion" after closing the wound. Via a telephone interpreter, he advised Petitioner that the laceration was complex and that he should see Dr. Mo, an orthopedic surgeon, the following day. He provided Petitioner with Cephalexin, an antibiotic, and a prescription for pain medication. PX 1, pp. 7, 19, 31-33 and 41 of 64. He also provided Petitioner with written instruction sheets directing him to keep the wound "clean and dry" and change the dressing at least once a day. PX 1, p. 26 of 64.

Petitioner testified that Daniel drove him home from the Emergency Room on the day of the accident.

Petitioner testified he later contacted Daniel via telephone in an effort to return to work for Arch Flooring Company. Daniel told him he was not needed anymore. He never resumed working for Respondent.

Petitioner testified that, after the accident, he remained off work through April 26, 2015. On April 27, 2015, he began performing a light duty job for a friend. He continued performing light duty for about three months and was then able to resume full duty, albeit at about half the salary he earned at Arch Flooring Company.

Petitioner testified he lacks sensitivity in the tip of his left thumb. He cannot control the thumb the way he could before the accident. The thumb feels weak. It is difficult for him to grasp small objects. When he uses a hammer, he cannot use his left thumb to grip the nail. He has to position the nail between his left index and middle fingers. When it is cold outside, his left thumb feels numb. When he tries to grip something, using the thumb, he experiences cramping.

The Arbitrator viewed both of Petitioner's hands. She noted the lack of a fat pad and a horizontal, suture-related scar on the tip of the left thumb. The tip of the left thumb was noticeably thinner than the tip of the right thumb.

Under cross-examination, Petitioner testified he originally found Arch Flooring Company through friends. Daniel owned Arch Flooring Company. When he first met Daniel, he did not sign any contracts. He did not undergo any formal training before being sent out to jobsites but Daniel showed him how to use a table saw. He and Daniel communicated via telephone to set his work schedule. He typically worked from 7:30 AM to 5:00 PM. If Daniel did not have work available, he did not work, but

this happened "very little." During the two months preceding the accident, he worked Monday through Saturday each week. He did not use any of his own equipment or wear a uniform while working for Arch Flooring Company. He could not have any outside work with a different employer during the time he worked for Arch Flooring Company. After the accident, he initially informed his co-worker of his injury and then told Daniel. He did not complete any documents concerning the accident. He did not undergo any treatment other than the treatment he received at the Emergency Room. He does not have any documents memorializing the pay he received from Arch Flooring Company.

On redirect, Petitioner reiterated that Daniel called an ambulance after the accident and drove him home from the Emergency Room.

In addition to the exhibits previously described, Petitioner offered into evidence itemized bills from Advocate Good Shepherd Hospital (PX 2) and Tri-County Emergency Physician (PX 3) relating to the care he underwent on April 1, 2015. The Fund raised no objection to the bills.

The Fund did not call any witnesses or offer any documentary evidence.

Arbitrator's Credibility Assessment

Petitioner responded to questions in a calm, direct manner. The Arbitrator found him very credible. His account of his injury is consistent with the Fire Department and hospital records. PX 1.

Arbitrator's Conclusions of Law

On April 1, 2015, were Petitioner and Arch Flooring Company operating under the Act and was their relationship one of employee and employer?

The Arbitrator finds that, as of April 1, 2015, Petitioner and Arch Flooring Company were operating under the Act. Petitioner credibly testified he was injured on that date while using an electrically powered table saw to cut wood. His Emergency Room records document an injury related to table saw usage. This evidence establishes the automatic coverage afforded by Section 3(8) and (15) of the Act.

The Arbitrator further finds that Petitioner was an employee of Arch Flooring Company prior to and as of the accident of April 1, 2015. Petitioner credibly testified he found Arch Flooring Company through friends and worked as an installer for the company for two or two and a half years before the accident. Petitioner also credibly testified that Daniel, Arch Flooring Company's owner, set his hours and directed his work during this period. Petitioner indicated that Daniel provided rides to him each workday and was usually present at the jobsites. Petitioner also credibly testified that Arch Flooring Company provided all of the tools and materials he used at these sites. Under cross-examination, he denied being able to work for any additional employers during his tenure with Arch Flooring Company. He also denied signing any contracts when Daniel first hired him.

The Illinois courts have long held that it is the element of control, and specifically the right to control, that is most significant in determining whether an individual was an employee or independent contractor. Roberson v. Industrial Commission, 225 Ill.2d 159 (2007). In the instant case, Arch Flooring Company, via its owner, Daniel, controlled Petitioner's work to the extent of transporting him to and from a designated location each day, scheduling his hours, providing him with tools and materials and

directing his tasks. The Arbitrator finds credible Petitioner's testimony that Daniel was present at most of the sites where he worked and that he was not able to accept outside employment. The "nature of the work" test also supports a finding of employment. The installation work that Petitioner performed was in the nature of Arch Flooring Company's business. While Petitioner was paid in cash, the courts have given less weight to the "method of payment" factor than to the issues of control and "nature of the work."

The Arbitrator also notes that the Emergency Room records identify Arch Flooring Company as Petitioner's employer as of the accident. PX 1.

Did an accident occur that arose out of and in the course of Petitioner's employment by Arch Flooring Company? What is the date of the accident?

Petitioner credibly testified his accident occurred on April 1, 2015, while he was using a table saw to cut wood at a residential jobsite in Barrington, Illinois. Petitioner's testimony is completely consistent with the histories recorded by the paramedics and hospital workers who rendered care on April 1, 2015. PX 1. There is no suggestion that Petitioner injured his left thumb in a non-work setting.

The Arbitrator finds that the accident occurred on April 1, 2015 and that it arose out of and in the course of Petitioner's employment by Arch Flooring Company. Petitioner was performing a work-related task, i.e., cutting wood to be used in the flooring process, at the time of the accident. His injury took place at a residential jobsite during his regular work hours.

Did Petitioner provide timely notice of his accident to Arch Flooring Company?

The Arbitrator finds that Petitioner provided timely notice of his injury to Arch Flooring Company. Petitioner credibly testified he cut his left thumb in the presence of Juvenal, a co-worker. Petitioner also credibly testified that Daniel, Arch Flooring Company's owner, came to his aid and observed his left thumb within minutes of the accident. Petitioner indicated it was Daniel who dialed 911 and later gave him a ride home from the hospital.

Did Petitioner establish a causal connection between the accident of April 1, 2015 and his current left thumb condition of ill-being?

The Arbitrator finds in Petitioner's favor on the issue of causation. In so finding, the Arbitrator relies on the following: 1) Petitioner's credible denial of any pre-accident left thumb injuries; 2) Petitioner's credible account of the mechanism of injury; 3) the Fire Department and Emergency Room records (PX 1), which reflect Petitioner was injured while working; 4) Petitioner's credible denial of any post-accident re-injuries; 5) the viewing and comparison of the appearance of the left and right thumbs; and 6) Petitioner's credible testimony concerning his ongoing left thumb symptoms and limitations.

In finding causation as to Petitioner's current left thumb condition, the Arbitrator also notes that the Fund did not offer any medical evidence.

What were Petitioner's earnings?

Petitioner testified he typically worked from 7:30 AM to 5:00 PM, Monday through Saturday. He also testified that Arch Flooring Company paid him, in cash, at the rate of $150 per day. He indicated

he received his pay each Saturday. Under cross-examination, he acknowledged that Daniel did not always have work available for him during his tenure with Arch Flooring Company but indicated this was unusual. He testified he worked his usual schedule during the two months preceding the accident.

Petitioner did not offer any wage-related documents but the Arbitrator finds credible his testimony as to his schedule, rate of pay and method of payment. The Arbitrator relies on that testimony in finding that Petitioner's average weekly wage was $900.

What was Petitioner's age as of the accident? What was Petitioner's marital status as of the accident? Did he have any minor dependents?

Petitioner testified he was born on April 13, 1986. This is the birth date reflected in his medical records. PX 1. The Arbitrator finds that Petitioner was 28 years old as of the April 1, 2015 accident.

Petitioner credibly testified he was single and had one minor child as of the accident. He indicated this child was eleven years old as of the hearing. His hospital records describe him as single. PX 1. The Arbitrator finds that Petitioner was 28 years old and single, with one dependent child, as of the accident.

Were the medical services that were provided to Petitioner reasonable and necessary? Has Arch Flooring Company paid all appropriate charges for all reasonable and necessary medical services?

Petitioner claims bills from Advocate Good Shepherd Hospital (PX 2, $2,019.00) and Tri-County Emergency Physician (PX 3, $558.00). Both of these bills relate to the Emergency Room care Petitioner underwent on April 1, 2015. The Arbitrator finds that care to be causally related to the left thumb laceration. The Arbitrator also finds the treatment reasonable and necessary. The Arbitrator awards the claimed bills, subject to the fee schedule.

Is Petitioner entitled to temporary total disability benefits?

Petitioner claims he was temporarily totally disabled from April 2, 2015, the day after the accident, through April 26, 2015, the day before he began performing light duty for a friend.

While the Emergency Room records of April 1, 2015 do not contain any note directing Petitioner to refrain from working, they do contain instructions sheets directing him to keep his thumb wound "clean and dry." Petitioner testified the work he performed for Respondent involved cutting wood and installing floors. These duties are incompatible with the instructions Petitioner received. Petitioner was also given narcotic pain medication that could have affected his ability to safely operate electrical saws or other machinery.

Petitioner testified he contacted Daniel, Respondent's owner, in an effort to return to work but was rebuffed.

The Fund offered no evidence refuting the Emergency Room directives or suggesting Petitioner could have resumed working prior to April 27, 2015.

The Arbitrator finds that Petitioner was temporarily totally disabled from April 2, 2015 through April 26, 2015, a period of 3 4/7 weeks.

What is the nature and extent of the injury?

Because the accident occurred after September 1, 2011, the Arbitrator looks to Section 8.1b of the Act for guidance in assessing permanency. That section sets forth five factors to be considered in determining the nature and extent of an injury, with no single factor predominating. The Arbitrator assigns no weight to the first factor, any AMA Guides impairment rating, since neither party offered such a rating into evidence. The Arbitrator assigns weight to the second and third factors, Petitioner's occupation and age at the time of the injury. Petitioner's installer job with Respondent involved manual labor, as does his current job for a different flooring contractor. Petitioner credibly testified to having difficulty using his left thumb to grasp small items such as nails. Petitioner also testified to a lack of sensation in the tip of the thumb. His records show he lost the fat pad of the thumb secondary to the injury. Petitioner was 28 years old as of the accident. He could potentially remain in the workforce for another 35 to 40 years. During that time, he will continue to have difficulty manipulating small objects. The Arbitrator also assigns weight to the fourth factor, future earning capacity. Petitioner testified he was eventually able to resume full duty for a different contractor following the accident. He did not claim any diminution of wages. As for the fifth and final factor, evidence of disability corroborated by the treatment records, the Arbitrator notes the Emergency Room physician's description of the nature of the laceration and the loss of the fat pad. PX 1.

Based on the foregoing, as well as the viewing, the Arbitrator finds that Petitioner established permanency equivalent to 25% loss of use of the left thumb, representing 19 weeks of benefits under Section 8(e) of the Act.

50IMCC0018

STATE OF ILLINOIS)
) SS.
COUNTY OF McHENRY)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

CONSUELO HERNANDEZ,

Petitioner,

vs.

NO: 15 WC 9372
15 WC 9373 (cons.)

ACCURATE PERSONNEL SERVICES,

Respondent.

20IWCC0020

DECISION ON REVIEW AND ORDER

This matter comes before the Commission on Respondent's review of Arbitrator Glaub's order granting Petitioner's petition for reinstatement as well as Respondent's Motion to Rescind Approved Settlement Contract. Notice given to all parties, the Commission, after considering the issues and being advised of the facts and law, affirms the Arbitrator's Order granting reinstatement, which is attached hereto and made a part hereof. Further, as set forth below, the Commission grants Respondent's Motion to Rescind Approved Settlement Contract and remands the matter to the Arbitrator.

FINDINGS OF FACT:

1. On March 20, 2015, Petitioner filed Applications for Adjustment of Claim alleging a right thumb injury on January 22, 2014 (15 WC 9372) and a left thumb injury on January 13, 2015 (15 WC 9373). The claims were subsequently consolidated.

2. On August 28, 2018, Arbitrator Glaub dismissed Petitioner's claims for want of prosecution.

3. On August 31, 2018, E-Notices of Dismissal were generated by the Commission.

4. On November 20, 2018, Petitioner filed a Petition to Reinstate the consolidated claims. The Petition reads as follows:

> On 8/28/18, this case was dismissed for want of prosecution. I received the dismissal order on 11/15/18. On 12/12/18. I will present this petition to reinstate the case before Arbitrator Michael Glaub for the following reason: **We did not receive proper notice**. (Emphasis in original.) ArbX1.

5. On January 4, 2019, counsel for both parties appeared before Arbitrator Glaub to argue the merits of Petitioner's Petition to Reinstate. A record was made.

Petitioner's Counsel argued reinstatement was warranted because the claims were being actively moved toward resolution prior to dismissal, and he did not receive the E-Notice of dismissal but rather learned of the dismissal from his clerk when he attempted to secure a trial date at the November 15, 2018 call:

> After this case was dismissed on August 28, 2018, my office did not receive any e-mail indicating the case has been dismissed, nor did we receive any notice in the regular mail that this case had been dismissed. While this case was up and pending before your Honor and even after it was dismissed, the Petitioner and Petitioner's attorneys were diligently pursuing resolution of this claim. As Respondent I'm sure is going to mention, there was a settlement contract for a final offer that had been sent to Petitioner's counsel. There were outstanding medical bills which were in the process of being resolved. Unfortunately, that took a little bit longer than Petitioner anticipated due to some changes in the billers. But regardless, those actions were ongoing and being undertaken during the pendency of this claim before it was dismissed and even after it was dismissed.
>
> In fact, Petitioner's attorneys found out the case was dismissed when they attempted to get a trial date in November. The Petitioner's clerk informed Petitioner's attorneys that she couldn't get a date because the case had been dismissed and asked if we had a petition to reinstate. It was at that moment - - and that was November 15, 2018. So that was the day Petitioner received notice that the case was dismissed.
>
> Petitioner did not receive notice from the Commission itself, but from Petitioner's attorney's clerk. So almost immediately thereafter, Petitioner's counsel filed the present motion to reinstate. It was filed on November 20. Petitioner's attorney continued to work to resolve the case; and, in fact, the Petitioner finally agreed to accept the settlement offer and signed settlement contracts, which prior to this hearing today have actually been sent in the mail to your Honor. I understand those won't be approved, obviously, until this is resolved.
>
> This is a situation where the case was dismissed for want of prosecution despite Petitioner actively pursuing the case. Petitioner's counsel did not receive notice and continued to work on it and continued to pursue resolution, and my position – our Petitioner's position is we have a resolution now. So the case should be reinstated so that it can be finalized, so that it can be resolved. T. 9-11.

Respondent's Counsel countered the petition to reinstate was not filed within 60 days of the E-Notice, and therefore, the Arbitrator had no jurisdiction to reinstate:

> Opposing counsel was sent a settlement contract, that is true, on September 15 of 2017. Between then and around Christmas, December 2018, Respondent had assumed the Petitioner was lost, because there's been about [three] or [four] motions to dismiss. You did not dismiss the claim. The claim was not dismissed the first time it was up.
> There had been numerous efforts to try to stimulate activity, resolution of the case. It was finally dismissed, as stated, in both petitions on August 28, 2018. We received an e-mail notice, which is attached to my motion - - or objection. It's Respondent's A. We received it on September 4 on both consolidated cases, it's reflected that it was - - the notice date was August 31, 2018. It was Labor Day weekend. We received it September 4, 2018.
> I understand the Commission policy which was adopted July 1, 2018, that all Commission notices were going to be sent by e-mail with the presumption that notice was received by the next business day. All firms are to have a proper registration of their firm address or e-mail.
> The notice that we received on both cases shows - - doesn't show an e-mail address by either party, but it does show it was sent to John S. Eliasik at 180 North LaSalle, Suite 3700, Chicago, Illinois 60601. There is a presumption that it was sent on August 31. The next business day would have been September 4, 2018. And that is, in fact, when the Commission notice was received at Respondent's counsel's office at Krakar, Fanning and Olsen - - it's Grant and Fanning on the notice. The name was subsequently changed.
> Given the presumptive notice that was given to the Law Firm of John Eliasik as of September 4, he had 60 days…
> Obviously, yesterday we filed a written objection to the reinstatement. At the call, an attorney from my office appeared to object to the reinstatement or approval of the settlement contracts, because you or the Commission doesn't have jurisdiction as the case is still dismissed and needed to be reinstated first.
> The petition of Petitioner's counsel merely states we did not receive proper notice. There is a presumption that must be rebutted that he did not receive notice in this case. The rules state the parties permitted to present evidence in support of or in opposition to the petition, and the Commission can set forth grounds relied on by the Petitioner, the objection of the Respondent, and the precedence set forth in Commission decisions.
> For whatever reason, Petitioner's office didn't reinstate the case within 60 days of September 4, 2018; and, therefore, the case should remain dismissed, and not reinstated. T. 11-14.

In response, Petitioner's Counsel asserted the time lapsed before the contract was executed is irrelevant given Respondent never rescinded the offer and moreover his firm has a registered email and a subsequent review of that email account confirmed no notice was received:

> …it's not relevant to whether the case was reinstated, because the fact is Petitioner's counsel and Petitioner actively pursued settlement. The best proof of that is the signed

settlement contract by the Petitioner.
Furthermore, I don't believe at any time despite Respondent complains that it took a long time they withdrew their offer or decided we don't want to settle it anymore or we want to go to trial now, the deal is off the table, that never happened.
The only thing that happened was that this case was up. It was dismissed, and we didn't get notice. And counsel is right. There is a rebuttable presumption that we received notice; but, in fact, we didn't. The fact that the notice that he received has our address on it, it doesn't matter at all, particularly if the Commission has switched their system, and they are e-mailing them. And there is no e-mail address on the notice of dismissal, as counsel indicated. So the fact is we did not receive notice.
The other thing - - I would also like to point out that we are registered with the Commission. In fact, we checked after this that we're registered. I'm not sure what happened. I know we did not receive notice. T. 15-16.

Petitioner's Counsel later reiterated, "What I'm saying in this case there was no notice. This wasn't our failure to check our e-mail. We just never got it." T. 21.

6. On January 24, 2019, Respondent's Counsel emailed the following message to Petitioner's Counsel:

> Failure to register a firm e-mail at the Commission is not a valid defense. Therefore in light of your rejection of the compromise $3000 offer, the offer is rescinded, just like the void settlement contract on the dismissed case, which was executed by Petitioner 1 1/3 years after receipt of the contract offer. (Mot. Exhibit 5)

7. On February 6, 2019, Arbitrator Glaub issued an Order granting reinstatement of Petitioner's claims:

> The Arbitrator bases his Decision on petitioner's attorney representation that he never received a Written Notice of Case Dismissal from the Illinois Workers' Compensation Commission. The Arbitrator strongly takes into consideration that petitioner's attorney had been attentive to these claims and had performed all the work necessary to put the claims in a position to be resolved. The Arbitrator strongly takes into consideration that the Illinois Workers' Compensation Commission had just implemented a new system of tendering written Notice of Cases Dismissals. The Arbitrator strongly takes into consideration the fact that the Motion to Reinstate was filed promptly after he discovered that the cases were dismissed and that the Motion to Reinstate was only filed 17 days after the 60 day period to file a Motion to Reinstate had expired had petitioner's attorney received a Written Notice of Case Dismissal on September 4, 2018 as the respondent's attorney represented that he received it. The Arbitrator also strongly takes into consideration that the petitioner has been located by [his] attorney, has signed the settlement contracts, or in the alternative, is prepared to proceed to Arbitration.

8. On February 7, 2019, Respondent filed a Petition for Review of Arbitrator Glaub's reinstatement order. The matter was assigned to Commissioner Coppoletti.

9. On February 22, 2019, Arbitrator Glaub approved the settlement contract which had been previously tendered to him.

10. On March 22, 2019, Respondent filed a Motion to Rescind Approved Settlement Contract.

11. On May 17, 2019, the parties appeared before Commissioner Coppoletti to present arguments on Respondent's motion. A record was made, and the matter was taken under advisement with a decision from the full panel to issue.

CONCLUSIONS OF LAW

I. Petition to Reinstate

Rule 9020.90 governs reinstatement and provides, in pertinent part:

> a) When a cause has been dismissed from the Arbitration call for want of prosecution, the parties shall have 60 days from receipt of the dismissal order to file a Petition to Reinstate the cause onto the Arbitration call. Notices of dismissal shall be sent to the parties.
>
> b) Petitions to Reinstate must be in writing. The Petition shall set forth the reason the cause was dismissed and the grounds relied upon for reinstatement. The Petition must also set forth the date on which the Petitioner will appear before the Arbitrator to present the Petition. A copy of the Petition must be served on the other side at the time of filing with the Commission in accordance with the requirements of Section 9020.70. The Respondent may file a response to the Petition.
>
> c) Petitions to Reinstate shall be docketed and heard by the same Arbitrator to whom the case is assigned. Both parties must appear at the time and place set for hearing. Parties will be permitted to present evidence in support of, or in opposition to, the Petition. The Arbitrator shall apply standards of fairness and equity in ruling on the Petition to Reinstate and shall consider the grounds relied on by the Petitioner, the objections of the Respondent, and the precedents set forth in Commission decisions. A record shall be made of a hearing on any contested Petition. *50 Ill. Adm. Code 9020.90.*

As such, the Commission is tasked with analyzing both the timeliness and the merits of Petitioner's petition for reinstatement.

A. Timeliness

According to the plain language of Rule 9020.90(a), "receipt of the dismissal order" triggers the 60-day filing period for a Petition to Reinstate. Therefore, the Commission must

determine when Petitioner received the dismissal order.

Petitioner's Petition to Reinstate was filed on November 20, 2018, and it reflects the dismissal order was received on November 15, 2018. At the reinstatement hearing, Petitioner's Counsel asserted his office never received a notice of dismissal from the Commission then explained he did not become aware of the dismissal until his clerk attempted to obtain a trial date at Arbitrator Glaub's November 15, 2018 call. T. 10.

In challenging the timeliness of the petition, Respondent emphasizes the E-Notice of Dismissal was sent on August 31, 2018, and there is a presumption the parties received it the next business day, September 4, 2018. Respondent argues Petitioner's Counsel's statement that he did not receive the E-Notice is insufficient to rebut the presumption, and instead counsel was required to perform a "forensic investigation"; because Petitioner's Counsel "did not exercise any intellectual curiosity or diligence" to conduct such an investigation, the presumption was not rebutted. The Commission disagrees.

The E-Notices themselves do not disclose the recipient email, so there is no evidence on the face of the document to establish to whom it was sent. Petitioner's Counsel asserted on the record before Arbitrator Glaub that his firm does have a registered email address as required by the Commission; the firm has verified the email address is properly recorded with the Commission; and yet despite being in compliance with the Commission rule, a search of the firm's email account revealed no E-Notice of Dismissal was received. T. 16, 21. The Commission finds Petitioner's Counsel's statements are credible, and we accept them as truthful. The Commission notes all practicing attorneys are bound by the Rules of Professional Conduct, including the rule requiring candor toward the tribunal: Rule 3.3 of the Illinois Rules of Professional Conduct provides, "A lawyer shall not knowingly: (1) make a false statement of fact or law to a tribunal or fail to correct a false statement of material fact or law previously made to the tribunal by the lawyer." *Ill. R. Prof. Cond. 3.3(a)(1) (eff. Jan. 1, 2010).*

The Commission finds the affirmative statement on the record from an officer of the court is sufficient to rebut the E-notice presumption. The Commission finds Petitioner's Counsel did not receive notice of the dismissal until November 15, 2018, and therefore the November 20, 2018 petition to reinstate was timely.

B. Merits of reinstatement

"A party must exercise due diligence in pursuing his or her claim before the Commission." *Banks v. Industrial Commission*, 345 Ill. App. 3d 1138, 1143, 804 N.E.2d 629 (2004). On a petition to reinstate before the Commission, the burden is on the claimant to allege and prove facts justifying the relief sought. *Banks*, 345 Ill. App. 3d at 1140. Petitioner argues the claims merit reinstatement because they have been diligently pursued, and despite the fact the interactions with billing providers extended the process longer than expected, the claims are at the point of resolution, either via settlement or trial on the merits. The Commission agrees and finds Petitioner exercised due diligence in prosecuting the claims. In so doing, the Commission places great emphasis on the fact that prior to learning of the dismissal, Petitioner's Counsel prepared for, and requested, a hearing on the merits. The Commission finds Petitioner diligently

prosecuted the claims and demonstrated sufficient justification for reinstatement. The Commission finds the Petition to Reinstate was properly granted, and we affirm and adopt the Arbitrator's order.

II. Respondent's Motion to Rescind Approved Settlement Contract

On February 22, 2019, Arbitrator Glaub approved the settlement contract. Respondent argues the settlement contract should be rescinded because there was no meeting of the minds. In so doing, Respondent suggests the original offer was orally revoked by a counteroffer made the morning of January 4, 2019 and revoked in writing in his January 24, 2019 email, yet despite it being "crystal clear" there was no meeting of the minds, "Petitioner's counsel essentially misrepresented to the Arbitrator that there was an agreement to settle the case for $5,768.40 when he submitted settlement contracts for approval, under the totality of the circumstances."

A. January 4, 2019

At the January 4, 2019 hearing, Petitioner's Counsel made the following statements:

> Petitioner's attorney continued to work to resolve the case; and, in fact, the Petitioner finally agreed to accept the settlement offer and signed settlement contracts, which prior to this hearing today have actually been sent in the mail to your Honor. I understand those won't be approved, obviously, until this is resolved. (T. 10-11) (Emphasis added); and
>
> Furthermore, I don't believe at any time despite Respondent complains that it took a long time they withdrew their offer or decided we don't want to settle it anymore or we want to go to trial now, the deal is off the table, that never happened. (T. 15).

The Commission finds these statements evidence Petitioner's Counsel was clearly operating under the understanding that the settlement agreement remained in effect. We emphasize Respondent was present when Petitioner advised the Arbitrator that the executed settlement contracts had already been mailed to him, with approval dependent on how the reinstatement petition was resolved, and did nothing to suggest the contract was void. Instead, Counsel's statement to Arbitrator Glaub reflects the only issue with the contract was the petition to reinstate must be resolved first:

> I feel this is a jurisdictional argument; and that unless you reinstate, there is no jurisdiction to approve the contracts, and I attach the case to my motion which specifically holds or demonstrates the failure to read an e-mail or failure to properly register a firm's e-mail address with the Illinois Workers' Compensation Commission is not an excuse or valid defense to proper notice of an e-mail being sent. T. 19.

The Commission finds the record does not support Respondent's contention there was no longer a meeting of the minds as of January 4, 2019. To be clear, when the parties appeared before Arbitrator Glaub, nothing was said or done which would indicate the offer had been revoked and

the parties' executed contract was no longer valid. The Commission finds the tenor of Respondent's brief is unnecessarily obstreperous, and we are troubled by the casual accusation of malfeasance.

B. January 24, 2019 Email

The Commission finds the January 24, 2019 email served as a clear statement that the settlement agreement was no longer in effect. Therein, Respondent's Counsel expressly stated the compromise offer was rescinded and indicated he considered the original offer void:

> Failure to register a firm e-mail at the Commission is not a valid defense. Therefore in light of your rejection of the compromise $3000 offer, the offer is rescinded, just like the void settlement contract on the dismissed case, which was executed by Petitioner 1 1/3 years after receipt of the contract offer.

At that point, there was definitive evidence there was no longer a meeting of the minds. Unfortunately, that was not communicated to the Arbitrator prior to his approval of the contract. The Commission grants Respondent's Motion to Rescind Approved Settlement Contract and remands the matters to the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's Order granting reinstatement is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent's Motion to Rescind Approved Settlement Contract is granted, and the cases are remanded to the Arbitrator for further proceedings consistent with this Decision.

DATED: JAN 10 2020

L. Elizabeth Coppoletti

L. Elizabeth Coppoletti

Stephen J. Mathis

Stephen Mathis

D. Douglas McCarthy

D. Douglas McCarthy

LEC/mck

D: 11/6/19

43

State of Illinois)
) SS.
McHenry Country)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

CONSUELO HERNANDEZ,	)	
	)	
Petitioner,	)	
	)	
v.	)	
	)	IWCC Nos.: 15 WC 9372
ACCURATE PERSONNEL SERVICES,	)	15 WC 9373
	)	
	)	
Respondent.	)	

20IWCC0020

ORDER

The Petitioner's Motion to Reinstate cases 15 WC 9372 and 15 WC 9373 is allowed. The Arbitrator notes that the Illinois Workers' Compensation Commission implemented a new system to send out Notices of Dismissal. That new system was only implemented on July 1, 2018. Under the new system, written Notice of Dismissals were to be send out via electronic mail transmission. Under the prior system, written Notice of Dismissals were sent out via US Mail.

The Arbitrator had granted Respondent's Motion to dismiss these matters on August 28, 2018. The Arbitrator notes that the cases were above the Red Line on August 28, 2018 and that the Arbitrator had denied multiple previous requests from the respondent's attorney to dismiss this claim. The Arbitrator notes petitioner's attorney was not present on August 28, 2018.

Respondent's attorney represented to the Arbitrator that he received a Notice of Case dismissal on September 4, 2018. The Notice of Case Dismissals are dated 8/31/18 by the Illinois Workers' Compensation Commission. Respondent's attorney advised the Arbitrator that he did not mail or e-mail a copy of Notice of Case Dismissals that he received to the petitioner's attorney.

Petitioner's attorney represented to the Arbitrator that he never received a copy of the Notice of Case Dismissal via e-mail or via US Mail from the Illinois Workers' Compensation Commission. Petitioner's attorney represented to the Arbitrator that he only discovered on November 15, 2018 that the cases had been dismissed when he requested his clerk obtain a trial date at the next status call. Petitioner's attorney represented that when his clerk advised him that the cases had been dismissed, he promptly filed a Motion to Reinstate on November 20, 2018. The Notice of Motion filed with the Commission indicated that the Motion would be presented to the Arbitrator on

12/12/18. The parties by agreement reset that the Motion to the 1/2/19 status call. The parties selected a Hearing date of 1/4/19 for full arguments On the Record.

The Arbitrator further notes that the petitioner's attorney had been actively working on these claims. Specifically, petitioner's attorney had actually worked out a resolution of these claims with respondent's attorney. Petitioner's attorney represented to the Arbitrator that he had been working to resolve disputed medical bills. The petitioner's attorney represented to the Arbitrator he had been unable to locate his client to execute the settlement contracts. The petitioner's attorney represented to the Arbitrator that subsequent to filing his Motion to Reinstate, he had located his client. Petitioner's attorney represented to the Arbitrator on 1/4/19 that his client had signed the settlement contracts. Petitioner's attorney represented to the Arbitrator that he would also be prepared to proceed Arbitration.

The Arbitrator bases his Decision on petitioner's attorney representation that he never received a Written Notice of Case Dismissal from the Illinois Workers' Compensation Commission. The Arbitrator strongly takes into consideration that petitioner's attorney had been attentive to these claims and had performed all the work necessary to put the claims in a position to be resolved. The Arbitrator strongly takes into consideration that the Illinois Workers' Compensation Commission had just implemented a new system for tendering written Notice of Cases Dismissals. The Arbitrator strongly takes into consideration the fact that the Motion to Reinstate was filed promptly after he discovered that the cases were dismissed and that the Motion to Reinstate was only filed 17 days after the 60 day period to file a Motion to Reinstate had expired had petitioner's attorney received a Written Notice of Case Dismissal on September 4, 2018 as the respondent's attorney represented that he received it. The Arbitrator also strongly takes into consideration that the petitioner has been located by her attorney, has signed the settlement contracts, or in the alternative, is prepared to proceed to Arbitration.

Based on all of the above, the Arbitrator grants the petitioner's attorney Motion to Reinstate consolidated cases 15 WC 9372 and 15 WC 9373.

Arbitrator Michael Glaub

February 5, 2019
Date

FEB 6 - 2019

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 Temporary Disability, Medical	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

CHRISTIAN CRAWFORD,

Petitioner,

vs. NO: 15 WC 34957

PHILLIPS ELECTRONICS NORTH AMERICA CORP.,

Respondent.

20IWCC0021

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent and Petitioner herein and notice given to all parties, the Commission, after considering the issues of causation, temporary disability, medical expenses, and prospective medical, and being advised of the facts and law, reverses the Corrected Decision of the Arbitrator. The Commission finds Petitioner sustained an accidental injury arising out of and in the course of his employment on June 8, 2015 which stabilized by September 18, 2015, and his current condition of ill-being is not causally related to that work injury. The Commission remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill. 2d 327, 399 N.E.2d 1322 (1980).

STATEMENT OF FACTS

A. Petitioner's Testimony

This matter proceeded to arbitration on three separate occasions: November 18, 2016 (hereinafter TA); July 13, 2017 (hereinafter TB); and July 19, 2017 (hereinafter TC). Petitioner testified he was employed by Respondent as a field installer which required him to travel to customers' homes to install Lifeline equipment. TA. 20. On June 8, 2015, while traveling to a

customer's home for an installation, Petitioner was involved in a motor vehicle accident. TA. 22. Petitioner testified he was jolted by the force of impact causing his neck to snap forward and backwards as well experiencing pain in his back. TA. 22. Petitioner was transported via ambulance to St. Bernard Hospital in Chicago. TA. 24.

Petitioner testified upon discharge from St. Bernard Hospital he was instructed to follow-up with his primary care physician who evaluated Petitioner the following day. TA. 27; 30. Petitioner subsequently sought treatment from Advance Physical Medicine (APM) consisting of physical therapy, stimulation treatment, and heat packs. TA. 31. On referral from APM, Petitioner testified he sought treatment from Dr. Jain who administered injections which provided little relief. TA. 33. Petitioner testified on July 15, 2015 he underwent an MRI regarding the lumbar spine and right elbow. TA. 35. Petitioner completed his treatment with APM and Dr. Jain on August 15, 2015. TA. 36.

Petitioner testified he returned to work full-duty but continued to experience leg pain and constant back pain. TA. 36; 39. On November 9, 2015, Respondent terminated Petitioner's employment which Petitioner believed to be in retaliation for his reporting of unsanitary conditions at a HUD residence. TA. 43.

Petitioner testified due to ongoing pain, he sought further medical care from Dr. Glaser who continues to treat Petitioner. TA. 46. Dr. Glaser provides Petitioner with medication-Oxycodone which helps with his pain. TA. 49. On the referral of Dr. Glaser, Petitioner was evaluated on April 5, 2016 by Dr. Miz who is recommending a fusion. TA. 50; 52. Petitioner testified he previously underwent three spinal fusions- June 2007, July 2008, and August 2009. TA. 53. Following the third spinal fusion, Petitioner continued to experience back pain but was able to return to work. TA. 54.

Petitioner testified his employment history includes working as a home health aide; a counselor; and at Dish Satellite Company which required him to crawl, carry ladders and equipment as well as wear a utility belt. TA. 56. Petitioner subsequently left Dish Satellite Company to work for Respondent due to its superior benefits. TA. 57-58. Petitioner began his employment with Respondent in December of 2014 at which time he continued to experience small amounts of back pain requiring some medication. TA. 62. Petitioner testified prior to his accident on June 8, 2015, he rated his pain two to three on a scale of ten and after, seven to eight on a scale of ten. TA. 66. Petitioner testified he is not currently working and would like to undergo the procedure being recommended by Dr. Miz. TA. 70-71.

The hearing was thereafter continued to a later date. On July 13, 2017, the hearing resumed with additional testimony, the commencement of Respondent's cross-examination of Petitioner.

On cross-examination, Petitioner testified prior to his accident, he took both Tramadol for back pain and diazepam for anxiety. TB. 10. Petitioner confirmed he advised the personnel at the emergency room regarding his history of chronic back pain. TB. 11. Petitioner confirmed he sought treatment with his primary care physician, Dr. Sedicase [*sic*] at the emergency room's referral. TB. 17. Petitioner agreed Dr. Sedicase [*sic*] released Petitioner to return to work full-

duty as of June 29, 2015, but he did not return to work until August of 2015. TB. 20-21. Petitioner testified he was unable to return to work in June of 2015 due to new symptoms of shooting pain down his right leg and increased back pain. TB. 22.

Petitioner was unable to recall who referred him to Dr. Goldvekht for treatment. TB. 23. Petitioner treated with both Dr. Goldvekht who released him to return to work without restrictions as of August 21, 2015 and Dr. Jain who released him to return to work without restrictions as of August 17, 2015. TB. 25-27. Petitioner testified he sought treatment with Dr. Glaser on November 17, 2015 as a second opinion and continues to treat with Dr. Glaser. TB. 32-33.

Petitioner testified he advised Dr. Glaser regarding his prior three surgeries as well as his use of opioids for the past ten years. TB. 33-34. Petitioner confirmed he submitted to a drug test which tested positive for cocaine. TB. 38-39. Petitioner denied using cocaine to Dr. Glaser and believed he was inadvertently exposed due to his mother's use of cocaine. TB. 39-40.

Petitioner was tendered RX22- medical records of Dr. Glaser dated September 19, 2016 which he agreed memorialized a positive drug test for cocaine use. TB. 42-44. Petitioner's counsel made a standing objection to relevancy which was allowed by the arbitrator relative to the questions posed to Petitioner regarding his drug use. TB. 45.

Petitioner testified he was referred to Dr. Miz by a friend. TB. 49. Petitioner underwent a discogram as recommended by Dr. Miz. TB. 49-50. Petitioner agreed he consulted with physicians beginning in 2005 for his back condition, and his first fusion surgery performed was due to a work-related injury. TB. 50-51.

Petitioner reviewed the medical record of Dr. Payne dated June 30, 2008 which memorialized Petitioner's use of methadone. TB. 64. Petitioner testified he used methadone in 2008. *Id.* Over Petitioner's attorney's continued objection, Petitioner testified Dr. Payne's records memorialized that Petitioner was unable to attend the June 30, 2008 appointment due to cocaine use. TB. 66. Petitioner stated it was his mother and not he who called Dr. Payne's office regarding the missed appointment. *Id.* Petitioner denied having missed the appointment due to cocaine use. TB. 67. Petitioner denied ever using cocaine. TB. 68. Despite testing positive for cocaine, Petitioner again denied using cocaine. TB. 72.

Petitioner testified he injured his back on February 19, 2015 while moving an elliptical machine necessitating treatment at St. Mary's Hospital in Dyer, IN. TB. 75-76. Petitioner agreed Dr. Payne's records memorialized a history of chronic back pain since Petitioner's third surgery. TB. 77. Petitioner testified he did not seek treatment with Dr. Payne after the visit of February 19, 2015 associated with the elliptical incident. TB. 78.

Petitioner testified he treated with Dr. An in relation to his 2005 back injury. TB. 80. Dr. An performed two surgeries, on July 14, 2008 and July 30, 2009. TB. 81. Petitioner could not recall attending a functional capacity evaluation (FCE) request by Dr. An. TB. 82. Petitioner was tendered RX10, a report of an FCE dated March 16, 2010. TB. 82. Petitioner reviewed the

record and agreed it stated Petitioner failed to provide maximal effort rendering the test invalid. TB. 83.

Petitioner testified while under the care of Dr. An, he also treated with Dr. Buvanendran, a pain physician. TB. 84. Dr. Buvanendran provided injections, and during Petitioner's treatment, he again tested positive for cocaine use. TB. 85. Petitioner agreed he tested positive for cocaine use in 2010 but again denied ever using cocaine. TB. 94. Petitioner explained he lived with his drug-addicted mother, and because of the living arrangements, he inadvertently ingested cocaine. TB. 95. Petitioner emphatically stated he did not use cocaine. TB. 98. Petitioner could not recall having been administered other drug tests besides the two about which he previously testified. TB. 101.

Petitioner testified in 2011 he was under the care of Dr. Budanendran for pain management. When asked about a drug test administered in 2011 wherein he again tested positive for cocaine use, he could not recall the test. TB. 103. When shown a document memorializing that Petitioner was discharged from pain management due to testing positive for cocaine use, Petitioner agreed. TB. 104. Petitioner testified he was discharged by Dr. An as no further treatment could be provided for his back condition. *Id.*

Petitioner was questioned regarding his smoking habit while treating with Dr. An and Dr. Budanendran and testified he both smoked and did not smoke. TB. 105. Petitioner was tendered a complete copy of Dr. An's medical records and was asked to read the following passage from the September 11, 2009 record: "The patient did verbalize that he did quit smoking which he stated that is critical for fusion to occur. We have filled out a Workers' Compensation letter for him. We will see him back in two-weeks at a time." TB. 108. Petitioner was tendered a note dated July 17, 2009 which states "The patient states he's now stopped smoking. He understands that smoking increases his risk for pseudarthrosis, right?" *Id.* Petitioner was tendered a note dated March 6, 2009 which states "We have had the opportunity to discuss this and the possibility that smoking may have contributed to the fusion non-union. The patient denies vehemently having smoked." TB. 109. Petitioner agreed both Dr. An and Dr. Buvanendran advised smoking was not helpful for recovery from a spinal fusion. TB. 110. Petitioner testified he continued to smoke, but despite the prior failed surgeries, he wished to proceed with another surgery. TB. 111-12.

Petitioner testified he was evaluated by Dr. Candido pursuant to Section 12 of the Act on September 29, 2015. TB. 113. Petitioner testified he fully cooperated with Dr. Candido and provided a history of prior back surgeries. TB. 113-14. Petitioner could not recall telling Dr. Candido that he did not smoke. TB. 115. Petitioner could not recall discussing illicit drug use with Dr. Candido or discussing his prior positive drug test. TB. 116.

Petitioner verified his receipt of temporary total disability benefits from the insurance carrier for the period of June 19, 2015 through August 23, 2015. TB. 116-17. Petitioner agreed he worked at Dish Network from April to December of 2014, and his work duties required significant physical activity. TB. 119. Petitioner testified he was terminated from Respondent's employ due to a conflict of interest. TB. 112. Petitioner testified he was notified of his termination on November 19, 2015. TB. 128.

On November 2, 2015, Petitioner used a vacation day and visited his mother. TB. 129. Even though Petitioner was on vacation, he wore his uniform while visiting his mother and spoke with her landlord threatening to report him to the state on abuse grounds. TB. 129. Petitioner denied using the visit for a non-work-related matter and explained he was attempting to obtain two more referrals. TB. 130. Respondent's counsel began questioning Petitioner regarding his unemployment hearing, and Petitioner's counsel's objection was sustained. Respondent's counsel requested an offer of proof be allowed as to the unemployment records, and his request was denied. TB. 134.

Petitioner reiterated he experienced a small amount of pain necessitating medication prior to his work injury. TB. 135. Petitioner testified he was not currently seeking medical treatment for his neck. TB. 136. The hearing was thereafter continued to a later date. TB. 138.

On July 19, 2017, the hearing resumed with additional testimony on cross-examination. Petitioner was tendered RX24, a record from Domain Diagnostics dated July 16, 2010. TC. 7-8. Petitioner verified the test evidenced positive use of cocaine. TC. 8. Petitioner reviewed another Domain Diagnostics record dated September 3, 2010 which also evidenced the use of cocaine by Petitioner. TC. 9-10. Petitioner reiterated he did not use cocaine but came into contact with it as he lived with his drug-addicted mother. TC. 11-12.

On re-direct examination, Petitioner testified he has a terrible memory, and he answered the questions posed to the best of his recollection. TC. 13. Petitioner testified he now recalled that Dr. Glaser referred Petitioner to Dr. Miz, and his friend referred him to Dr. Glaser and not Dr. Miz. TC. 14.

As for his back pain, Petitioner rated it on a scale of ten as a one or two prior to his accident and seven or eight after the accident. TC. 16. On re-cross examination, Petitioner was questioned as to his admitted terrible memory and how he was, though, able to remember the exact nature of his back pain prior to the accident. TC. 19. Petitioner testified he remembers some things. TC. 20. As for his memory regarding the referral to Dr. Miz, Petitioner testified Brian Odaneal was the friend who provided the referral. Petitioner conceded his testimony during the present hearing regarding the referral is different than the testimony he provided six days prior. TC. 23.

B. Medical Treatment

The medical records evidence the Chicago Fire Department was dispatched on June 18, 2015 at 10:24AM. Petitioner was found sitting in his vehicle restrained. There was no airbag deployment, and minimal damage to the vehicle. Petitioner complained of back and neck pain and was transported to St. Bernard Hospital ER. PX6.

Petitioner was evaluated at St. Bernard Hospital ER where he complained of low back pain. A CT scan was undertaken which evidenced post-surgical changes in the low back. Petitioner was provided morphine which did not relieve his pain which Petitioner attributed to his chronic use of pain medications. PX5.

On June 19, 2015, Petitioner presented to Dr. Settecase, his primary care physician, for follow-up as directed by the emergency room personnel. Petitioner complained of general soreness and stiffness throughout his body but especially in his neck and back. Dr. Settecase diagnosed an acute exacerbation of chronic back pain; renewed Petitioner's prescription for Tramadol and Norco; and authorized Petitioner off-work through June 29, 2015. PX3.

On June 22, 2015, Dr. Goldvekht evaluated Petitioner who provided a history of a motor vehicle accident resulting in pain in his neck, right elbow, mid and lower back. Dr. Goldvekht diagnosed a sprain/strain and prescribed Flexeril and Naproxen as well as physical therapy. On July 6, 2015, Dr. Goldvekht re-evaluated Petitioner who continued to complain of neck and back pain with severe pain in the elbow. Dr. Goldvekht prescribed Mobic, Flexeril and Protonix; recommended Petitioner continue with physical therapy; and recommended an MRI of the right elbow. PX4.

Thereafter, Petitioner presented to Dr. Jain, a pain specialist, on July 13, 2015. Petitioner provided a history of a motor vehicle accident causing substantial low back pain radiating into his right leg as well as right elbow pain. Dr. Jain recommended an MRI of the spine as well as injections. A caudal epidural steroid injection was provided. Petitioner was advised to continue physical therapy and current medications. Petitioner's off-work status was maintained. PX2.

On July 15, 2015, an MRI of the lumbar spine was performed which evidenced post-surgical changes as well as a protrusion at the L3-L4 level. A right elbow MRI was performed which was normal. PX2.

On July 17, 2015, Dr. Goldvekht evaluated Petitioner who continued to complain of significant back pain which was temporarily relieved by the injection. Dr. Goldvekht recommended Petitioner continue medications and treatment prescribed by Dr. Jain as well as physical therapy. Petitioner's work status remained unchanged. PX4.

On July 27, 2015, Dr. Jain reviewed the MRI finding a herniated disc at the L3-L4 level as well as L2-L3 level. Dr. Jain recommended transforaminal injections as well as possible facet injections. On August 3, 2015, Dr. Jain performed bilateral L2-L3 and L3-L4 transforaminal ESI with selective nerve root block. PX2.

On August 7, 2015, Petitioner presented to Dr. Goldvekht with continued complaints of pain in the back, neck, and elbow. Petitioner advised the injections provided him mild improvement relative to his back pain. Dr. Goldvekht recommended continued physical therapy and released Petitioner to return to work with restrictions of no lifting, alternating between sitting and standing, and no driving more than 45 minutes continuously. PX4.

On August 17, 2015, Dr. Jain evaluated Petitioner who advised the injections provided 50% relief. Petitioner stated:

> he did an hour and half of driving without stopping to evaluate whether he could return to work. He then attempted to do three installations of the product that he installs, which is lifeline for elderly people. He attempted the installations

> consecutively after driving an hour and a half. The patient reports that he was able to complete the simulated work successfully and feels that he would like to go back to do a trial of full duty at work.

Dr. Jain released Petitioner for a trial return to work with a refill of his Norco medication. PX2.

On August 21, 2015, Dr. Goldvekht evaluated Petitioner who advised his lower back was improving, but he was still unable to sit for an extended period of time. Dr. Goldvekht advised Petitioner to cease physical therapy and released Petitioner to return to work without restrictions with the caution that if a flair up in symptoms occurred, Petitioner should not wait to be seen at the four-week follow-up appointment. On September 18, 2015, Dr. Goldvekht evaluated Petitioner for a final time. Petitioner continued to complain of intermittent pain in his back and neck but was otherwise fine. Dr. Goldvekht placed Petitioner at maximum medical improvement and stated, "his condition is now stable." PX4.

On November 17, 2015, Petitioner presented to Dr. Glaser for evaluation. Petitioner provided a history of back pain due to a motor vehicle accident occurring on June 18, 2015. Petitioner complained of bilateral back pain, right buttock and leg pain. Petitioner advised he previously underwent interventional treatment with Dr. Jain as well as physical therapy neither of which improved his pain. Dr. Glaser diagnosed lumbar radiculopathy, hip pain, and post-laminectomy syndrome of the lumbar spine. The implantation of a spinal cord stimulator (SCS) was discussed, and Petitioner was advised to follow-up in two weeks. On December 4, 2015, Dr. Glaser re-evaluated Petitioner whose complaints were unchanged. Dr. Glaser again discussed the implantation of SCS and continued Petitioner's medications. On January 4, 2016, Petitioner presented to Dr. Glaser with consistent complaints of pain. Dr. Glaser reviewed the IL PMP which was found inconsistent. Petitioner was cautioned and remined of his contract wherein he agreed that no other physicians would provide opioid medication. PX9.

Petitioner continued to treat with Dr. Glaser on a monthly basis from February 3, 2016 through June 22, 2016. Throughout his treatment, Petitioner complained of increased back pain with a corresponding increase in medication usage. On June 22, 2016, Petitioner advised Dr. Glaser regarding his recent evaluation with Dr. Miz who recommended a fusion at the L3-L4 level with hardware removal. PX9.

In the interim, on April 5, 2016, Dr. Miz evaluated Petitioner who complained of low back and neck pain due to a work-related injury. Petitioner recounted his prior surgeries which resulted in ongoing mechanical back pain. Petitioner denied experiencing radicular symptoms in relation to his prior back surgeries and resultant problems. Petitioner provided an additional history of a motor vehicle accident wherein he was rear-ended leading to an immediate onset of pain. Petitioner related his low back pain began to radiate into his right lower extremity. Petitioner explained his prior medical treatment consisting of multiple injections and physical therapy none of which provided sustained relief. Dr. Miz reviewed the MRI from July finding it evidenced an L3-L4 right-sided disc bulge and recommended further pain management; a possible discogram; and depending on the results of the discogram, surgery. As for the cervical spine, Dr. Miz felt surgery was not indicated. PX7.

Petitioner subsequently underwent the discogram on April 28, 2016, and, thereafter, presented to Dr. Miz on May 10, 2016. Dr. Miz reviewed the discogram and felt it was indicative of the L3-L4 disc being the pain generator. Dr. Miz recommended surgery consisting of an extension of the prior fusion to the L3 level with removal of the old instrumentation and replacement with new hardware. PX7.

Regarding Petitioner's prior back history of injury and treatment, Petitioner underwent a fusion at the L4-L5 and L5-S1 levels performed by Dr. Payne on July 26, 2006. (Dr. Payne also evaluated Petitioner on February 15, 2015 due to increased back complaints associated to Petitioner's lifting of an elliptical machine. Dr. Payne diagnosed a strain.) RX23. Due to ongoing pain complaints, Petitioner underwent revision surgeries performed by Dr. An on July 14, 2008 (two level fusion due to non-union) and July 30, 2009 (three level fusion due to pseudarthrosis). Dr. An discharged Petitioner from care but noted residual back pain. Dr. An released Petitioner to return to work with a 25 lbs. lifting restriction and avoidance of repetitive bending and twisting. Petitioner was advised to continue pain management with Dr. Buvanendran. RX24.

C. Expert Testimony

On July 28, 2016, Dr. Miz provided testimony via evidence deposition. PX1. Dr. Miz testified he is a board-certified orthopedic physician. PX1, p. 15. Dr. Miz testified consistent with his medical records. Petitioner presented on April 5, 2016 complaining of back pain radiating into the right leg. PX1, p. 10. Dr. Miz performed a physical examination and diagnosed right lumbar radiculopathy at L3-L4. PX1, p. 12. Dr. Miz testified he recommended ongoing pain management such as injections and therapy, and if such failed, then a discogram. PX1, p.13. Dr. Miz testified he re-evaluated Petitioner on May 10, 2016 following the completion of the discogram performed on April 28, 2016. PX1, p. 16. Petitioner continued to complain of pain and radicular symptoms. *Id.* Dr. Miz reviewed the CT scans post-discogram which he opined evidence an annular tear with dye leaking into a herniation at the L3-L4 level. PX1, p. 17. Given Petitioner's symptoms, Dr. Miz optioned Petitioner was "a reasonable candidate for his extension of decompression and fusion to the L3 level." PX1, p. 18.

Dr. Miz testified based upon a reasonable degree of medical and surgical certainty, Petitioner's current low back complaints are related to the June 18, 2015 injury. PX1, p. 18. Dr. Miz based his opinion on Petitioner's ability to function reasonably well regarding his significant back problems, albeit with some pain, but the work injury caused an onset of back pain particularly right leg pain which was previously absent. PX1, p. 19. Dr. Miz recommended further surgery consisting of an extension of the fusion to the L3-L4 level. PX1, p. 20.

On cross-examination, Dr. Miz testified he has not reviewed medical records concerning Petitioner's prior back surgeries, but he had requested Petitioner obtain the records as it would be necessary for him to review the same prior to undertaking surgery. PX1, p.24. Dr. Miz testified he reviewed the MRI images performed on July 15, 2015 and determined there were right-sided bulging discs at the L3 and L4 levels with foraminal stenosis. PX1, p.24. Respondent's counsel tender DepExRx1, a CT lumbar spine report dated October 2, 2008, to Dr. Miz who agreed such evidences findings at the L3-L4 level. PX1, p. 26-27. Dr. Miz testified the findings from the CT

scan and the MRI bore some similarities but explained the CT scan describes a diffuse disc bulge whereas the MRI describes a right-sided foraminal encroachment. PX1, p. 27. Dr. Miz further explained the difference between a CT scan and an MRI- that being CT scans evaluate bone detail well, and an MRI evaluates soft tissues such as discs and nerves well. PX1, p. 28. Respondent's counsel tendered DepExRX2, a CT lumbar spine with contrast post-myelography dated April 8, 2009, to Dr. Miz who agreed it evidences a "mild diffuse posterior disc bulge with a small disc herniation in the right neuroforamen without significant stenosis." PX1, p. 29. Dr. Miz opined neither report caused him to alter his opinions as to causation. PX1, p. 30.

Dr. Miz agreed Petitioner suffered from lumbar spondylosis which was classified as a chronic condition not associated with Petitioner's motor vehicle accident. PX1, p. 32. Dr. Miz testified he discussed with Petitioner the possibility of further pain management, but Petitioner did not pursue such treatment prior to the surgical recommendation. PX1, p. 35.

Dr. Miz confirmed Petitioner continued to smoke and use tobacco. PX1, p. 37. Dr. Miz explained smoking has a significant effect and a negative impact on fusion success especially in light of Petitioner's prior failed fusions. PX1, P. 38.

On October 20, 2016, Dr. Candido provided testimony via evidence deposition. RX17. Dr. Candido testified he is a board-certified anesthesiologist with an added qualification in pain management. RX17, p.5. Dr. Candido evaluated Petitioner on September 29, 2015 pursuant to Section 12 of the Act. RX17, p. 9. Dr. Candido obtained a history from Petitioner who stated he suffered from chronic lumbar pain and was involved in a motor vehicle accident on June 18, 2015. RX17, p. 14. Petitioner described pain in his neck, both shoulders, his trunk, right chest area, and right elbow. RX17, p. 14-15. Petitioner reviewed his prior treatment with Dr. Settecase, Dr. Goldvekht, and Dr. Jain. Dr. Jain provided several injections. RX17, p. 16. Petitioner described his back pain as an 8 or 8 1/2 as well as intermittent muscle spasms. RX17, p. 16-17. Petitioner was able to drive 40 minutes before experiencing shooting pains down his leg. RX17, p. 17.

Dr. Candido stated Petitioner's medications were as follows: Norco, Tramadol, diazepam, Oxybutynin, Albuterol, Nebulizer, a transcutaneous electrical nerve stimulator, and a Polar Ice Machine. RX17, p.18. Dr. Candido performed a physical evaluation from head to feet with positive findings in the lumbar spine specifically tenderness at the lumbar L4 facet joints and "radiating pain in a dermatomal distribution at L4-L5 bilaterally, but sensation was intact in all dermatomes." PX17, p. 21. Dr. Candido opined Petitioner's cervical and right elbow exhibit no problems in relation to the work-related injury; as for Petitioner's lumbar spine, the motor vehicle accident resulted "in a transient worsening of the lumbar facet joints at L4 and possibly at L5 and that the transient worsening was not expected to be permanent or to result in any long-term impairment." RX17, p. 24-5. Dr. Candido based his opinion, in part, on Petitioner's history of a lack of back problems and very little pain prior to the motor vehicle accident. RX17, p. 25-6. Dr. Candido explained his opinion regarding the July 15, 2015 MRI- that the MRI evidenced a long-term degenerative process and not an acute trauma. RX17, p. 27. Dr. Candido opined Petitioner suffered an acute exacerbation of his chronic lumbar spondylosis which was improving as of September 25, 2015. RX17, p. 28. Dr. Candido found no evidence of radiculopathy only pain in the lumbar facet joints. *Id.*

Dr. Candido performed Waddell testing and identified only one of five positive categories. RX17, p.30. Dr. Candido was perplexed as to why Petitioner underwent epidural steroid injections as Petitioner's examination was negative for radiculopathy. RX17, p. 31. Dr. Candido recommended lumbar facet and/or medial branch block injections. RX17, p. 32. At the time of the evaluation, Petitioner was working full-duty, and Dr. Candido expected maximum medical improvement to be obtained in four weeks' time. RX17, p. 33.

Dr. Candido was subsequently provided with additional medical records and, thereafter, prepared an addendum report. RX17, p. 34. Based on his review of the additional records, Dr. Candido opined Petitioner's lumbar facet syndrome was not related to the motor vehicle accident. RX17, p. 35. Dr. Candido explained the records he reviewed evidence a lengthy history of low back pain with an injury in February of 2015 and chronic pain since Petitioner's third surgery. RX17, p. 36. The medical records contradicted Petitioner's history of an asymptomatic back prior to the motor vehicle accident. RX17, p. 35-6. Dr. Candido testified it was his opinion Petitioner suffered from chronic lumbar spondylosis which pre-dated the motor vehicle accident. RX17, p.37. Dr. Candido neither agreed nor disagreed with Dr. Settecase's opinion that the motor vehicle accident caused an acute exacerbation of Petitioner lumbar pain as Dr. Candido did not evaluate Petitioner until September 29, 2015 at which time he found no condition of ill-being associated to the motor vehicle accident. *Id.* Dr. Candido testified the transforaminal and caudal injections were not reasonable as they were not medically indicated. RX17, p. 39.

On cross-examination, Dr. Candido testified he is not board-certified in either orthopedics or neurosurgery and has not performed fusion surgery. RX17, p.42-3. Dr. Candido testified he did not review the actual films from the diagnostic tests, only the reports. RX17, p.45. Dr. Candido reviewed the CT scan report from October 2, 2008 which found "a diffuse disc bulge, mild central canal stenosis, mild bilateral foramina, and moderate to severe facet joint arthropathy; and there is a laminectomy at L4 with bilateral pedicle screws" and the CT scan report of April 7, 2009 which found "a mild diffuse disc bulge rightward, a small disc herniation in the right neural foramen without significant stenosis." RX17, p. 46. Dr. Candido reviewed the MRI report of July 15, 2015 which "showed lumbar spondylosis with a right paracentral, slash, neural foraminal disc/osteophyte complex at L3-4 contributing to right neural foraminal and lateral recess stenosis at this level." RX17, p. 47. Dr. Candido explained, "I think it's not a fair comparison to compare a CT scan with an MRI. The two imaging modalities are grossly inconsistent one with the other." RX17, p. 48. Dr. Candido further explained CT scans are useful for identifying bone structures but much less useful for identifying soft tissues like discs and ligaments whereas an MRI visualizes soft tissue structures exceptional well. RX17, p. 48-9. Dr. Candido explained the CT scan and MRI are different studies such that the language used is different, but the ultimate findings are essentially the same. RX17, p.50

Dr. Candido testified Petitioner complained of right leg pain during his evaluation. RX17, p. 53. Dr. Candido explained right leg pain can be caused by stenosis as well as a variety of other causes. RX17, p. 53. Dr. Candido further explained radiculopathy is not solely pain but implies pain coupled with sensory changes, motor weakness, and reflex change. RX17, p. 56. Dr. Candido testified an asymptomatic disc herniation can become symptomatic due to a car accident as well as with no provocation at all. RX17, p.59. Dr. Candido re-iterated his opinion

regarding causation changed after he was provided medical records which contradicted Petitioner's history to him of no pain following Petitioner's back surgeries and an immediate onset of pain after the motor vehicle accident. RX17, p. 60.

CONCLUSION OF LAW

A. Accident/Average Weekly Wage

It is undisputed Petitioner sustained an accident on June 18, 2015 when he was involved in a motor vehicle collision which lead to an injury to his back. The parties stipulated to an average weekly wage equaling $640.00.

B. Causal Relationship

The Commission finds Petitioner sustained a temporary aggravation of his lumbar spine condition (chronic lumbar pain with three prior fusion surgeries) which stabilized as of September 18, 2015, the date of maximum medical improvement as found by Dr. Goldvehkt and consistent with the opinions of Dr. Candido. For the reasons stated below, Petitioner failed to prove his current condition of ill-being and need for treatment is related to his accident of June 18, 2015.

"[T]he 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. [citation omitted]." *R.A. Cullinan and Sons v. The Industrial Commission*, 216 Ill. App. 3d 1048, 1054, 575 N.E.2d 1240 (1991). The "interpretation of the testimony of medical witnesses is particularly within the province of the Industrial Commission. [citation omitted]." *A.O. Smith Corporation v. The Industrial Commission*, 51 Ill. 2d 533, 537, 283 N.E.2d 875 (1972).

Immediately following the accident, Petitioner was transported via ambulance to St. Bernard Hospital ER where he complained of back pain. A CT scan was performed evidencing post-surgical changes with the remainder of findings normal. PX5. On June 19, 2015, at the direction of the emergency room personnel, Petitioner sought treatment with his primary care physician, Dr. Settecase complaining of general soreness especially in his neck and back. Dr. Settecase diagnosed an acute exacerbation of Petitioner's chronic back pain and authorized him off-work for ten days. PX3.

Due to Petitioner's continued back pain, he sought treatment with both Dr. Goldvekht and Dr. Jain, simultaneously. Both Dr. Goldvehkt and Dr. Jain prescribed physical therapy and medications. Dr. Jain additionally provided injections in July and August of 2015. On August 7, 2015, Dr. Goldvekht released Petitioner to return to work of no lifting, alternating between sitting and standing, and no driving more than 45 minutes continuously. PX4.

On August 17, 2015, Dr. Jain evaluated Petitioner who advised the injections provided 50% relief. Petitioner stated:

> he did an hour and half of driving without stopping to evaluate whether he could return to work. He then attempted to do three installations of the product that he installs, which is lifeline for elderly people. He attempted the installations consecutively after driving an hour and a half. The patient reports that he was able to complete the simulated work successfully and fells that he would like to go back to do a trial of full duty at work.

Dr. Jain released Petitioner for a trial return to work with a refill of his Norco medication. PX2.

Petitioner testified he returned to work for Respondent in August of 2015 performing his full-duty responsibilities. TA. 36. Petitioner continued to work full-duty until his termination by Respondent in November of 2015. TB. 119.

During his return to full-duty work from August to November of 2015, Petitioner was re-evaluated by Dr. Goldvekht on two occasions, August 21, 2015 and September 18, 2015. During both evaluations Petitioner voiced improvement with his complaints focused on intermittent back pain. Dr. Goldvekht placed Petitioner at maximum medical improvement as of September 18, 2015 finding Petitioner's condition had stabilized, and Petitioner sought no further treatment from either Dr. Goldvekht or Dr. Jain thereafter.

At trial Petitioner testified he continued to experience significant low back pain as well as a new symptom of right leg pain. The Commission affords little weight to Petitioner's testimony in this regard as the medical records fail to support the same. On August 21, 2015, Dr. Goldvekht specifically advised Petitioner to return sooner if he should experience any increase in symptoms. More importantly, the medical records relating to Petitioner's treatment prior to November of 2015 fail to memorialize right leg pain save one history provided to Dr. Jain on July 13, 2015. In the emergency room, Petitioner denied experiencing lower extremity symptoms and made no mention of such symptoms to either Dr. Settecase or Dr. Goldvekht. Moreover, there is no question Petitioner suffered from a long-standing pre-existing back condition necessitating the continued use of narcotic pain medication. The records memorialize a significant history of ongoing back pain as well as radiculopathy regarding the lower extremities. RX23; RX24.

During the multiple days of testimony, Petitioner was questioned repeatedly regarding his illicit drug use specifically as to his cocaine use as well as his history of smoking. Petitioner's explanations regarding his positive drug testing results strain credibility, and Petitioner was certainly less than forthright to his medical providers concerning his smoking habit; neither issue, though, bears on Petitioner's credibility as it relates to his testimony concerning his back and leg pain post-accident. As stated above, Petitioner's credibility is impugned by the contemporaneous medical records as well as the pre-accident records.

Additionally, Dr. Goldvekht's opinion placing Petitioner at maximum medical improvement as of September 18, 2015 is supported by the opinions of Dr. Candido. Dr.

Candido initially found a causal relationship between Petitioner's accident and his condition of ill-being and need for treatment. As Dr. Candido explained he predicated his opinion on the history provided by Petitioner "—the low back condition had been relatively quiescent until the motor vehicle accident had occurred." RX17, p.25. Moreover, as of September 29, 2015, Dr. Candido found no evidence of radiculopathy. RX17, p.28. Once Dr. Candido was presented with additional medical documentation, he revised his opinion finding Petitioner's present condition of ill-being and need for ongoing treatment was unrelated to his accident but due to his chronic degenerative condition. RX17, p. 36. Dr. Candido explained Petitioner's underlying condition of chronic lumbar spondylosis and chronic failed lumbar spine surgeries as well as chronic pain complaints were long-standing in nature as evidenced by the medical records as well as the diagnostic testing which pre-dated his work accident. RX17, p.36-7.

Both Dr. Candido and Dr. Miz testified at length regarding the differences between a CT scan image and MRI image, and both agreed each scan evaluated different body structures with more precision, CT scan- bone structures and MRI- soft tissues and discs. PX1, p. 28; RX17, p. 48-9. Ultimately, Dr. Candido opined Petitioner's pre and post-accident scans evidence essentially the same findings. RX17, p. 50.

Certainly, Dr. Miz offered an opinion contrary to that of Dr. Candido in finding the accident aggravated Petitioner's long-standing condition. PX1, p. 19. Dr. Miz, though, predicated his entire opinion on Petitioner's subjective history of increase of back pain and new right leg symptoms, admitting he had requested pre-accident medical records but had failed to receive and review the same. PX1, p.24. An expert's opinion is only as valid as the facts upon which it is based. *Gross v. Illinois Workers' Compensation Commission*, 2011 IL App (4th) 100615WC. Dr. Miz did not alter his opinion as to causation when presented with Petitioner's pre-accident scans, but given Dr. Miz' lack of a complete understanding of Petitioner's long-standing pre-existing medical condition, the Commission affords little weight to his opinion.

Therefore, based on the opinion of Dr. Goldvekht finding Petitioner sustained a sprain/strain and his back condition stabilized as of September 18, 2015 which is further supported by the opinions of Dr. Candido, the Commission finds Petitioner failed to prove a causal relationship between his work accident and his current condition of ill-being and need for additional treatment.

C. Temporary Total Disability Benefits

"To show entitlement to TTD benefits, claimant must prove not only that he did not work, but that he was unable to work. [citation omitted]." *City of Granite City v. The Industrial Commission*, 279 Ill. App. 3d 1087, 1090, 666 N.E.2d 827 (1996). Further "[t]he dispositive test is whether the claimant's condition has stabilized, that is, whether the claimant has reached maximum medical improvement. [citation omitted]." *Mechanical Devices v. The Industrial Commission*, 344 Ill. App. 3d 752, 759. Petitioner reached maximum medical improvement as of September 18, 2015.

20IWCC0021

The Commission finds Petitioner entitled to temporary total disability benefits for the period of June 19, 2015 through August 23, 2015, the date Petitioner returned to work full duty. The Respondent is granted a credit of $5904.16 for benefits paid.

D. Medical Expenses

Section 8(a) of the Illinois Workers' Compensation Act entitles a claimant to recover medical expenses which are reasonable, necessary, and causally related to an accident. *820 ILCS 305/8(a)* (West 2010); *Zarley v. The Industrial Commission*, 84 Ill. 2d 380, 418 N.E.2d 718 (1981). The same standard applies to prospective medical care. *Homebrite Ace Hardware v. The Industrial Commission*, 351 Ill. App. 3d 333, 814 N.E.2d 126 (2004). Petitioner sustained a temporary aggravation to his low back condition due to his accident of June 8, 2015 with maximum medical improvement being reached by September 18, 2015. The Commission finds Petitioner's treatment rendered through September 18, 2015 is causal connected to his work accident, and the medical expenses associated with that care are reasonable and necessary under Section 8(a) of the Act. Petitioner's request for prospective medical care is denied.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's condition of ill-being following his undisputed June 18, 2015 work accident reached maximum medical improvement as of September 18, 2015.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $426.67 per week for a period of 9 3/7 weeks, representing June 19, 2015 through August 23, 2015, 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 the reasonable, necessary and related medical expenses as contained in Petitioner's Exhibit 2 incurred prior to and including September 18, 2015, pursuant to §8(a) of the Act, subject to the Medical Fee Schedule pursuant to §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 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 is entitled to a credit under §8(j) of the Act; provided Respondent shall hold Petitioner harmless from any

20IWCC0021

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 shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury. The Respondent paid $5,904.16 in benefits.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $47,800.00. 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: JAN 10 2020

L. Elizabeth Coppoletti

LEC

Stephen Mathis

O: 6/19/19

43

DISSENT

I find that the evidence supports that Petitioner's current condition is causally related to his June 18, 2015 accident and further would order the Respondent to provide and pay for the surgery proposed by Dr. Miz.

The Petitioner openly testified that he had three prior fusions. The first was performed in June 2007; the second in July 2008; and, the third in August 2009. Following the third fusion, Petitioner testified that he was able to return to work despite experiencing a little pain. Between the third fusion in August 2009 and the start of his employment with Respondent in December 2014, Petitioner worked as a home health care aide, a counselor at a juvenile sex offender facility, and with Dish Satellite Company. While employed with Dish, he would install satellite dishes, which required him to carry 50-pound ladders, carry equipment up the ladders, wear a utility belt, make connections, and crawl on his hands and knees. He described his job duties as physical in nature. Despite experiencing a small amount of pain, he was able to work without any restrictions. Petitioner was then hired by the Respondent on December 8, 2014. At the time of his hire, he testified that he had a small amount of back pain for which he would take Ibuprofen or Tramadol. He rated his pain as a 2-3 out of 10, and he was able to work without restrictions.

On February 15, 2015, Petitioner injured his back while moving an elliptical. Petitioner presented to Dr. Payne and was taken off work for this non-work-related event. Petitioner returned to work one week later and last saw Dr. Payne on February 19, 2015. Petitioner continued to work without restrictions thereafter.

Petitioner was involved in a motor vehicle accident on June 18, 2015. He was rear ended while driving the company vehicle. This caused damage to the rear of the vehicle. Petitioner was transported via ambulance to St. Bernard Hospital where he was treated and released. Petitioner followed-up with his primary care physician and later received physical therapy and injections for lumbar pain radiating to the right leg.

Petitioner underwent a lumbar MRI on July 15, 2015. The MRI revealed postsurgical changes from the posterior spinal fusion and laminectomies with mild postcontrast enhancement consistent with scar tissue/fibrosis. The MRI also revealed lumbar spondylosis with a right paracentral/neural foraminal disc/osteophyte complex at L3-4 contributing to right neural foraminal and lateral recess stenosis at this level.

Petitioner testified that following the accident, his pain was 7-8 out of 10. He described his pain as constant and severe, and never goes away.

It is well established that employers take their employees as they find them. *O'Fallen School District No. 90 v. Industrial Comm'n*, 313 Ill. App. 3d 413, 417, 729 N.E.2d 523, 246 Ill. Dec. 150 (2000). To result in compensation under the Act, a claimant's employment need only be a causative factor in his condition of ill-being; it need not be the sole cause or even the primary cause. *Sisbro Inc. v. Industrial Comm'n*, 207 Ill. 2d 193, 205, 797 N.E.2d 665, 278 Ill. Dec. 70 (2003). "[A] preexisting condition does not prevent recovery under the Act if that condition was aggravated or accelerated by the claimant's employment." *Caterpillar Tractor Co. v. Industrial Comm'n*, 92 Ill. 2d 30, 36, 440 N.E.2d 861, 65 Ill. Dec. 6 (1982). Further, 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. *Int'l Harvester v. Indus. Comm'n*, 93 Ill. 2d 59, 63-64 (1982).

Without question, Petitioner had a pre-existing back condition that was causing him some pain. While he was not in a condition of "good health" prior to the accident, he was able to work full-duty and without restriction until the accident. Since the accident, Petitioner has complained of constant pain, an increase in his pain level, and has been taken off work. I find that the Respondent has offered no credible evidence that his current condition is related to anything other than the accident. Because of this, I would find that the accident, in the very least, caused an aggravation of his pre-existing condition and that his current condition is causally related to the work accident.

The Respondent argues that the Petitioner's credibility was so damaged by his denials concerning drug use that his claim should be denied. I agree that the Petitioner's credibility is suspect but find that the objective evidence in this matter supports his claim. He was in a motor vehicle accident requiring emergency room care. The MRI done within one month of the accident showed objectively that the Petitioner has pathology at the level of L3-4, the level above his prior fusions. While a discogram does include some subjective components, the Petitioner did show damage to the L3-4 disc which corresponded to his MRI findings. Dr. Miz, whom I find persuasive, based his opinions on those objective test findings.

I find the opinion of Dr. Miz more persuasive than the opinion of Dr. Candido. Dr. Miz opined that Petitioner's current condition and need for the L3-L4 fusion was related to the motor vehicle accident. His opinion was based, in part, upon the fact that Petitioner was functioning reasonably well and working full-time at the time of the accident. He was involved in the accident and developed a subsequent onset of back pain including radicular right leg pain that Dr. Miz noted was not present prior to the accident.

Dr. Miz noted that the July 15, 2015 MRI revealed right sided bulges and some foraminal stenosis at L3-L4. He noted that this finding was different than the prior CT scan which described a diffused disc bulge. Dr. Miz noted that the July 15, 2015 MRI revealed a more significant condition than the older diagnostic studies. He noted that the stenosis seen on the MRI correlated with the radicular symptoms and was not present on the prior reports.

Dr. Candido's opinion is not supported by the evidence. Dr. Candido diagnosed Petitioner with facet joint syndrome that was not related to the accident. His opinion was based on the prior medical records and he noted that the injury from moving the elliptical caused an additional exacerbation of Petitioner's underlying condition. He notes, however, that the work accident did result in transient worsening of Petitioner's L4 lumbar facet joint, but it was not expected to be permanent. After reviewing the record, I find no evidence that Petitioner's post-accident condition was temporary or ever returned to its pre-accident condition.

Therefore, I would find the Petitioner's current condition is causally related to his accident and that the proposed surgery is a reasonable treatment option warranted under Section 8 of the Act.

D. Douglas McCarthy

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

CRAWFORD, CHRISTIAN Case# **15WC034957**
Employee/Petitioner

PHILIPS ELECTRONICS NORTH AMERICA CORP
Employer/Respondent

20IWCC0021

On 3/7/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.83% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1067 ANKIN LAW OFFICE LLC
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CHICAGO, IL 60602

4696 POULOS & DeBENEDETTO
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CHICAGO, IL 60607

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION

CORRECTED ARBITRATION DECISION

19(b), 8(a)

Christian Crawford
Employee/Petitioner

v.

Phillips Electronics North America Corp.
Employer/Respondent

Case # **15** WC **34957**

Consolidated cases: **N/A**

20IWCC0021

An *Application for Adjustment 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 **Chicago**, on **11/18/16, 7/13/17, and 7/19/17**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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, **6/18/15**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did*** 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 $**33,280.00**; the average weekly wage was $**640.00**.

On the date of accident, Petitioner was **36** 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 $**4,368.16** for TTD, $**0** for TPD, $**0** for maintenance, and $**1,536.00 ppd advance** for other benefits, for a total credit of $**5,904.16**.

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

ORDER

Medical benefits

Respondent shall pay reasonable and necessary medical services of $113,155.51, as provided in Section 8(a) & 8.2 of the Act, as amended. The payments are to be made to the Petitioner and his attorney.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $34,158.80 to Elmwood Park Same Day Surgery Center, $21,090.00 to Pain Specialists of Greater Chicago, $12,310.00 to Pinnacle Pain Management Specialists, $11,200.00 to APM Surgical Group, $15,857.46 to Injured Worker's Pharmacy, $6,190.00 to Archer Open MRI, $3,431.25 to Advanced Physical Medicine, $2,610.00 to RM Anesthesia, $1,034.00 to City of Chicago EMS, $3,998.00 to St. Bernard Hospital, $430.00 to Bone & Joint Physicians,$115.00 to Franciscian Alliance, and $731.00 to Universal Radiology, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay reasonable and necessary medical services of $113,155.51, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit of $0.00, unless stipulated to on Arbitrator Exhibit one, 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.

Temporary Total Disability

Respondent shall pay Petitioner & his attorney : temporary total disability benefits of $426.67/week for **29 & 4/7th weeks,** commencing June 19, 2015 through August 23, 2105 **(66 days, amounting to 9 & 3/7ths)** and November 17, 2015 though April 5th, 2016 **(141 days, amounting to 20 & 1/7th weeks).**

Respondent shall pay Petitioner and his attorney, the temporary total disability benefits that have accrued from 6/19/15 through 7/19/17 the date proofs were closed , and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall be given a credit of $4,368.16 for temporary total disability benefits and additional compensation that have been paid.

Prospective Medical Care

The Arbitrator denies awarding Petitioner the L3-L4 lumbar fusion surgery prescribed by Dr. George Miz.

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.

#001 Arb. George J. Andros **CORRECTED March 6, 2018**

Signature of Arbitrator Date

MAR 7 - 2018

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FINDINGS OF FACT 15 WC 034 957

The Arbitrator notes the hearing in this matter occurred on three separate dates including November 18, 2016, July 13, 2017 & July 19, 2017.Citations to the transcript include specific testimony date where necessary.

Petitioner, a 35-year-old male, worked for Respondent as a Field Installer, which entails installing "Lifeline" devices in customers' homes (Tx. 20). Petitioner claims a date of accident of June 18, 2015 on his Application. He testified that on June 18, 2015 he was driving to his next installation. While driving on Interstate – 94 he was in a motor vehicle accident (Tx. 21). He was rear-ended then immediately driven via ambulance from the scene of the motor vehicle accident to St. Bernard Hospital. (Tx. 22).

Petitioner's Medical Treatment

Petitioner was seen at the emergency department of St. Bernard Hospital on June 18, 2015. Petitioner testified the examining physician at St. Bernard instructed him to follow up with his primary care physician (11/18/2016 Tx. 27). Emergency room referrals do not under law constitute a first choice of doctors by the patient under case law for section 8 choice purposes.

On direct examination, Petitioner testified he did not treat with his primary care doctor, Dr. Michael Settecase (Tx. 30). However he later said he saw Dr. Settecase as a follow-up from the emergency room visit, and the attending physician at St. Bernard Hospital told him to see Dr. Settecase (07/13/2017 Tx. 17). Petitioner testified he has been seeing Dr. Settecase since 2004 (Tx. 17). A work status letter dated June 19, 2015 by Dr. Settecase is Rx. 1). Dr. Settecase wrote Petitioner may return to work on June 29, 2015 "after reevaluation due to motor vehicle collision." (Rx. 1) Petitioner testified he did not return to work for Philips after the June 29, 2015 full duty release date (Tx. 20). He stated he did not return to work for Philips until August of 2015 (Tx. 21).

Petitioner testified when he started working for Respondent he still had small amounts of pain in his back (11/18/2016 Tx. 62). He noted he was taking Ibuprofen throughout the day, and his doctor gave him a narcotic to help sleeping at night. He testified Dr. Settecase, his primary care physician, is the doctor who gave him pain medications (Tx. 62).

Petitioner testified he next went to Advanced Physical Medicine to obtain treatment (11/18/2016 Tx. 30). He stated that at Advanced Physical Medicine he was provided physical therapy, stim treatments and heat packs (Tx. 31). On cross examination, Petitioner testified he could not recall who referred him to see Dr. Goldvekht at Advanced Physical Medicine (07/13/2017 Tx. 23). While treating at Advanced Physical Medicine Petitioner was referred to Dr. Jain for injections in his mid-back (11/18/2016 Tx. 32). Dr. Jain issued a Patient Status Form through Pinnacle Pain Management Specialists indicating that Petitioner may continue regular duty work as of August 17, 2015. (Rx. 2). Petitioner testified he also underwent MRI scans to the lumbar spine and right elbow (Tx. 35).

Petitioner testified he was released to work without any restrictions as of August 21, 2015 by Dr. Goldvekht at Advanced Physical Medicine, and he did in fact return to work at that time (07/13/2017 Tx. 26-27). Advanced Physical Medicine and Dr. Goldvekht records read Petitioner was released to return to work with no restrictions as of September 18, 2015. (Rx. 4). Petitioner confirmed on cross examination that he did return to work without restrictions for Philips after the September 18, 2015 Disability Release was issued (Tx. 28). On direct examination, Petitioner testified he returned to work for Philips shortly after he completed his treatment with Advanced Physical Medicine (11/18/2016 Tx. 36). He was performing his full job duties when he returned to work (Tx. 37).

Petitioner testified he next sought further treatment with Dr. Glaser with Pain Specialists (11/18/2016 Tx. 46). He testified he decided to seek a "second opinion" with Dr. Glaser (Tx. 46). On cross examination, Petitioner testified he did not recall originally stating he sought a second opinion for his back pain with Dr. Glaser (07/13/2017 Tx. 29). He later testified that he was referred to Dr. Glaser by his friend named Brian (07/19/2017 Tx. 14, 21). Petitioner's initial visit with Dr. Glaser was on November 17, 2015. (Rx. 5). He was still following up with Dr. Glaser as of the hearing on November 18, 2016, and continued to follow up with Dr. Glaser as of the hearing on July 13, 2017 (07/13/2017 Tx. 32). Petitioner testified he notified Dr. Glaser of the three prior surgical procedures performed on his back (Tx. 33-34).

On direct examination, Petitioner testified that there was a time on one occasion where he failed a drug test and tested positive for an illicit narcotic (11/18/2016 Tx. 72). Petitioner testified on cross examination that he has never "knowingly" used cocaine (07/13/2017 Tx. 39).
The Arbitrator finds no proof of intoxication exists under the 2005 reform section 11 of the Act.

On cross examination, Petitioner admitted that he answered in the affirmative on direct examination when he was asked whether there was an instance that he tested positive for cocaine (07/13/2017 Tx. 37). Petitioner admitted that he underwent drug testing through Dr. Glaser's practice on August 22, 2016, and further admitted that he tested positive for cocaine on this date (Tx. 47). Dr. Glaser's office visit notes dated September 19, 2016 indicate Petitioner's last drug test was on 08/22/2016, which "was inconsistent with medications prescribed + cocaine, benzo, opiates, oxycodone." (Rx. 22). Dr. Glaser's notes from this date also state, "Pt remains adamant that he did not take cocaine." (Rx. 22).

Petitioner testified that on October 21, 2016, during his visit with Dr. Glaser he told Dr. Glaser that his mother had been using cocaine (Rx. 6; 07/13/2017 Tx. 38). He also admitted that he told Dr. Glaser his mother had been staying with him during that time (Tx. 38). Petitioner testified that the drug test to which he submitted indicated a positive result for cocaine (Tx. 39). However, Petitioner testified that he told Dr. Glaser that any cocaine detected in his system was inadvertent. He testified, "I never knowingly used cocaine" (Tx. 39). When Petitioner was asked to clarify on cross examination how he would test positive for cocaine while never having knowingly used cocaine, Petitioner stated, "My guess is cleaning up after my mother, there is residue on countertops that you think was sugar, was wiping it off, it turns out to be or inadvertently injecting [sic] it somehow, getting through the pours [sic], I don't know." (Tx. 39-40). When asked during cross examination whether he previously testified that he had used cocaine, Petitioner stated, "I can't recall. I can't recall." (Tx. 42). Petitioner testified that the drug test in question, in which he blamed his mother for the positive result, took place on August 22, 2016 (Tx. 47).

The evidence or reasonable inference of addictive behavior is not determinative of the ultimate prescriptive advice on the medical side- whether Dr. Miz' surgical recommendation is reasonable, necessary and causally related to the accident. Assuming the addictive behavior underscored heavily upon cross examination under a continuing objection of relevance, is accepted , it did not rise to the level of required proof under the specific black letter law of section 11 of the 2005 " reform" Act. Respondent's intent is on an attack of credibility as indicated on the record.

Petitioner testified that he was seen by Dr. George Miz, who recommended further surgery to the lumbar spine, but he has not received the recommended treatment to date (11/18/2016 Tx. 70). He testified that he wishes to proceed with the surgical treatment that has been recommended (Tx. 70). With regard to his treatment with Dr. Miz, Petitioner testified he was referred to Dr. Miz by a friend (07/13/2017 Tx. 49). Petitioner later said Dr. Glaser had referred him to Dr. Miz (07/19/2017 Tx. 14). Respondent holds to the first testimony , however, the records of the doctors indicate and are the best evidence of the actual referral by Dr. Glaser to Dr. Miz

Petitioner testified Dr. Miz recommended that Petitioner undergo a lumbar discogram (07/13/2017 Tx. 49).

Petitioner testified he received Temporary Total Disability benefits for the time period of June 19, 2015 through August 23, 2015 (07/13/2017 Tx. 117).

Moreover, Mr. Crawford testified he underwent three previous lumbar surgeries (11/18/2016 Tx. 53). The first fusion procedure occurred in 2007, the second was in July of 2008, and the third was in July of 2009 (Tx. 53). Petitioner testified after the third procedure in 2009, there was still pain, but it was enough to manage to go back to work (Tx. 54).

When he was asked during redirect examination how his memory is in general, Petitioner responded, "It's terrible" (07/19/2017 Tx. 12).

Prior Medical Treatment with Dr. William Payne

On cross examination, Petitioner testified he has been seeing doctors for treatment to his back since 2005 (07/13/2017 Tx. 50). Petitioner testified that he treated with Dr. William Payne in 2006 and 2007 for his low back as part of a work-related injury (Tx. 51). Dr. Payne's treatment records are contained in a response pursuant to subpoena and identified as Rx. 23. Petitioner was asked if he believes he has an addictive personality, and testified, "I smoke cigarettes for 20 years." (Tx. 60). The medical records of Dr. Payne dated June 3, 2008 indicate Petitioner had been taking Methadone (Rx. 23). Petitioner admitted on cross examination that he had been taking Methadone at that time (Tx. 64). Petitioner admitted that on June 3, 2008 Dr. Payne stated Petitioner's mother called him and said he could not attend his appointment because of cocaine use (Rx. 23; Tx. 66). However, Petitioner testified he did not actually miss that appointment due to cocaine use (Tx. 67). He testified, "Dr. Payne stated that my mother called and stated that, that is not coming from me. I missed the appointment due to transportation issues probably he's getting that from my mother, not me" (Tx. 67). Petitioner reiterated during his testimony on cross examination that he has not used cocaine in the past (Tx. 68). He testified, "My mother has been an addict since I was born." (Tx. 68).

Petitioner testified on cross examination that he injured his back in February of 2015 when he was trying to move an elliptical machine. (Rx. 23, 07/13/2017 Tx. 73). Petitioner was shown the office notes of Dr. Payne dated February 19, 2015 and admitted the notes state he injured his back while trying to move an elliptical machine on February 15, 2015 (Tx. 75). He stated he was working for Philips at the time of that incident, and he noted this was not a work-related injury (Tx. 76). Petitioner admitted that he had been moving an elliptical machine in his home at the time of that incident. He also stated he was experiencing pain in his back after the incident occurred on February 15, 2015 (Tx. 76). He testified he was taken off work for one week following the incident with the elliptical machine (Tx. 77). He testified he has not seen Dr. Payne since February 19, 2015 (Tx. 78).

Prior Medical Treatment with Dr. Howard An

Petitioner testified his treatment with respect to his 2005 injury included treatment with Dr. Howard An (07/13/2017 Tx. 80). Dr. An's medical records returned pursuant to subpoena were admitted into evidence as Rx. 24. Petitioner underwent two separate surgical procedures with Dr. An. (Rx. 24). Dr. An performed surgery to Petitioner's lumbar spine on July 14, 2008 and July 30, 2009 (Rx. 24; Tx. 81). Petitioner testified that while he was under Dr. An's care, he was also seeing Dr. Buvanendran for pain management, which included injections to the lumbar spine (Tx. 84).

On cross examination Petitioner admitted that while he was treating with Dr. An and Dr. Buvanendran in 2010, he tested positive for cocaine (07/13/2017 Tx. 84-85). When Petitioner was asked what happened in 2010 that would lead to a positive test, he stated, "I was living with my mother I was kicked out of my house at that time" (Tx. 94). Petitioner elaborated with regard to his mother and testing positive for cocaine: "Because I was living with my drug addict of a mother again, and she is a drug addict. There is stuff around. I inadvertently ingested it, it gets in your pours [sic]. It's water soluble, I don't know, it just happens. That's what happens when you take care of a drug addict mother" (Tx. 95). Petitioner was asked whether he was going to stand by his answer that he has never knowingly ingested cocaine before. He responded, "Not on my own free will, not taking it for the drug to get high" (Tx. 98).

Petitioner testified that from 2005 to 2011 he cannot remember anything because of the surgeries (07/13/2017 Tx. 100-101). He testified he could not recall whether he was discharged from the pain clinic in May of 2011 for another positive test for cocaine, and he testified he doesn't know if he was told by the pain clinic that his positive test had violated the pain management contract (Rx. 24; Tx. 103).

Petitioner testified with regard to his current and past cigarette smoking habit. Petitioner was shown a portion of Rx. 24, Dr. An notes dated July 17, 2009, and acknowledged that the notes state, "the risks and benefits of the procedure were discussed at length. The patient states he's now stopped smoking. He understands that smoking increases his risk for pseudoarthrosis" (07/13/2017 Tx. 108). Another portion of Dr. An's records read as follows: "We have had the opportunity to discuss this and the possibility that smoking may have contributed to the fusion non-union. The patient denies vehemently having smoked" (Rx. 24; Tx. 109).

Petitioner acknowledged he was told by multiple doctors that smoking increases the risk of non-union for a spinal fusion (Tx. 110). He admitted he was still smoking as of the hearing date on July 13, 2017; he was told by treating doctors that he should not smoke cigarettes because his fusion may fail (Tx. 111).

Testimony of Dr. George Miz

The deposition of Dr. Miz took place on July 8, 2016 (Px. 1). He testified he first saw Petitioner on April 5, 2016, and was referred by Dr. Glaser (Px. 1 p. 8). Dr. Miz testified Petitioner had a history of back problems dating back to approximately 2007, and he had undergone three surgeries to complete healing for an L4-S1 fusion (Px. 1 p. 9). Upon review of the lumbar spine MRI, Dr. Miz testified that Petitioner had a right-sided disc bulge with narrowing of the foramen (Px. 1 p.12). He testified that he diagnosed Petitioner with right lumbar radiculopathy corresponding with L3-L4 findings on the MRI.

Dr. Miz testified that, in his opinion, the Petitioner's spine condition is causally related to the June 18, 2015 incident (Px. 1 p.18). The reasoning for this opinion was that, despite Petitioner's previous back problems, he was functioning reasonably well and working full time at the time of the injury, with only residual pain, and the radicular pain in the right leg had not been present at any time before (Px. 1 p. 19). (emphasis added.)

The Arbitrator notes, during the deposition, Respondent raised an objection to Dr. Miz's opinion testimony with regard to the causal connection between Petitioner's spine condition and the June 18, 2015 motor vehicle accident. Respondent objected to Dr. Miz's testimony based on the grounds that Dr. Miz's causation opinions were not disclosed in any treatment notes or narrative reports previously made available to Respondent, pursuant to *Ghere v. Industrial Commission,* 278 Ill. App. 3d 840 (4th Dist. 1996). Subsequent cases and Commission decisions indicate that if causation, for example is clearly an issue before the deposition then any Ghere objection is not applicable. Dr. Miz answers need not be, as a scrivener, emboldened in the records before a deposition. It is clear causation has been, is plus will be a continuing issue in the case. No surprise to either side can be inferred. The Ghere objection is overruled.

On cross examination, Dr. Miz reviewed a report with regard to a CT scan of the lumbar spine dated October 2, 2008, and testified that the findings included diffuse disc bulging, mild spinal stenosis and a moderate-to-severe facet joint arthropathy at the L3-L4 level (Px. 1 p. 26). Dr. Miz admitted on cross examination that nicotine use does have a negative impact with regard to fusion success, and may have contributed to Petitioner's previous fusion recovery (Px. 1 p. 38). Dr. Miz testified nicotine's effects on recovery really matter only post-surgery, and if Petitioner were able to cease using nicotine for about three months post-surgery, his risk on non-union would return to that of a non-smoker (Px. 1 p. 39).

Testimony of Dr. Kenneth Candido- anesthesiologist

20IWCC0021

Dr. Candido performed a Section 12 examination of Petitioner on September 29, 2015. Petitioner testified on cross examination he told Dr. Candido about his prior back problems since 2005, as well as his three previous lumbar spine surgeries (07/13/2017 Tx. 114-115). Petitioner testified he does not recall whether he told Dr. Candido about any of the previous positive drug test results (Tx. 116).

Dr. Candido's deposition took place on October 20, 2016. (Rx. 17). Dr. Candido testified that he is board certified by the American Board of Anesthesiology, and through that board he also has qualifications in pain medicine (Rx. 17 p. 5). He specializes in anesthesiology and pain medicine (Rx. 17 p. 7). Dr. Candido testified his report prepared in conjunction with the September 29, 2015 evaluation was based on medical records reviewed, which dated from June 18, 2015 through August of 2015; the records dating back to 2006 were not available until the addendum report that he authored on March 10, 2016 was prepared (Rx. 17 p. 13). Dr. Candido testified the Petitioner admitted to having chronic lumbar back pain prior to June 18, 2015 and had surgery with Dr. Payne in 2007 as well as Dr. An at Rush in 2008 and 2009 (Rx. 17 pp.13-14).

Dr. Candido testified that Petitioner stated he was operating his work vehicle when he was struck in the rear of his vehicle. It was about ten o'clock in the morning and he was driving about 35 miles per hour. He called his supervisor and a technical team to alert them that he was in an accident. (Rx. 17 pp. 13-14). Dr. Candido noted Petitioner went to St. Bernard Hospital, had CT scans and X-rays. His primary care provider, Dr. Settecase, told him he had only whiplash. (Rx. 17, p.15). He noted Petitioner had four epidural steroid injections in July of 2015; he underwent additional injections in August 2015 (Rx. 17 p. 16).

Dr. Candido testified he performed a physical examination of Petitioner, which elicited the following findings: Normal range of motion for the neck (Rx. 17 p. 20); negative Tinel's sign for the bilateral upper extremities (Rx. 17 p. 21); sensation was intact to all dermatomes; straight leg raise was negative bilaterally at 60 degrees (Rx. 17 pp. 21-22). Dr. Candido testified that he assessed no cervical spine issues, and sensation and range of motion of the neck were normal (Rx. 17 p. 23). He stated Petitioner had some tenderness at the right lateral epicondyle, which Dr. Candido said may be a mild form of tennis elbow, but he could not link this condition to the June 18, 2015 accident, as tennis elbow is a repetitive motion injury (Rx. 17 p. 23).

Dr. Candido testified Petitioner had pain with extension and tenderness to palpation over the facet joints at L4 bilaterally, and that this was possibly a response to an acceleration process which was superimposed on a history of three prior lumbar spine surgeries (Rx. 17 p.24). He stated he did not identify any radiculopathy with regard to the lumbar spine because there was no radiating leg pain or indication of sensory or motor deficits in the lower extremities (Rx. 17 p. 24).

This expert witness testified his diagnosis based on the examination was lumbar facet joint syndrome on a pre-existing condition and history of post-laminectomy syndrome. He testified his opinion was that the post-laminectomy syndrome was unrelated to the work accident and the lumbar facet syndrome was possibly related, with the understanding that the condition was based on a compromise underlying a chronic degenerative lumbar spondylosis condition (Rx. 17 p. 24).

Dr. Candido went on to testify that the accident likely resulted in a transient worsening of L4 and L5 lumbar facet joints but said worsening was not expected to be permanent or result in long-term impairment (Rx. 17 p. 24).

The expert testified the lumbar spine MRI dated July 15, 2015 did not show an acute injury to the lumbar spine. Rather, the MRI findings were consistent with chronic, stable, long term degenerative processes related to prior surgery and trauma, not an acute process (Rx. 17 p. 24). Dr. Candido testified Petitioner's symptoms during the evaluation on September 29, 2015 were due to an acute exacerbation of a chronic underlying lumbar spondylosis (Rx. 17 p. 28). Dr. Candido testified there was a strong probability that some of Petitioner's then-current symptoms were directly related to the chronic underlying lumbar spondylosis and the accident may have triggered a transient exacerbation of those symptoms (Rx. 17 pp.30-31). He stated he felt the diagnostic testing had been reasonable and necessary; Although he did note he was perplexed that caudal epidural injections and lumbar transforaminal injections were performed, since Dr. Candido's examination was inconsistent with the diagnosis of radiculopathy. Dr. Candido reiterated in his testimony that the Petitioner's pain on examination only came from one source: the lumbar facet joints, pinpointed at L4 and possibly L5 (Rx. 17 p. 31).

Dr. Candido testified certainly rather speculatively Petitioner "should"have reached maximum medical improvement with regard to the reported conditions within four weeks from the evaluation date on September 29, 2015, and Petitioner would not have any permanency related to the motor vehicle accident on June 18, 2015 (Rx. 17 p. 33).

Any cervical symptoms resulting from the June 18, 2015 motor vehicle accident had resolved by the September 29, 2015 evaluation date as well (Rx. 17 p. 35). He further testified Petitioner had also exacerbated his underlying condition when lifting an elliptical machine, and this was contrary to Petitioner's reporting of being asymptomatic at the time of the Section 12 evaluation (Rx. 17 pp. 35-36). The Arbitrator finds this to be a litigation driven non-sequitur given the records in their entirety.

Dr. Candido testified to preparing an addendum report on March 10, 2016 after being provided with additional medical records for review. Dr. Candido testified that after reviewing additional materials, his diagnosis was chronic lumbar spondylosis and chronic failed lumbar spine surgery (Rx. 17 p. 36). Dr. Candido testified that no interventional treatment could be linked to the June 18, 2015 motor vehicle accident because there were no new acute issues and no radiculopathy (Rx. 17 p. 39). He confirmed his opinion that Petitioner was at maximum medical improvement for the June 18, 2015 accident as of the date of the addendum report on March 10, 2016 (Rx. 17 p. 39). (emphasis added)Additionally, Dr. Candido testified that despite Petitioner reporting he did not smoke cigarettes and had no history of drug use, past treatment notes mentioned extensively that Petitioner had a history of smoking, chemical substance abuse and an addictive personality condition (Rx. 17 p. 40-41). Dr. Candido noted that studies show people with these conditions describe pain excessive to what a person without these conditions would describe. Dr. Candido's IME report and addendum report were entered into the record as Respondent's Deposition Exhibits 2 and 3. (Rx. 17).

On cross examination, Dr. Candido testified that hypothetically, spinal stenosis could be caused by an acute injury (Rx. 17 p. 52). He testified Petitioner's right leg pain was only indicative of radicular pain, not radiculopathy, as the latter involves weakness, sensory change, and reflex changes, which Petitioner did not have (Rx. 17 p. 56).

He testified that at any time, with or without provocation, a herniated disc can become symptomatic. When asked on cross examination why his causation opinion changed in his addendum report, Dr. Candido testified,

"It changed because I carefully queried Mr. Crawford about any pain condition and after he told me he had no pain at all since his prior surgeries, medical documentation became available that showed an ongoing history of repetitive low back pain, which included a February 2015 note suggesting that he had been lifting an elliptical machine and had sustained one of several exacerbations of his chronic underlying condition. And at that point, I felt that the veracity of his history was subject to some scrutiny, and I didn't think that he would benefit from those treatments except as they would be useful to him to treat his chronic underlying degenerative condition but not as a result of a discrete event such as the motor vehicle accident." (Rx. 17 p. 60-61).

Prior IWCC Cases

Respondent submitted into evidence information from the IWCC regarding Petitioner's prior Illinois Workers' Compensation claim while working for the State of Illinois (Rx. 21). Petitioner admitted on cross examination that he received a settlement payment in conjunction with this prior IWCC claim (07/13/2017 Tx. 134). Petitioner testified on cross examination that his claims before the IWCC that were settled emanated from a 2005 injury to the low back, which necessitated Petitioner's three surgical procedures. No credit, if any, is allowable in the case at bar, nor is the settlement of cases probative of the issue of accident or causation at bar without medical opinion on each event. See Voykin and Vogel cases.

Utilization Review

Respondent obtained a Utilization Review (medical opinion review) dated May 3, 2016 with regard to the requested lumbar discography at L3-4 with post CT scan. (Rx. 19). According to the Review Determination Recommendation, the tests were non-certified.

Utilization review reports can be one piece of medical evidence in a case, they are noted herein. The ODG are not considered as binding in the State of Illinois workers compensation Act.

In support of the Arbitrator's decision relating to Disputed Issue "C" – Did an accident occur that arose out of and in the course of Petitioner's employment with Respondent, the Arbitrator finds the following:

Petitioner was involved in a motor vehicle accident on June 18, 2015 when he was driving a company vehicle that was struck from behind by another motorist. He testified he was working on behalf of Respondent when the accident occurred. Petitioner sought medical attention on the date of accident and continued to seek care for injuries allegedly sustained in the June 18, 2015 motor vehicle accident. Moreover, he was provided with treatment modalities and medication as a result of the June 18, 2015 incident.

His testimony about exposure to drugs may possibly show addictive behavior or self denial-but is not determinative in terms of denying the accident at the case at bar. Nor does it negate causation even as found in the anesthesia's expert report from Dr. Candido. No section 11 proof required by the reform legislation, so to speak -by statutory mandate was submitted. The

Arbitrator acknowledges this persons deficit in recollection and being a self admitted poor historian.

Based upon the totality of the evidence adduced over three hearings, the Arbitrator finds that Petitioner has met the burden of proving-by a preponderance of the evidence - that he sustained an accident arising out of and in the course of his employment with Respondent as alleged in the case at bar.

In support of the Arbitrator's decision relating to Disputed Issue "F" - Is the petitioner's present condition of ill-being causally related to the injury, plus issue " O" whether the Petitioner is entitled to Prospective 4th low back surgery, the Arbitrator finds the following:

This case was highly disputed on both sides for the obvious reasons after hearing the testimony and studying the medical evidence. Both sides completed their advocacy at the highest level despite weaknesses in both cases. The medical testimony on both sides has inherent weaknesses. Dr. Miz had challenges regarding the facts of three prior back surgeries despite the actual return to work of the patient for the Respondent at bar. Dr. Candido.

Based upon the totality of the evidence, the Arbitrator gives greater weight in determining this issue of causation to the opinions of this very experienced, treating orthopedic surgeon who has treated the Petitioner over the years over the less weight of an anesthesiologist , a non surgeon, who examined this Petitioner on a limited time frame as a Sect.12 expert.

Dr. Candido's deposition reads more akin to a legal argument than a sophisticated, medical opinion. Dr. Candido's opinion that the accident may have aggravated the preexisting condition can not be dismissed. Contrawise, his statement that the condition should have resolved in some hypothetical type frame is extremely speculative.

Frankly, neither doctor's deposition testimony was of the greatest of weight over the other, and somewhat speculative on parts of both doctors. No rising phoenix of medical opinion/logic/ testimony, so to speak lifted one side or the other to great heights in terms of great persuasiveness. That conclusion only fuels the disputes on most issues.

As to the issue of need for future surgery, this patient has significant challenges replete in the record, and underscored in long and deliberate cross examination; The Arbitrator can not simply defer to the 4th surgical recommendation of Dr. Miz , whose testimony in this regard reads more like a default, fall- back option so to speak. Given all the prior opinions early on in the chronology, the Arbitrator will not rely upon Dr. Miz's simple conclusion akin to saying unless my surgery is approved, the patient can not work. The Arbitrator on these points can not ignore all the prior doctor's findings plus ignore Dr. Candido's expressed concern about the reasonableness/necessity of any contemplated, additional spine surgery given all the facts of the case. This is so despite his lack of surgical credentials plus his opinions reading like bent for litigation purposes.

Thus, based upon the totality of the evidence, albeit highly disputed and subject to various interpretations, the Arbitrator finds causation between the accident and his cervical plus lumbar condition in favor of the Petitioner - but at the same time denies the prospective, fourth low back surgery to this Petitioner.

In support of the Arbitrator's decision relating to Disputed Issue "J" – Were the medical services that were provided to Petitioner reasonable and necessary, and "O" the Two Doctor Rule, , plus second issue " O" prospective medical treatment, the Arbitrator finds the following:

The Arbitrator finds the Petitioner did not exceed the Act provision called the two doctor rule. First of all, the rule includes two doctors of the patient's choice plus all those doctors" referrals" from those doctors. Many stakeholders misunderstand the concept of the emergency room doctor's referral to an outside practitioner, as being a "1st choice".

Secondly, the IWCC has since its inception via case law affirmed in the Appellate Court that, as in the case at bar, any referral by an emergency room doctor to another outside doctor does not mean the patient seeing than " referred doctor" on his own volition actually chooses that referred doctor as his first choice, or any choice for that matter. No distinction is made if the "referred doctor" by the ER is the Petitioner's PCP, prior treating doctor or even for example – an orthopedic doctor of the petitioner's own choice. This issue has been litigated ad nausem before the IWCC.

Based upon the totality of the evidence, the Arbitrator finds that Petitioner has not exceeded the two-physician rule with regard to his medical treatment. The ER records are crystal clear that the emergency doctor referred the patients in the actual notes to his personal doctor, as fully described, infra.

St Bernards ER doctor referred the Petitioner to a "primary care doctor" i.e. to his personal doctor for follow up care. That is an ER referred doctor and not deemed a first choice by the Patient under the case law. Petitioner was treated by Dr. Settecase via ER referral.

The Patient's first choice of providers under the first reform Act, so to speak , terms is best deemed APM; he chose Advanced Physical Medicine, where he treated with Dr. Goldvekht and Dr. Jain. This was Petitioner's first choice of physician under the Act, as amended.

. Petitioner admitted he then took the recommendation of a friend and chose Dr. Scott Glaser. This was Petitioner's second legally interpreted choice of physician-under section 8, as amended.

Dr. George Miz is clearly a referred doctor from Dr. Glazer as shown in the records (Px.9) in evidence, deemed most reliable given the Petitioner's memory issues.

Respondent entered into evidence a May 3, 2016 Medical Opinion Review and Review Determination Recommendation disputing the reasonableness and necessity of the lumbar discography at L3-4 and post-CT scan ordered by Dr. Miz. (Rx. 19). According to the Review Determination Recommendation, the testing in question was non-certified. Neither Petitioner nor the provider requested the clinical rationale used to determine the non-certification finding, and there was no appeal requested with regard to this non-certification recommendation.

The Arbitrator notes this Medical Opinion Review and Review Determination Recommendation dated May 3, 2016 deemed the lumbar discography and post-discography CT scan non-certified. Respondent contends this testing was not reasonable or necessary. Neither Petitioner nor Dr. Miz requested the clinical rationale used to determine the non-certification

finding, and there was no appeal requested with regard to this non-certification recommendation of the testing in question. Further, the Arbitrator notes the physician advisor review appears to satisfy the requirements of Section 8.7 of the Illinois Workers' Compensation Act. 820 ILCS 305/8.7 (West 2011). Medical ReviewStream by Concentra is a URAC-accredited provider of Utilization Reviews in accordance with Section 8.7(b) of the Act.

The Arbitrator adopts the opinion of the treating doctor over the UR; ODG guidelines are just guidelines- to be taken along with all the medical evidence in the case. UR is not an elevated piece of evidence nor are ODG guidelines adopted as a matter or law or even preference in the State of Illinois. All the relevant medical evidence must be evaluated in any case.

Thus, based upon the totality of the evidence, the Arbitrator finds by a preponderance of said evidence , that all the medical treatment the Petitioner has received to date has been reasonable and necessary under section 8 of the Act. The Repondent is liable for said treatment per the terms of section 8, including 8a and 8.2.

In support of the Arbitrator's decision relating to Disputed Issue "K" – What temporary benefits are in dispute, the Arbitrator finds the following:

The Arbitrator finds Petitioner was placed off work by Dr. Settecase from his visit on June 19, 2015 through the full-duty return to work on June 29, 2015. Petitioner testified that he did not return to work for Respondent at that time, despite being released to unrestricted duty by Dr. Settecase. On August 23, 2015 Dr. Jain released Petitioner to regular duty with no restrictions. Petitioner testified that he returned to work for Philips in August of 2015 after being released by Dr. Goldvekht and Dr. Jain. Petitioner testified that he received Temporary Total Disability benefits while he was off work per Dr. Settecase, Dr. Goldvekht and Dr. Jain from June 19, 2015 through August 23, 2015.

The next period of compensable lost time under section 8 is again from November 17th, 2015 to April 5th, 2016. This last date found in Dr. Scott Glazer's treatment records is not at all long after Dr. Candido the expert for the Respondent in definitive terms said on March 10th, 2016 the patient was at maximum medical improvement. Dr. Miz's referral from Dr. Scott Glazer occurred on said date of April 5th, 2016.

Dr. Glaser and later Dr. Miz placed Petitioner off work after Dr. Settecase and Advanced Physical Medicine, Petitioner was released from treatment and was working full duty without restrictions.

The Arbitrator further notes Dr. Candido opined Petitioner was able to return to work without restrictions as of the exam date on September 29, 2015. Dr. Candido also opined Petitioner was at maximum medical improvement as of that ate. However, Dr. Candido went on to say that essentially he expected that the injury would improve and resolve. Simple reading proves that the statement that the Petitioner reached maximum medical improvement is totally inconsistent with his final conclusion that the injury would improve and resolve. This is where Dr. Candido opinion sounds more like a legal argument. Dr. Candido's inconsistent, weak opinion is disregarded on the issue of the Petitioner reaching maximum medical improvement yet the injury would improve and resolve is disregarded in relation to cutting off reasonable and necessary treatment. Said treatment continued up through the last visit with Dr. Miz. Dr. Candido's statements are a total non-sequitor.

In support of the Arbitrator's decision relating to Disputed Issue "L" – What is the nature and extent of the injury, the Arbitrator finds the following:

The Arbitrator finds it is premature to rule on the issue of the nature and extent of the injury given the testimony of Dr. Miz.

In support of the Arbitrator's decision relating to Disputed Issue "N" – Is Respondent due any credit, the Arbitrator finds the following:

The Arbitrator finds that Respondent is entitled to a credit in the amount of $4,368.16 for initial benefits paid to Petitioner. Petitioner testified that he received TTD benefits from June 19, 2015 to August 23, 2015. Respondent also submitted a payment ledger into evidence, detailing the payments made to Petitioner. (Rx. 14).

The Arbitrator also finds that Respondent is entitled to an credit in the amount of $1,536.00 for additional compensation paid. Petitioner stipulated to this payment according to the Request for Hearing form (Arb. Ex. 1).

The Arbitrator further sayeth naught.

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

LAVONDA CLAYTON,

Petitioner,

vs.

NO: 17 WC 10459

OLIN CORPORATION,

Respondent.

20IWCC0022

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 10, 2019, 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.

SOINCC0055

20IWCC0022

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $50,100.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JAN 10 2020
KAD/bsd
O12319
42

Kathryn A. Doerries

Maria E. Portela

DISSENT

I believe that Petitioner proved by a preponderance of the credible evidence that she sustained accidental injuries arising out of and in the course of her employment on or about 2/3/17 with respect to her right/left shoulders, in addition to her right/left hands and right arm, and that a causal relationship exists between said accidental injuries and Petitioner's current condition of ill-being. As a result, I cannot join in the majority's summary affirmance of the Arbitrator's decision in this matter.

The Arbitrator determined that Petitioner's bilateral carpal tunnel syndrome and right epicondylitis conditions were causally related to the accident, and a manifestation date of 2/3/17, but that her bilateral shoulder condition was not. I disagree.

The record shows that Petitioner submitted more than sufficient evidence of the repetitive nature of her job, including overhead work. Along these lines, Petitioner testified that she has worked for Respondent for 13 years and that she has done factory work the entire time. She noted that in 2011 she began to have problems with her hands, elbows and shoulders, including pain in her elbows and shoulders as well as numbness and tingling in her hands. She reported her problems to the company's medical department, treated with heat and splints and was assigned to a new job in quality control. She noted that her symptoms improved, and she was transferred back to her previous job as a cap operator in July of 2016. She continued to work in this capacity through February of 2017, performing her full-time job, 8 hours a day, 5 to 6 days a week. As part of her job responsibilities she noted that she would have to, among other things, lift overhead and below waist level throughout the day. She indicated the job video submitted into evidence by Respondent did not accurately reflect the pace at which the cap operator job was performed, or all of the job duties associated with same. As a result of these activities, Petitioner noted that she developed pain in her shoulders, in addition to her elbows, as well as numbness and dropping things with her hands. She returned to the medical department with these complaints, noting that they were now worse than before.

SOIACC0085

Petitioner's testified credibly as to the onset of her symptoms, and her job responsibilities, and the re-emergence of her symptoms, including those associated with her shoulders, following her return to her cap operator job in July of 2016. While she admittedly would rotate tasks with her co-workers, and while some of those tasks involved reaching below or at mid-chest level, Petitioner's unrefuted testimony described activities that would also place a strain, on a repetitive basis, on her shoulder joints – including the act of reaching under a table while she was sitting on a chair that was higher up in order to scoop out primers to pour over the boards using a tin cup.

Furthermore, Dr. Vest persuasively testified that Petitioner's job activities contributed to her bilateral shoulder problems. Given what I would consider Petitioner's credible testimony regarding the repetitive and intensive hand/arm activities associated with her job, including those performed at or above shoulder level, I have no reason not to accept Dr. Vest's opinion on the question of causation, nor should this Commission.

As a result, I would modify the decision of the Arbitrator to find accident and causation with respect to Petitioner bilateral shoulder condition, in addition to the right/left hands and right arm injuries, and award benefits accordingly.

Therefore, I respectfully dissent.

Thomas J. Tyrrell

SOINCCOSS

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CLAYTON, LAVONDA
Employee/Petitioner

Case# **17WC010459**

OLIN CORPORATION
Employer/Respondent

20IWCC0022

On 4/10/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.39% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4620 ADWB LLC
JOHN WINTERSCHEIDT
51 EXECUTIVE PLAZA COURT
MARYVILLE, IL 62082

0299 KEEFE & DePAULI PC
MICHAEL KEEFE
#2 EXECUTIVE DR
FAIRVIEW HTS, IL 62208

20 1M 66 09 25

20IWCC0022

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

Lavonda Clayton
Employee/Petitioner

v.

Olin Corporation
Employer/Respondent

Case # 17 WC 10459

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 William R. Gallagher, Arbitrator of the Commission, in the city of Collinsville, on February 28, 2019. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On February 3, 2017, Respondent was operating under and subject 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 $54,912.00; the average weekly wage was $1,056.00.

On the date of accident, Petitioner was 43 years of age, single with 0 dependent child(ren).

Petitioner has received all reasonable and necessary medical services.

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

Respondent shall be given a credit of $0.00 for TTD, $0.00 for TPD, $0.00 for maintenance, and $12,797.50 for other benefits, for a total credit of $12,797.50.

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 9, for medical services provided to Petitioner for bilateral carpal tunnel syndrome and bilateral epicondylitis condition, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. The 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 pay Petitioner temporary total disability benefits of $704.00 per week for 16 1/7 weeks commencing April 17, 2017, through August 7, 2017, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $633.60 per week for 72.8 weeks because the injury sustained caused the five percent (5%) loss of use of the right arm, five percent (5%) loss of use of the left arm, 12 1/2% loss of use of the right hand and 12 1/2% loss of use of the left hand, as provided in Section 8(e) of the Act.

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

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

William R. Gallagher

William R. Gallagher, Arbitrator

April 8, 2019

Date

APR 10 2019

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged she sustained a repetitive trauma injury arising out of and in the course of her employment by Respondent. The Application alleged a date of accident (manifestation) of February 3, 2017, and that Petitioner sustained "Repetitive trauma" to the "Bilateral hands, arms, shoulders & Body as a whole" (Arbitrator's Exhibit 2). Respondent disputed liability on the basis of accident and causal relationship (Arbitrator's Exhibit 1).

Petitioner became employed by Respondent in 2006, and initially worked as a cap operator. Petitioner worked as a cap operator until sometime in 2011, when she began to experience symptoms in her hands, elbows and shoulders. Petitioner was transferred to a new position in quality control. At trial, Petitioner testified the quality control position was less hand and arm intensive and she experienced improvement of her symptoms, although she still continued to have numbness in her hands.

In July, 2016, Petitioner returned to working as a cap operator. Petitioner was working in that position at the time of the alleged date of manifestation of February 3, 2017.

Petitioner testified that when she was a cap operator, she usually work eight hours per day, five to six days per week. Petitioner's job duties included taking primers out of tin cups and placing them on metal boards which had holes. The boards were then placed on a machine which vibrated causing the primers to fall into the holes. The boards were then removed and turned over when a second board was placed on top of the original board. The boards were then placed back on the vibrating machine. The boards would then be removed and rubber banded so that they were bound together. The bound boards would then be taken to cases at or above shoulder height approximately one every two minutes. At trial, Petitioner testified she was required to forcefully grasp the boards with both hands and the job required repetitive flexion and extension of her wrists. Further, Petitioner stated both of her elbows were virtually always in a flexed position. When Petitioner stacked the cases at or above shoulder level, she would stack a case at the rate of about one every two minutes. Petitioner would rotate from one job task to another during a shift so she would do several different tasks in the course of a shift.

Respondent tendered into evidence a video of other individuals performing the duties of a cap operator. The Arbitrator watched the video and observed individuals putting caps on a rectangular shaped piece of metal which had holes. The piece of metal was then put in a machine which vibrated causing the caps to fall into the holes. The Arbitrator saw individuals using both hands to move the piece of metal, put it in the machine and remove it from the machine; however, none of the individuals touched the piece of metal while it was being vibrated. Upon removing the piece of metal with the caps, it would be moved to a table adjacent to the machine. Subsequently, two of the metal plates were bound together with rubber bands and placed in a stack. The Arbitrator did not observe the individuals performing any overhead work. The Arbitrator noted that during virtually all of the activities he observed, the individuals had their elbows in a flexed position (Respondent's Exhibit 1). At trial, Petitioner testified she watched the video and that it was not accurate because it did not show the pace she worked at and it did not show all of her job duties.

On February 3, 2017, Petitioner was seen at the plant medical department. At that time, Petitioner complained of tingling in both hands and pain in both elbows and shoulders. It was noted Petitioner had reported the symptoms years ago and, because she had returned to production, she was again having the symptoms. Petitioner was given wrist and elbow supports and directed to return to work (Petitioner's Exhibit 2).

Petitioner returned to work, but she was again seen in the plant medical department on February 10, 2017. At that time, Petitioner complained of bilateral hand numbness and bilateral elbow and shoulder pain. Petitioner attributed her symptoms to the job she was performing, specifically, closing plates. Petitioner was diagnosed with bilateral hand neuropathy, bilateral epicondylitis and median elbow pain. Petitioner was given bands and splints and directed to return to work (Petitioner's Exhibit 2).

Petitioner returned to the plant medical department on February 23, 2017, because of her continued upper extremity symptoms. At that time, Petitioner was informed that she should be seen by her primary care physician because her symptoms did not usually occur in workers' comp injuries and other medical conditions could be causing some of her some symptoms (Petitioner's Exhibit 2).

Petitioner testified she sought medical treatment from her personal physician, Dr. David O'Neill. However, Dr. O'Neill would not provide treatment to Petitioner because her condition was work-related.

Petitioner subsequently sought medical treatment from Dr. Ryan Diederich, a plastic surgeon, on April 17, 2017. At that time, Petitioner advised Dr. Diederich she had hand pain approximately five to six years ago and was moved to a different job, but that in July, 2016, she moved back to her original position. Petitioner informed Dr. Diederich she picked up heavy plates/tins, put them on some type of shaking machine and repetitively performed this task for hours every day. Petitioner would then do rubber banding as well as heavy lifting. Petitioner stated she could not lift the plates because they were too heavy. Petitioner complained of numbness/tingling in both hands and she used braces at work and while sleeping. Dr. Diederich examined Petitioner and opined she had bilateral carpal tunnel syndrome and bilateral medial/lateral epicondylitis. He ordered physical therapy as well as EMG/nerve conduction studies (Petitioner's Exhibit 3).

The EMG/nerve conduction studies were performed on May 22, 2017. The studies revealed moderately severe bilateral carpal tunnel syndrome (Petitioner's Exhibit 5).

On July 13, 2017, Dr. Diederich performed surgery which consisted of an open right carpal tunnel release and an injection in the right lateral elbow. On July 27, 2017, Dr. Diederich performed surgery which consisted of an open left carpal tunnel release and an injection in the left lateral elbow (Petitioner's Exhibit 3).

Dr. Diederich subsequently saw Petitioner on August 7, 2017, and observed Petitioner was doing well. He noted Petitioner's right hand and bilateral elbow symptoms had completely resolved, but Petitioner still had some occasional numbness in the left hand but it was much improved. Dr.

Diederich released Petitioner from care in regard to her hands/elbows, but referred her to Dr. Bruce Vest, an orthopedic surgeon, for her shoulder symptoms (Petitioner's Exhibit 3).

Dr. Vest initially evaluated Petitioner on August 18, 2017. At that time, Petitioner complained of bilateral shoulder pain, right worse than left. Petitioner informed Dr. Vest she had worked as an operator for Respondent for the preceding 11 years and did a lot of heavy lifting at work which included lifting tin boards multiple times a day overhead and below the waist. Dr. Vest opined Petitioner had bilateral rotator cuff tendinitis and mild bilateral acromioclavicular degenerative joint disease. Dr. Vest administered injections in both shoulders and ordered physical therapy. He also authorized Petitioner to remain off work (Petitioner's Exhibit 7).

Dr. Vest subsequently ordered an MRI scan of Petitioner's right shoulder. The MRI was performed on September 28, 2017. According to the radiologist, the MRI revealed rotator cuff tendinopathy without full thickness tear (Petitioner's Exhibit 7).

Dr. Vest performed arthroscopic surgery on Petitioner's right shoulder on October 20, 2017. The surgery consisted of extensive joint debridement, subacromial decompression and resection of the distal clavicle (Petitioner's Exhibit 8).

Petitioner was seen by Dr. Diederich on December 22, 2017, because of bilateral elbow symptoms. At that time, Dr. Diederich administered injections in both the right and left elbows (Petitioner's Exhibit 3).

Following shoulder surgery, Petitioner continued to be treated by Dr. Vest who ordered physical therapy. Petitioner was last seen by Dr. Vest on February 9, 2018. At that time, Petitioner's right shoulder condition had improved and there was a full range of motion. Dr. Vest authorized Petitioner to return to work on February 20, 2018 (Petitioner's Exhibit 7).

Petitioner returned to work for Respondent as a cap operator; however, she was laid off as of October 12, 2018. Petitioner has not worked since that time.

At the direction of Respondent, Petitioner was examined by Dr. Mitchell Rotman, an orthopedic surgeon, on September 24, 2018. In connection with his examination of Petitioner, Dr. Rotman reviewed medical records provided to him by Respondent as well as the video of other individuals performing the job of a cap operator. In his report, Dr. Rotman abstracted the medical records he reviewed and noted what he had observed in the video. Dr. Rotman opined Petitioner was at MMI and the surgeries performed by Dr. Diederich and Dr. Vest were reasonable and necessary (Respondent's Exhibit 2; Deposition Exhibit 2).

In regard to causality, Dr. Rotman opined that Petitioner's shoulder condition was not caused or aggravated by her work activities. He noted Petitioner did not do constant heavy lifting at or above shoulder level and most of her job duties as a cap operator were mainly from the elbow down. In regard to Petitioner's bilateral carpal tunnel syndrome condition, Dr. Rotman opined that this was not aggravated by her work activities. Dr. Rotman noted Petitioner had other risk factors, specifically, diabetes, obesity, her age and being female. However, Dr. Rotman opined

Petitioner's work activities may have been an aggravating factor in the development of epicondylitis (Respondent's Exhibit 2; Deposition Exhibit 2).

Dr. Rotman also opined Petitioner had impairment ratings based upon the AMA guidelines of zero percent (0%) of each upper extremity for the bilateral carpal tunnel syndrome and zero percent (0%) of the right shoulder. He did not opine as to an impairment rating in regard to Petitioner's bilateral epicondylitis (Respondent's Exhibit 2; Deposition Exhibit 2).

Dr. Vest was deposed on June 26, 2018, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Vest's testimony regarding his diagnosis and treatment of Petitioner's shoulder condition was consistent with his medical records. In regard to causality, Dr. Vest testified Petitioner's work activities, as stated in a hypothetical question, could have contributed to Petitioner's bilateral shoulder condition (Petitioner's Exhibit 11; pp 15-17).

On cross-examination, Dr. Vest agreed that his opinion regarding causality relied heavily on a history of Petitioner's job requiring repetitive overhead activities. Dr. Vest conceded Petitioner did not advise him that her work activities rotated during her shift and, if Petitioner's work, in fact, required little or no overhead activities, it could cause him to change his opinion regarding causality (Petitioner's Exhibit 11; pp 24-25).

Dr. Diederich was deposed on August 15, 2018, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Diederich's testimony regarding his diagnosis and treatment of Petitioner's hand and elbow conditions was consistent with his medical records. In regard to causality, Dr. Diederich testified Petitioner's repetitive work activities could contribute to the development of Petitioner's carpal tunnel and epicondylitis conditions. This was based upon information provided by Petitioner as well as a hypothetical question posed by Petitioner's counsel during the deposition (Petitioner's Exhibit 10; pp 10-17).

On cross-examination, Dr. Diederich agreed he had no knowledge as to the weight of the plates/tins Petitioner repetitively handled. He also agreed Petitioner's diabetes, sex, age and obesity were risk factors for the development of carpal tunnel syndrome (Petitioner's Exhibit 10; pp 27-29).

Dr. Rotman was deposed on October 22, 2018, and his deposition testimony was received into evidence at trial. At that time, Dr. Rotman's medical report was received into evidence as an evidentiary exhibit. In regard to causality of Petitioner's shoulder condition, Dr. Rotman testified that given Petitioner's description of her work and the video he watched, there was no relationship between Petitioner's shoulder condition and Petitioner's work activities (Respondent's Exhibit 2; p 11).

In regard to Petitioner's bilateral carpal tunnel syndrome condition, Dr. Rotman testified it was not caused or aggravated by Petitioner's work activities because Petitioner's hands were not subjected to vibration or awkward wrist positions. He also noted Petitioner had other significant risk factors, specifically, diabetes, obesity, age and being female. However, Dr. Rotman also testified Petitioner's epicondylitis could have been aggravated by her work activities (Respondent's Exhibit 2; pp 10-13).

On cross-examination, Dr. Rotman agreed he did not know the weight of the metal plates or how much force was required to grasp them. Further, he did not know if the video showed all of the job duties that were performed by Petitioner (Respondent's Exhibit 2; p 25).

At trial, Petitioner testified she was previously diagnosed with diabetes, but it is controlled with medication. Petitioner stated she has lost strength and has a decreased range of motion in her right shoulder. Petitioner has occasional pain in her left shoulder with activity. Petitioner also stated she continues to experience tenderness in both elbows joints. In regard to her hands, Petitioner stated she has decreased grip strength, experiences occasional tingling in her fingers and her hands get cold when she holds objects for an extended period of time.

Conclusions of Law

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

The Arbitrator concludes Petitioner sustained a repetitive trauma injury arising out of and in the course of her employment by Respondent that manifested itself on February 3, 2017, and her current condition of ill-being is, in part, causally related to same. Specifically, the Arbitrator concludes Petitioner's bilateral carpal tunnel syndrome and epicondylitis conditions are related to the repetitive trauma, but Petitioner's bilateral shoulder condition is not causally related.

In support of this conclusion the Arbitrator notes the following:

Petitioner previously worked as a cap operator until sometime in 2011 and experienced upper extremity symptoms. When Petitioner was moved to another position, the symptoms lessened to a significant degree, but Petitioner again experienced the symptoms shortly after she returned to work as a cap operator in July, 2016.

Petitioner's testimony was that her job duties as a cap operator required the active use of both hands with repetitive flexion and extension of the wrists. The video of other individuals performing the job duties of a cap operator also revealed the active and repetitive use of both hands, although Petitioner disputed the accuracy of the video in regard to the pace that she worked at.

Petitioner's treating physician, Dr. Diederich, testified Petitioner's repetitive work activities could have contributed to the development of Petitioner's bilateral carpal tunnel syndrome, while agreeing Petitioner did have other risk factors, such as diabetes, sex, age and obesity.

Respondent's Section 12 examiner, Dr. Rotman, testified Petitioner's work activities did not contribute to the development of Petitioner's carpal tunnel syndrome because Petitioner's hands were not subjected to vibration or awkward wrist positions and that Petitioner had numerous other risk factors. However, Dr. Rotman also testified Petitioner's epicondylitis could have been aggravated by her work activities.

The Arbitrator finds Dr. Rotman's opinion that Petitioner's bilateral epicondylitis could have been aggravated by her work activities, but that her bilateral carpal tunnel syndrome was not aggravated by her work activities to be rather inconsistent.

Based upon the preceding, the Arbitrator finds the opinion of Dr. Diederich to be more persuasive than that of Dr. Rotman in regard to the cause of Petitioner's bilateral carpal tunnel syndrome.

In regard to Petitioner's bilateral shoulder condition, Petitioner's testimony did not describe a significant amount of heavy overhead lifting. The video did not show any of the individuals performing overhead tasks.

Petitioner's treating physician, Dr. Vest, testified there was a causal relationship between Petitioner's work activities and her bilateral shoulder condition; however, Dr. Vest's opinion relied heavily on Petitioner having to perform repetitive overhead activities and if, in fact, Petitioner did not have to perform repetitive overhead activities, his opinion was subject to change.

Respondent's Section 12 examiner, Dr. Rotman, testified that given Petitioner's description of her job activities and the video, there was not a causal relationship between Petitioner's job activities and her bilateral shoulder condition.

Based upon the preceding, the Arbitrator finds the opinion of Dr. Rotman to be more persuasive than that of Dr. Vest, in regard to the causality of Petitioner's bilateral shoulder condition.

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 for her bilateral carpal tunnel syndrome and bilateral epicondylitis condition was reasonable and necessary and Respondent is liable for payment of the medical services incurred therewith.

Respondent shall pay reasonable and necessary medical services for treatment provided to Petitioner for her bilateral carpal tunnel syndrome and bilateral epicondylitis condition as identified in Petitioner's Exhibit 9, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit of amounts paid for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

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

The Arbitrator concludes Petitioner is entitled to 16 1/7 weeks of temporary total disability benefits commencing April 17, 2017, through August 7, 2017.

In support of this conclusion the Arbitrator notes the following:

Petitioner was receiving medical treatment and was authorized to be off work because of her bilateral hand and elbow conditions.

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

The Arbitrator concludes Petitioner has sustained permanent partial disability to the extent of five percent (5%) loss of use of the right arm, five percent (5%) loss of use of the left arm, 12 1/2% loss of use of the right hand and 12 1/2% loss of use of the left hand.

In support of this conclusion the Arbitrator notes the following:

Dr. Rotman opined Petitioner had an AMA impairment rating of zero percent (0%) of each upper extremity for the bilateral carpal tunnel syndrome. He did not opine as to an AMA impairment rating for Petitioner's bilateral epicondylitis. The Arbitrator gives this factor minimal weight.

Petitioner worked as a cap operator at the time she sustained the accidental injury. Petitioner's job was physically demanding and required the active and repetitive use of both upper extremities. The Arbitrator gives this factor significant weight.

Petitioner was 43 years old at the time of the accident. Petitioner was 46 years old at the time the case was tried and has approximately 20 years before she will reach normal retirement age. The Arbitrator gives this factor moderate weight.

There was no evidence the injury had any effect on Petitioner's future earning capacity. The Arbitrator gives this factor no weight.

Petitioner sustained an injury to both elbows and was diagnosed with bilateral epicondylitis for which Petitioner received conservative treatment, including injections. Petitioner also sustained an injury to both wrists/hands and was diagnosed with bilateral carpal tunnel syndrome. Open carpal tunnel release surgical procedures were performed on both wrists. Petitioner continues to have complaints referable to both elbows and wrists/hands consistent with the injuries she sustained. The Arbitrator gives this factor significant weight.

William R. Gallagher, Arbitrator

SOINCCOSS

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Steven Qualizza,

Petitioner,

vs.

No. 17 WC 15757

20IWCC0023

Tile Roofs, Inc.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the issue of employment relationship and being advised of the facts and law, reverses the Decision of the Arbitrator for the reasons stated below and remands the case to the Arbitrator for further proceedings on the remaining issues pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327 (1980).

Petitioner's application for adjustment of claim alleges that on April 13, 2017, Petitioner sustained multiple injuries when he fell from a scaffold. Following a section 19(b) hearing solely on the issue of employment relationship, the Arbitrator found no employment relationship and denied the claim. We disagree that Petitioner failed to prove an employment relationship.

Petitioner testified that he possessed special skills in the area of roof construction, including soldering sheet metal and laying out slate and tile roofs. Petitioner had done a lot of work on landmark buildings in and outside of Illinois. Petitioner began to work for Respondent Tile Roofs, Inc. in 2015 or 2016. Prior to that, Petitioner worked for Mortenson Roofing Company (Mortenson Roofing). Mortenson Roofing was owned by Michael Lucas, and Respondent was owned by Mr. Lucas's wife. Both companies (collectively, the Lucas entities) operated out of the same building. At Mortenson Roofing, Petitioner was a job site

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foreman/superintendent, managing roofing projects. Mortenson Roofing assigned the jobs. Petitioner ordered materials, "set up the job for work," supervised employees, and interacted with contractors regarding job scheduling for his (Mortenson Roofing) crew. Mortenson Roofing provided Petitioner with a company truck and paid for the gas. When Petitioner traveled for work, Mortenson Roofing paid for the hotels.

After semi-retiring, Petitioner did smaller projects for the Lucas entities and "[w]ent from Mortenson Roofing to [Respondent]" in terms of getting paid. Petitioner's job duties and hours did not change. It was the same type of work, but on a smaller scale. Although Petitioner was paid by Respondent, the crew he supervised was comprised of "[m]ostly Mortenson Roofing employees," "[r]eally just Mortenson employees." Petitioner continued to use the Mortenson Roofing company truck, and Mortenson Roofing continued to pay for the gas. When Petitioner traveled for work, Mortenson Roofing continued to pay for the hotels.

At first, Respondent issued payments by check to Petitioner personally. In December of 2016, Petitioner formed a business, Quantum Edge, LLC (Quantum Edge), at the request of Mr. Lucas. Petitioner "resisted for quite a while," but when Respondent stopped paying him, he "finally had to form the company to get paid." Respondent was the only client of Quantum Edge. After Petitioner formed Quantum Edge, his duties for the Lucas entities did not change. Petitioner continued to supervise a crew of workers. Petitioner owned some of the tools, but the majority were owned by Mortenson Roofing. Mortenson Roofing continued to pay for the hotels and provide the company truck.

Petitioner acknowledged that Quantum Edge had an employer identification number and was listed on the Secretary of State website. Quantum Edge did not have workers' compensation insurance. Between December 9, 2016 and April 4, 2017, Petitioner billed Respondent through Quantum Edge for the hours he worked at the rate of $40.00 per hour. He also billed Respondent through Quantum Edge for office supplies, fuel and other expenses. Respondent paid the invoices without withholding payroll taxes. When Petitioner worked for Mortenson Roofing, taxes were withheld from his pay.

On April 13, 2017, Petitioner was working on a residential project involving construction of a zinc roof. Petitioner sustained multiple injuries when he fell from a scaffold while doing layout work. Prior to the project, Petitioner had very little experience with zinc roofing. For the project, Petitioner and a foreman working for Mortenson Roofing received onsite training paid by Mortenson Roofing.

Michael Lucas, the owner of Mortenson Roofing, testified that he had known Petitioner for over 30 years and considered him a friend. Mr. Lucas valued Petitioner for his professional knowledge. After Petitioner retired from Mortenson Roofing, he went to work "outside of the union" for Respondent. Petitioner continued to supervise employees of Mortenson Roofing and Respondent. Petitioner also continued to order materials and rent equipment for Mortenson Roofing and Respondent. Mr. Lucas let Petitioner keep the company truck, and Mortenson

SOTRCC0053

Roofing or Respondent continued to reimburse Petitioner for the gas. At some point, Mr. Lucas and Petitioner spoke about Petitioner forming a business entity, and Petitioner eventually formed Quantum Edge.

We find the *substance* of the relationship between Petitioner and the Lucas entities—Mortenson Roofing and Respondent—remained unchanged after Petitioner formed Quantum Edge. Petitioner continued to supervise a crew of Mortenson Roofing employees; Petitioner continued to order materials and equipment for Mortenson Roofing or Respondent; Mortenson Roofing continued to furnish Petitioner's equipment and tools; Mortenson Roofing or Respondent continued to provide Petitioner with a company vehicle and pay for the gas; and Mortenson Roofing continued to pay for Petitioner's hotels while he traveled for work. Also, Mortenson Roofing paid for Petitioner's training in zinc roofing.

The Commission finds the corporate formalities between Quantum Edge and its only client, the Lucas entities acting through Respondent, existed on paper only. Petitioner was a *de facto* employee.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 15, 2018, is hereby reversed, and 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: JAN 13 2020
o-11/13/2019
SM/sk
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Stephen Mathis

Douglas McCarthy

L. Elizabeth Coppoletti

8800371 08

ILLINOIS WORKERS' COMPENSATION COMMISSION

NOTICE OF 19(b) ARBITRATOR DECISION

QUALIZZA, STEVEN
Employee/Petitioner

Case# **17WC015757**

TILE ROOFS INC
Employer/Respondent

20IWCC0023

On 11/15/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.46% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2553 McHARGUE & JONES LLC
BRENTON M SCHMITZ
123 W MADISON ST 18TH FL
CHICAGO, IL 60602

5265 WOLF LAW LTD
STEVE WOLF
25 E WASHINGTON ST SUITE 801
CHICAGO, IL 60602

STATE OF ILLINOIS)SS.

COUNTY OF COOK)

20 IWCC0023

☐ 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)

Steven Qualizza
Employee/Petitioner

v.

Tile Roofs, Inc.
Employer/Respondent

Case # 17 WC 15757

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Kurt Carlson**, Arbitrator of the Commission, in the city of **Chicago**, on **September 11, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

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FINDINGS

On the date of accident, **Tile Roofs, Inc.**, 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 *(N/A)* sustain an accident that arose out of and in the course of employment.

Timely notice of this accident *(N/A)* given to Respondent.

Petitioner's current condition of ill-being *(N/A)* causally related to the accident.

In the year preceding the injury, Petitioner earned $ *(N/A)*; the average weekly wage was $.

On the date of accident, Petitioner was *(N/A)* years of age, ***single*** with *(N/A)* dependent children.

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

Respondent shall be given a credit of $ *(N/A)* for TTD, $ *(N/A)* for TPD, $ *(N/A)* for maintenance, and $ *(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 evidence adduced at trial establishes that the petitioner was not an employee of respondent at the time he sustained his accidental injuries. Further, no other legal theory exists to otherwise establish any legal responsibility by respondent for the injuries petitioner sustained.

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

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

11-07-18
Date

ICArbDec19(b)

NOV 15 2018

20 IWCC0023

SUMMARY OF EVIDENCE

The petitioner testified that he was a longtime employee of Mortensen Roofing. He also testified that Mortensen Roofing and Tile Roofs had common ownership by Mike Lukis and his wife, Mary. Petitioner was employed by Mortensen as a site foreman/superintendent. Petitioner retired from Mortensen either in March 2015 or March 2016. Shortly thereafter, he began working for Tile Roofs.

Petitioner testified that over the course of his career, he developed special skills within the roofing industry. He testified that he learned how to solder on sheet metal, copper, and stainless steel and learned how to "lay out" slate and tile roofs. He had worked on a lot of landmark buildings. He bought his own tools.

When he first began working for Tile Roofs (after he had retired from Mortensen) the compensation he earned was paid directly to him personally. However, there was a discussion between him and Mike Lukis at which time it was decided that he would form a corporation and submit invoices for his time through the corporation. Thus, he formed a company by the name of Quantum Edge, LLC in December 2016.

Petitioner identified Respondent's Exhibit 2 as a series of invoices submitted by Quantum Edge to Tile Roofs from December 9, 2016 through April 4, 2017. The invoices identified the number of hours he worked as well as expenses that were incurred in conjunction with said work. Petitioner acknowledged that the invoices were paid in full without any deductions for taxes. When he previously worked for Mortensen, he received a traditional paycheck with taxes already deducted. In addition, Mortensen would make a separate payment to his union for insurance and other union benefits. Quantum Edge had its own bank account.

Petitioner also identified Respondent's Exhibit 2 as a W9 form issued by Quantum Edge. The form was signed on December 9, 2016. Petitioner testified that Quantum Edge was issued an employer identification number by the federal government. He also acknowledged that Quantum Edge was incorporated in Illinois and is listed as a corporation on the website for the Illinois Secretary of State.

Petitioner initially testified that the work he performed for Tile Roofs after he retired from Mortensen's was the same that he had performed for Mortensen's. On cross-examination, however, he acknowledged that he typically worked on smaller jobs for Tile Roofs. He also testified that he considered himself to be semi-retired while working for Tile Roofs. While he initially denied it, he ultimately admitted that he considered himself to be a consultant for Tile Roofs. Petitioner was repeatedly impeached with a recorded statement he had given prior to trial. The statement was introduced as Respondent's Exhibit 1. In fact, in his recorded statement, he stated that while working for Tile Roofs, "*... I am a consultant. I am not really a roofer anymore. I was a roofer for years, but now I am a consultant because I kind of retired. So um, that's the reason I started Quantum Edge to, you know, for tax purposes*".

Petitioner also initially testified that while working for Mortensen, he would not just supervise Mortensen employees. He would work alongside them. He testified that he continued

to work alongside Mortensen employees, even after he had formed Quantum Edge. However, he was again impeached with his recorded statement at which time he stated that he just does the layout work for the Mortensen employees and does NOT do any roof installation. In addition, in his recorded statement, he stated that "*I was doing, uh-huh, layout work, consulting work, preparing the areas that we were working on for them to install it*". He went on to state that "*well, I am a specialist in that material. So I have to measure the areas so they know how to lay it out and fabricate it and put it in*".

Further, petitioner testified that Quantum Edge did not perform work for any company other than Tile Roofs. However, he acknowledged when he gave his recorded statement that he was trying to expand the business and work for others.

Petitioner also testified that when he started Quantum Edge, he made a choice not to purchase workers compensation insurance coverage. He was the only employee of Quantum Edge. Michael Lukis testified that he told the petitioner, after he formed Quantum Edge, and before the accident at issue, that petitioner would need to have insurance. Mr. Lukis also testified that the petitioner (working through Quantum Edge) had worked for another separate Wisconsin Corporation that was owned by Mr. Lukis' wife and son, in addition to Tile Roofs.

FINDINGS OF FACT

In support of the Arbitrator's decision regarding whether an employee – employer relationship existed at the time of petitioner's accidental injuries, the Arbitrator finds the following facts:

An employer-employee relationship is required for benefits under the Act. Keating 68th & Paxton LLC., 401 Ill App. 3d 456, 464; 936 NE2d 1050, 1058 (2010). The claimant has the burden of proving the existence of an employer-employee relationship by a preponderance of the evidence, and when the evidence is conflicting and subject to diverse interpretation, the issue is a question of fact to be resolved by the Commission. Pearson v. Industrial Comm'n, 318 Ill.App.3d 932, 935; 743 N.E.2d 685, 686-87 (2001).

In analyzing whether an employer-employee relationship exists, there is no rule applicable in all situations. Morgan Cab Co. v. Industrial Comm'n, 60 Ill.2d 92, 97; 324 N.E.2d 425, 427 (1975). Instead, the analysis is based on all the evidentiary facts in connection with the applicable principles of law. Lawrence v. Industrial Comm'n, 391 Ill. 80, 84; 62 N.E.2d 686, 688 (1945).

The Act defines the "employer" to include every firm "who has any person in service or under contract for hire, express or implied, oral or written." 820 ILCS 305/1(a)(2) (West 2012). The Act does not define who is an "independent contractor" as opposed to an employee. The supreme court has defined an independent contractor as "one who renders service in accordance with the will of the person for whom the work is done only as the results of the work, and who is free to exercise his own judgement and discretion as to the method or means by which the work is accomplished, entirely exclusive of the control and direction of the party for whom the work is done." Lawrence, 391 Ill at 85; 62 N.E.2d at 688.

No single factor is determinative concerning what the relationship is between the parties in a given case. Morgan Cab Co. 60 Ill. 2d at 97, 324 N.E.2d at 428. "It may be necessary to consider a number of factors with evidentiary value, such as the right to control the manner in which is done, the method of payment, the right to discharge, the skill required in the work to be done, and who provides the tools, materials or equipment." Id. Other factors include whether the worker's occupation is related to that of the alleged employer and whether the alleged employer deducted withholding tax." Lister v. Industrial Comm'n, 149 Ill. App. 3d 286, 290; 500 N.E.2d 134, 136 (1986). The right to control the way the work is performed is often cited as the most important factor in determining the relationship. Kirkwood, 84 Ill.2d at 21, 416 N.E.2d at 1081. J.R. Auto Transp., LLC v. Ill. Workers' Comp. Comm'n, 2015 IL App (3d) 140198WC-U (Ill. App., 2015).

Another factor of great significance is the nature of the work performed by the alleged employee in relation to the general business of the employer. Ware, 318 Ill.App.3d at 1122, 252 Ill.Dec. 711, 743 N.E.2d at 583. "Because the theory of the workman's compensation legislation is that the cost of industrial accidents should be borne by the consumer as a part of the cost of the product, and whose work does not constitute a separate business which allows a distinct channel through which the cost of an accident may flow, is presumptively within the area of intended protection of the compensation act." Ragler Motor Sales v. Industrial Comm'n, 93 Ill.2d 66, 71, 44 N.E.3d 652 (Ill. App., 2015) City of Bridgeport v. Ill. Workers' Comp. Comm'n, 44 N.E.3d 652 (Ill. App., 2015).

It is the petitioner's position that he was an employee of Tile Roofs at the time he sustained his accidental injuries. It is clear that the petitioner performed work in the same field (specialized roofing) after he formed Quantum Edge, as he did when he had been previously employed by Mortensen Roofing. However, the precise nature of his work clearly changed. He was no longer a roofer. After all, at the time of the accident, Petitioner was 61 years old, 5'-9" and weighed 252 pounds. He probably no longer had any business being up on a roof.

Petitioner acknowledged that he was "semi-retired" when he formed Quantum Edge. He also acknowledged that he was working as a "consultant" for Tile Roofs. (RX #1 p.6, 8) He acknowledged that he had developed special expertise throughout his work life and that he used that special expertise to "lay out" work for Mortensen's employees while working as a consultant for Tile Roofs. (Id. p. 9) He no longer worked alongside Mortensen roofers. He just did the layout of highly specialized roofs such as copper, tile and slate. (Id. p.14) This included being a consultant on landmark buildings.

More importantly, he established a legitimate corporation (Quantum Edge), provided a corporate W9 form to Tile Roofs, submitted invoices through Quantum Edge for his time and expenses incurred, took responsibility for paying any taxes that he may have owed for revenue that was generated by Quantum Edge. (RX #3) All of this evidence establishes that the petitioner was, indeed, working as an independent contractor at the time he was injured.

Quantum Edge was by no means a sham corporation. It was a legitimate business recognized by the federal government and the State of Illinois through which the petitioner was conducting business. The fact that petitioner testified that he established Quantum Edge for "tax

purposes" supports this conclusion. Petitioner billed out his services under "Quantum Edge." (RX #2) Likewise, when paid, checks were made out to "Quantum Edge," not Steven Qualizza. (RX #1 p.19) Quantum Edge had its own bank account. (Id. p. 20) One of the main reasons people establish corporations is to enjoy the tax benefits associated with corporate status.

Also, it is common practice for a longtime employee of a corporation to act as a consultant after the employment relationship has terminated. Corporations recognize that past employees have special skills and unique knowledge relating to the business of the corporation and it is desirable and beneficial to draw upon that skill and knowledge after the employment relationship has ended. That is precisely what happened here.

Petitioner was solely responsible for making decisions relative to the business of Quantum Edge. As the sole owner, officer and employee he made a choice not to purchase workers compensation coverage. Subparagraph 20 of Section 305/3 of the Illinois Workers Compensation Act states as follows:

> *Nothing contained in this Act shall be construed to apply to any sole proprietor or partner or member of a limited liability company who elects not to provide and pay compensation for accidental injuries sustained by himself, arising out of and in the course of the employment according to the provisions of this Act.*

Petitioner bought his own tools. (RX#1 p. 23) Petitioner started the project in July of 2016 but stopped for a time to take care of a rental property of his own that he had to "straighten things out." (RX 1 p.15, 18) Thus, it appears he had some flexibility to design his own schedule which not normally afforded to employees. Additionally, it appears that Petitioner decided when not to work because it was too dangerously hot, cold, windy or rainy. (PX #1,2,3,4) Obviously, these are valid reasons not to work at heights and petitioner made the call, not respondent.

Thus, based upon the totality of the evidence, the Arbitrator finds that petitioner was not an employee of the respondent at the time of his accidental injuries. Further, respondent has no liability for petitioner's injuries based upon any alternative theories given petitioner's election as the sole owner and officer of Quantum Edge not to purchase workers compensation coverage. Petitioner ostensibly knew the risks he was taking as he had formed his own business in the past.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Norman W. Howard, IV,

Petitioner,

vs. NO: 17 WC 28806

City of Springfield,

20IWCC0024

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

In the interest of efficiency, the Commission primarily relies on the Arbitrator's detailed recitation of facts. Petitioner is right hand dominant. On the date of accident, Respondent employed Petitioner as a truck driver and laborer. Petitioner sustained a right scapholunate ligament tear and a right wrist TFCC tear due to the August 10, 2017, work incident.

In November 2017, he underwent surgery that included a right wrist arthroscopy with debridement of the TFCC tear and a right wrist arthrotomy with open repair of the scapholunate ligament. Unfortunately, the soft tissue reconstruction of the right scapholunate ligament tear failed. Petitioner underwent a second surgery that included a scaphoid excision and fusion in January 2018. He returned to work without restrictions in May 2018. Petitioner's physician, Dr. Greatting, placed Petitioner at MMI in June 2018. While Dr. Greatting did not prescribe any permanent restrictions, he determined that Petitioner sustained a significant loss of range of motion in his right wrist with a loss of approximately 40% wrist extension and 65-70% loss of wrist flexion in the right wrist compared to his left wrist. Dr. Greatting also documented that Petitioner has lost approximately 50-55% of the grip strength in his right wrist compared to the left. In his August 2018 narrative report, Dr. Greatting opined that this significantly reduced range of motion and grip strength is permanent.

During the arbitration hearing, Petitioner testified that he continues to work in his original position. He testified that while his treatment did improve his condition, he continues to suffer

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from chronic complaints regarding his right wrist. He testified that his grip strength and range of motion is significantly limited in the right wrist. He no longer plays sports such as baseball, basketball, and football with his son. He testified that he tries to use his left hand to lift and throw items as it is stronger than his right hand. Petitioner testified that he uses over the counter medication three to four days a week and regularly ices his right wrist.

After carefully considering the evidence, including the opinion of Dr. Greatting and Petitioner's testimony regarding ongoing complaints, the Commission finds Petitioner sustained a 55% loss of use of his right hand. It is indisputable that Petitioner sustained a significant injury to his right wrist due to the work accident. He underwent two right wrist surgeries because the initial soft tissue reconstruction of the scapholunate ligament failed. The second surgery included a fusion. Despite surgical intervention and occupational therapy, Petitioner has not regained his normal strength and range of motion. Petitioner is unable to fully grip and lift heavy items with his dominant hand. His lack of strength and limited range of motion is permanent. However, despite his significantly reduced range of motion and grip strength, Petitioner has returned to his regular heavy-duty job as a truck driver and laborer and has no prescribed work or activity restrictions. After weighing the five factors pursuant to Section 8.1b of the Act, the Commission finds Petitioner sustained a 55% loss of use of the right hand.

The Commission otherwise affirms and adopts the Decision of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 8, 2019, is modified as stated herein.

IT IS FURTHER ORDERED that Respondent shall pay to Petitioner permanent partial disability benefits of **$664.21** for **112.75** weeks, because Petitioner's injuries caused **55%** loss of use of the right hand, as provided for in §8(e) of the Act.

IT IS FURTHER ORDERED 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 that Respondent pay to Petitioner interest pursuant to §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: JAN 13 2020
d: 12/10/19
TJT/jds
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Thomas J. Tyrrell

Maria E. Portela

AS0039W10S

20IWCC0024

DISSENT

After reviewing the facts of the case in light of the five factors enumerated in §8.1b(b) of the Workers' Compensation Act, I dissent from the majority's permanent partial disability award of 55% loss of use of a right hand.

According to Section 8.1b(b) of the Act, for injuries that occur after September 1, 2011, in determining the level of permanent partial disability, the Commission shall base its determination on the following factors:

(i) The reported level of impairment pursuant to AMA guidelines;
(ii) The occupation of the injured employee;
(iii) The age of the employee at the time of the injury;
(iv) The employee's future earning capacity; and
(v) Evidence of disability corroborated by the treating medical records.

In considering the degree to which Petitioner is permanently partially disabled as a result of the work-related accident, I weigh the five factors in Section 8.1b(b) of the Act as follows:

(i) No AMA impairment rating was submitted by either party, so this factor is given no weight.

(ii) Petitioner is employed as a truck driver/laborer for the City of Springfield. Petitioner does heavy duty work on a regular basis. Petitioner returned to work in his prior capacity with no restrictions. Thus, this factor is assigned moderate weight.

(iii) Petitioner was 31 years old at the time of the accident and has a significant amount of work life remaining until retirement. This factor is assigned greater weight.

(iv) Petitioner returned to his regular job as a truck driver/laborer for the City of Springfield. He has no restrictions on his job duties and Petitioner continues to work in this position, as of the date of hearing. There is no evidence of reduced future earning capacity as a result of the work-related accident thus this factor should receive no weight.

(v) Regarding evidence of disability corroborated by the treating medical records, as a result of the work-related accident of August 10, 2017, Petitioner underwent a right wrist arthroscopy with a debridement of a triangular fibrocartilage complex tear and a right wrist arthrotomy with an open repair of the scapholunate ligament and a dorsal capsulodesis. Petitioner underwent a second surgery consisting of a right wrist scaphoid excision and a midcarpal arthrodesis in January, 2018. He completed a course of physical therapy and work hardening. In May, 2018, Petitioner asked his physician, Dr. Greatting, to release him to return to work. The medical records reflect Petitioner sustained 50-55% loss of grip strength, 40% loss of extension and 65-70% loss of flexion.

AS0030108

Petitioner returned to work as a truck driver/laborer with no restrictions on his activities and testified at Arbitration he is able to do his job. During his last visit with Dr. Greatting, on June 25, 2018, Petitioner advised his strength had significantly improved. He complained of intermittent, mild discomfort but indicated the discomfort did not limit him. Petitioner testified he experiences pain and aching in the wrist and hand for which he takes over the counter medication and applies ice. He testified he is unable to engage in sporting activities with his son, such as baseball, basketball and football. I would assign moderate weight to this factor.

Based on the evidence presented that Petitioner sustained a work-related injury requiring two surgeries, completed medical treatment and returned to work in a heavy duty job with no restrictions, I would find that Petitioner sustained permanent partial disability in the amount of 45% loss of use of the right hand. Thus, I respectfully dissent.

Kathryn A. Doerries

SOIACC005

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HOWARD IV, NORMAN W
Employee/Petitioner

Case# **17WC028806**

CITY OF SPRINGFIELD
Employer/Respondent

20IWCC0024

On 7/8/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.04% 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:

1157 DELANO LAW OFFICES LLC
CHARLES H DELANO
1 SE OLD STATE CAPITOL PLZ
SPRINGFIELD, IL 62705

0332 LIVINGSTONE MUELLER ET AL
L ROBERT MUELLER
620 E EDWARD ST PO BOX 335
SPRINGFIELD, IL 62705

18IWCC0105

20IWCC0024

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

Norman W. Howard, IV
Employee/Petitioner

v.

City of Springfield
Employer/Respondent

Case # **17** WC **28806**

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 **Michael Nowak**, Arbitrator of the Commission, in the city of **Springfield**, on **8/24/18**. By stipulation, the parties agree:

On the date of accident, **8/10/17**, 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 $**57,565.04**, and the average weekly wage was $**1,107.02**.

At the time of injury, Petitioner was **31** years of age, ***single*** with **no** 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

Based on the factors enumerated in §8.1b of the Act, which the Arbitrator addressed in the attached findings of fact and conclusions of law, and the record taken as a whole, Respondent shall pay Petitioner the sum of **$664.21**/week for a further period of **123** weeks, as provided in Section **8(e)** of the Act, because the injuries sustained caused **60% loss of use of the right hand**.

Respondent shall pay Petitioner compensation that has accrued from **8/10/17** through **8/24/18**, 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.

Michael K. Nowak, Arbitrator

7/3/19
Date

ICArbDecN&E p.2

JUL 8 - 2019

FINDINGS OF FACT

The only matter at issue in this case is the nature and extent of the Petitioner's disability. The Parties stipulated that the Respondent will pay all related medical pursuant to the fee schedule. The Petitioner, Norman Howard, testified that on August 10, 2017, he was employed by the City of Springfield Sewer Department as a truck driver/laborer. (Arbitration Transcript hereinafter A.T., Page 10). Prior to August 10, 2017, Petitioner, who is right handed, had not had any problems with his right hand or wrist. (A.T., Pages 10 & 11). Petitioner testified that his right hand was his dominant hand and that is how he used it. (A.T., Page 11).

On August 10, 2017, Petitioner was with his crew trying to break open a manhole that was rusted. (A.T., Pages 11 & 12). Petitioner was using a large pry bar to open the manhole. When the manhole popped loose, the pry bar he was using kicked back and pulled his fingers all the way back. (A.T., Pages 11 & 12). Petitioner testified that he immediately knew something was wrong with his right hand because he went to pick up a chain and could not do it. (A.T., Page 12). Petitioner had no grip strength at all. (A.T., Page 12). Petitioner was also experiencing pain in his right hand and testified that when his injury occurred, he felt a pop in his hand. (A.T., Pages 12 & 13).

The medical records for the treatment Petitioner received are included in the record as Petitioner's Exhibits 2 through 7 and Petitioner's Exhibits 11, 14 and 15. Petitioner testified that he went to Memorial Express Care on South Sixth Street after his injury. (A.T., Page 14). He was put in a brace and instructed to follow up if he continued to have pain. After he returned to Express Care he was referred to Angela Royer, a physician's assistant at Springfield Clinic. (A.T., Pages 14 & 15). Nurse Practitioner Royer placed Petitioner's right arm in a cast. (A.T., Page 15). Petitioner wore the cast for six to eight weeks and then returned to Nurse Practitioner Royer. (A.T., Pages 15 & 16). He still had pain in his hand and no strength. He was then referred to Dr. Mark Greatting at the Springfield Clinic. (A.T., Pages 15, & 16). Dr. Greatting is an orthopedic surgeon. (A.T., Page 16). Dr. Greatting concentrates his practice in issues regarding the arm. (A.T., Page 16). Dr. Greatting's records are included in the record as Petitioner's Exhibit 6. Petitioner's Exhibit 7 are operative reports for surgeries performed by Dr. Greatting on Petitioner's right hand/wrist. The records indicate that on November 21, 2017, Petitioner underwent a right wrist arthroscopy with debridement of triangular fibrocartilage complex tear and a right wrist arthrotomy with open repair of scapholunate ligament and dorsal capsulodesis with dorsal midcarpal ligament.

Petitioner testified that he remained under Dr. Greatting's care after his surgery on November 21, 2017. His arm was casted and he went back at approximately the end of December 2017 or early January 2018 and the case was removed. The pins which had been placed in his wrist were also removed and another surgery was recommended. (A.T., Pages 18 & 19). The second surgery took place on January 17, 2018. The operative report is also included in Petitioner's Exhibit 7. The operative report from that surgery indicates that Petitioner had undergone a failed scapholunate ligament repair of his right wrist. He underwent a right wrist scaphoid excision and midcarpal arthrodesis with TriMed upper fusion.

During this second surgery, a plate and screws were placed in Petitioner's wrist which remained there at the time of hearing.

Petitioner testified that after the second surgery he had the cast removed and underwent a course of physical therapy at SIU Hand Therapy. (A.T., Page 20). The physical therapy lasted for approximately two months. (A.T., Page 21). After the physical therapy was completed, Petitioner engaged in work hardening. (A.T., Pages 21 & 22). After his work hardening was completed, he went back to Dr. Greatting's office on June 25, 2018. (A.T., Page 23). Dr. Greatting released him at that time. (A.T., Page 23). Petitioner testified that when he was released by Dr. Greatting, Dr. Greatting also ordered a round of testing to determine the loss of strength and motion in his hand. (A.T., Pages 23 & 24). The results of Petitioner's strength testing are summarized by Dr. Greatting in an August 19, 2018 letter. That letter is included in Petitioner's Exhibit 6. It states:

> To Whom it May Concern,
>
> Norman W. Howard (date of birth October 9, 1985) has had surgery on his right wrist secondary to an injury with a scapholunate ligament tear. He had 2 surgical procedures on his wrist with the most recent surgical procedure consisting of scaphoid excision and midcarpal arthrodesis on January 16, 2018. Norm was seen by SIU Hand Therapy June 25, 2018 and had strength and range of motion measurements made of both wrists. Based on the results of that evaluation, Norm has a significant loss of range of motion in his right wrist with loss of about 40% of wrist extension and 65-70% loss of wrist flexion of his right wrist compared to his uninjured left wrist. He has lost approximately 50-55% of the grip strength in his dominant right wrist compared to his left wrist. I feel these losses are permanent and will not improve or change with time…

During the hearing, Petitioner testified as to the loss of grip strength and motion in his hand. He also demonstrated the loss of motion for the Arbitrator. (A.T., Page 25). Petitioner testified that before this injury occurred, his right hand had the same unimpeded range of motion as his left. (A.T., Pages 25 & 26). Petitioner testified that he has very little side to side motion of his right wrist and hand and the up and down motion of his right hand is significantly diminished. (A.T., Page 26). In his own words, Petitioner testified that he does not have much movement up or down and he basically has no movement from side to side. (A.T., Pages 26 & 27).

Lastly, Petitioner testified that he has lost a lot of strength in his right hand. (A.T., Page 27). He considers his left hand to now be his dominant hand and it is stronger than his right hand. (A.T., Page 27). Petitioner testified that he has rearranged his activities at work to use his left hand whenever possible as opposed to using his right hand. (A.T., Pages 27 & 28). For example, when swinging a sledgehammer, instead of using his right hand to bring it down with force, he now uses his left. (A.T., Page 28). When carrying heavy things, he uses his left hand. Petitioner testified that he jackhammers and does a lot of picking up of large pieces of concrete, asphalt and things like that where his left hand is now the dominant force when performing those functions. (A.T., Page 28).

Petitioner testified that he is no longer able to engage in sporting activities with his son such as baseball, basketball, football and things like that. (A.T., Page 29). Even though his left hand is now his dominant hand, he is not able to throw a baseball with his left hand very well. (A.T., Page 29). The same is true with a football. (A.T, Page 29). Petitioner testified that he also still experiences pain on a regular basis. (A.T., Page 30). He ices his wrist a lot and rotates between Ibuprofen and Tylenol for the swelling and some of the pain. (A.T., Page 30). Petitioner testified that in an average week, he has to ice his wrist and take Ibuprofen and Tylenol about

three or four days. (A.T, Page 30). After a week of work, Petitioner's wrist stiffens up and he has to loosen it up again when he starts work the following week. (A.T., Pages 30 & 31).

CONCLUSIONS

Pursuant to §8.1b of the Act, permanent partial disability from injuries that occur after September 1, 2011 is to be established using the following criteria: (i) the reported level of impairment pursuant to subsection (a) of §8.1b of the Act; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. 820 ILCS 305/8.1b. The Act provides that, "No single enumerated factor shall be the sole determinant of disability." 820 ILCS 305/8.1b(b)(v).

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that neither party submitted an impairment rating. The Arbitrator therefore gives *no* weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes Petitioner is employed by the City of Springfield Sewer Department as a truck driver/laborer. The Petitioner does heavy duty work on a regular basis. That work causes Petitioner to experience pain several times a week for which he must take over the counter pain medication and apply ice to his wrist. Given the stress put on his wrist by performing this work, it is conceivable that Petitioner may develop further problems with the wrist which would affect his ability to perform his job at some point in the future. The Arbitrator therefore gives *greater* weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that at the time of the injury, Petitioner was 31 years old. Petitioner continues to experience problems with his wrist and hand and has pain regularly. The Petitioner has lost most of the motion and strength in his right hand. His right hand was his dominant hand. He has a plate and screws in his right wrist and hand as a result of this injury. Dr. Greatting's letter of August 19, 2018, indicated that these conditions were permanent. Given the fact that these problems will continue throughout the course of Petitioner's life, they will continue for a lengthy period of time if Petitioner lives a normal life expectancy. The Arbitrator places significant weight on the fact that Petitioner is a young man who will experience these problems for the rest of his life. The Arbitrator therefore gives *greater* weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner returned to his regular job with the City of Springfield Sewer Department. There was no direct evidence of wage loss in this case. However, as indicated above, Petitioner's job is a heavy duty one. Performing it places stress on Petitioner hand and wrist. There may come a point where Petitioner is no longer able to engage in this type of employment. The Arbitrator therefore gives *some* weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes the Petitioner was a credible witness. The medical records indicate that Petitioner underwent multiple surgeries on his right wrist/hand because of the problems he was experiencing. He underwent physical therapy and work hardening. He has a plate and screws in his wrist. He has lost most of the strength and motion in his right hand. He is right hand dominant. He experiences pain and aching in his wrist and hand and has to take over the counter pain medications and apply ice to his wrist and hand multiple times per

week. He has restructured his activities at work to use his left hand as his dominant hand. He is unable to engage in sporting activities with is son because he does not have significant range of motion or strength in his right hand and wrist to do so. Specifically, Petitioner is no longer able to throw a football or baseball. Dr. Greatting's records indicated that Petitioner's condition is permanent and will not improve.

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 60% loss of use of the right hand pursuant to §8(e) of the Act.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Vladimir Fedorov,

Petitioner,

vs.

NO: 10 WC 42930

20IWCC0025

Park District of Highland Park,

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 all issues, and being advised of the facts and law, modifies the Decision of the Arbitrator and corrects the period of temporary total disability ("TTD") awarded to conform with the Request for Hearing form. The Commission otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

Initially, Petitioner claimed entitlement to TTD from February 2, 2010, through July 15, 2012. However, Petitioner amended the sought-after TTD period to February 11, 2010, through July 15, 2012. Petitioner's stipulation regarding the TTD period is memorialized in the Record. (Arb. Ex. 2; Tr. at 8). Pursuant to Petitioner's stipulation, the Commission hereby amends the Decision of the Arbitrator and finds Petitioner was temporarily totally disabled from February 11, 2010, through July 15, 2012, for a period of 126-4/7 weeks.

The Commission otherwise affirms and adopts the Decision of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 13, 2016, is modified as stated herein.

IT IS FURTHER ORDERED that Respondent shall pay to Petitioner temporary total disability benefits of $**76.90**/week for **126-4/7** weeks, commencing **February 11, 2010,** through **July 15, 2012**, as provided in Section 8(b) of the Act.

3S0003WI0S

20IWCC0025

IT IS FURTHER ORDERED that Respondent shall pay to Petitioner permanent partial disability benefits of **$76.90** for **69.875** weeks, because Petitioner's injuries caused **32.5%** loss of use of the left leg, as provided for in §8(e)12 of the Act.

IT IS FURTHER ORDERED that Respondent shall receive a credit of **$21,822.54** for TTD previously paid for a total credit of **$21,822.54**.

IT IS FURTHER ORDERED 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 that Respondent pay to Petitioner interest pursuant to §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: JAN 13 2020

o: 11/19/19
TJT/jds
51

Thomas J. Tyrrell

Maria E. Portela

Kathryn A. Doerries

SOIACC0052

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

FEDOROV, VLADIMIR
Employee/Petitioner

Case# **10WC042930**

PARK DISTRICT OF HIGHLAND PARK
Employer/Respondent

20IWCC0025

On 12/13/2016, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.64% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4073 LAW OFFICES OF SCOTT B SHAPIRO
218 N JEFFERSON ST
SUITE 401
CHICAGO, IL 60661

0075 POWER & CRONIN LTD
ELENA CINCIONE
900 COMMERCE DR SUITE 300
OAKBROOK, IL 60523

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

20IWCC0025

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Vladimir Fedorov
Employee/Petitioner

v.

Park District of Highland Park
Employer/Respondent

Case # **10** WC **42930**

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 **Waukegan, Illinois**, on **October 26, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **February 2, 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, the Petitioner earned $2,922.50; the average weekly wage was $76.90.

On the date of accident, Petitioner was **38** years of age, ***married*** with **1** dependent children.

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

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

Respondent shall be given a credit of $**21,822.54** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**21,822.54**.

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 $76.90/week for 125 and 2/7ths weeks, commencing February 2, 2010 through July 15, 2012, as provided in Section 8(a) of the Act.

Respondent shall pay Petitioner a sum of $76.90/week for a period of 69.875 weeks, as provided in §8(e)12 of the Act, because the injuries sustained caused 32-1/2% loss of use of the left leg.

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

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

Signature of Arbitrator

12/12/16
Date

DEC 13 2016

20IWCC0025

STATEMENT OF FACTS

Respondent, Park District of Highland Park ("Respondent") employed Petitioner, Vladimir Fedorov ("Petitioner") as an ice dancing and ice skating instructor. Petitioner is an experienced professional ice dancer and former Olympian. Petitioner testified that he started at age six in Russia where he was placed in the Russian Institute for athletics, and began to learn his trade of ice skating. He testified that he went on to win the bronze medal in the Junior World Championships, bronze medal in the World Ice Dancing Championships, fourth place in the European Championships, and his competitive career culminated with 6th Place finish in the Lillehammer Olympics in 1994. Thereafter he came to the United States, and began instructing and coaching professionally. During his coaching career he coached several competitive national championship qualifying teams prior to and during his employment with Respondent. Petitioner testified that his sole trade is that of an ice skating instructor, and has never been employed in any other trade or field other than ice skating and ice dancing.

Petitioner sustained an undisputed work accident while working for Respondent on February 2, 2010. Petitioner testified that on February 2, 2010, he began work at his usual time in the morning instructing a class of beginner children ice skaters. He stated that as they were doing the warm ups, one student fell very hard on her hip. Petitioner picked the child up, and began to carry her to the door in the skating rink boards to take her off the ice. While exiting from the ice to the floor the child's leg became caught on the boards in the doorway, causing Petitioner to fall backwards. He continued to hold the child and she landed on his chest, while his left leg twisted behind him. He testified he felt a snap, and immediately knew that he had severely injured his left knee. He stated the leg immediately swelled, and he went to the emergency room, where he came under the care of Dr. Charles Lettvin of Illinois Bone & Joint Institute. (PX 1)

Petitioner immediately underwent a left patellar open repair surgery with Dr. Lettvin on February 5, 2010. Thereafter, he had post-surgical blood clotting, and his knee was locked in full extension for approximately two weeks. Petitioner began physical therapy on March 24, 2010, and continued to treat with Dr. Lettvin through November 8, 2010. (PX 1)

By March 2011 Petitioner had not reached maximum improvement and was referred to Dr. James Jill at Northwestern for further care. Petitioner testified that he sought a second opinion with Dr. James Hill, of Northwestern University Hospital, upon the recommendation of the one of Respondent's human resources employees. Records submitted show Petitioner saw Dr. Hill on March 3, 2011. A MRI was recommended which when completed revealed that he had a defect of the superior central portion of the lateral facet of the patella. It was noted that he also had extensive postoperative changes of the patella with evidence of ongoing scarring. On March 16, 2011, Dr. Hill noted his impression that Petitioner had a defect of the lateral facet of his patella with scarring of the patella tendon. The doctor felt Petitioner would not improve with further conservative care and recommended a left knee arthroscopy with excision of the scar tissue and treatment for the defect in the lateral facet of the patella. (PX 2)

On April 15, 2011, Dr. Hill performed a second surgery consisting of a left knee arthroscopy with debridement of synovium and plica. Petitioner continued in physical therapy and under the care of Dr. Hill. On November 28, 2011, Dr. Hill recommended a Functional Capacity Evaluation. The doctor's recommendation was carried out on December 15, 2011, at Athletico. The evaluator noted that Petitioner demonstrated high levels of effort throughout the evaluation. The evaluator felt Petitioner was not capable of performing the physical demands of the target job of Figure Skating Instructor. Because of Petitioner's left knee range of

20 I W CC 0025

motion and strength deficits, it was recommended that he undergo a formal and organized work conditioning program to assist in balance training, functional single leg strength and the ability to tolerate twisting motions without disabling left knee pain. (PX 3)

Petitioner continued with additional therapy. On his return visit to Dr. Hill on March 2, 2012, Petitioner reported that he was improving. His gait was normal. He had full range of motion of his knee. There was 2 cm of atrophy of the left thigh and he had crepitus on flexion and extension of the knee. Physical therapy was continued. (PX 2)

Pursuant to Dr. Hill's referral, Petitioner underwent a second Functional Capacity Evaluation on June 18, 2012. In his Summary Report, the evaluator noted the results were valid indicating Petitioner was capable of performing at a "medium level and with some modifications a heavy physical demand level when done occasionally." The evaluator noted Petitioner was able to carry, push and pull at the heavy physical demand tolerance. Petitioner demonstrated limitations with walking or standing completing greater than 2-1/2 hours of repetitive standing and walking. Petitioner also demonstrated single leg balance equally between legs with eyes open and closed. He further performed single leg balanced activity with safe form and without loss of balance. Lastly, the evaluator stated, "[Petitioner] does have the physical strength and stability in his left knee to perform and be on the ice close to his students, but he will have difficulty performing demonstrations that require deep knee bending or lifting. If he can be assisted with this he may be able to return to his job as a figure skating instructor." (PX 3)

In addition to working part-time as an ice skating instructor, Petitioner also taught ice skating lessons as part of a personal business, F & B On Ice. Petitioner testified that the corporation is a business he runs in addition to working for Respondent. It is undisputed that Respondent knew of this secondary business. He worked for Respondent Monday afternoons, Tuesday mornings, and Wednesday afternoons. He also worked for Respondent Friday and Saturday mornings from time to time when needed, or when there was an upcoming competition. Petitioner concurrently conducted and taught his own private lessons in addition to the work he performed for Respondent. Petitioner used Respondent's ice rink and facilities for his own business, as well as other facilities, to instruct clients in the same manner as the type of work he performed for Respondent. Petitioner testified that in both his private lessons, and working for Respondent, he would instruct from the very basic level ice dancing routines, through elite professional Olympic and World Championship competitive level routines. These routines included up to 37 different routines, and required him to actively participate on the ice with his students at all times.

Petitioner is the sole shareholder of F & B On Ice, an S Corporation. The corporation's income is earned through Petitioner's private business as an ice skating instructor. From 2009 to 2015, Petitioner claimed the net profits from the corporation as income from an S corporation under line 17 on his personal tax returns. From 2009 to 2015, the corporation did not pay wages to any employees or compensate any officers, including Petitioner. (PX 4, PX 5) Petitioner testified that his personal tax returns and tax returns for F & B On Ice for the years 2009, 2010, 2011, 2012, 2013, 2014, and 2015 were prepared by an accountant. Petitioner also testified he was given the opportunity to review each tax return prior to it being filed. He also testified that he has not filed any amendments to those tax returns.

Petitioner testified that he returned to skating instruction for Respondent in July 2012, "the 24th or 25th." Respondent paid Petitioner temporary total disability benefits from February 2, 2010, through July 15, 2012, or $21,822.54 over said period. Petitioner testified that currently, he is in constant pain. He has difficulty with ice dancing instruction. He can only instruct up to the most basic levels both for Respondent and at his own private lessons. He testified that many times he only instructs from off ice, and that when he attempts to skate on ice he suffers from instability and pain, which prevents him from skating as a partner with any of his students, or from

doing any activities which require him to bend his left leg at all. He stated he constantly has to take pain medications and ice his leg.

Petitioner testified that still maintains his business as an ice skating instructor. He continues to maintain certification from the US Figure Skating Association to coach and teach skaters of all levels. He was first certified in 1999 and currently maintains that certification. Petitioner also currently maintains membership in the Professional Skaters Association, an organization of ice skating professionals engaged in the instruction and training of ice skating. Prior to the accident of February 2, 2010, Petitioner charged the same hourly rate for ice skating lessons for skaters of all skill levels. Petitioner testified that the annual income of F & B On Ice fluctuates and is influenced by numerous factors. Petitioner maintains a LinkedIn webpage in which he identifies himself as a national and international level coach of professional figure skating from 1999 to present.

With respect to (F.) Whether Petitioner's present condition of ill being is causally related to the injury, the Arbitrator finds the following:

Petitioner sustained an undisputed work accident while working for Respondent on February 2, 2010. At that time he sustained an injury to his left leg when he fell while carrying a beginner ice skater who had hurt herself. Immediately thereafter, Petitioner underwent a left patellar open repair surgery with Dr. Lettvin on February 5, 2010. By March 2011 Petitioner had not reached maximum improvement and was referred to Dr. Hill. The doctor ultimately performed a second surgery consisting of a left knee arthroscopy with debridement of synovium and plica. On June 18, 2012, Petitioner underwent a valid Functional Capacity Evaluation indicating Petitioner was capable of performing at a "medium level and with some modifications a heavy physical demand level when done occasionally."

Relying on the sequence of events, together with Petitioner's treating medical records from Illinois Bone & Joint Institute, Dr. James Hill of Northwestern University Hospital, and Athletico, the Arbitrator finds Petitioner's present left leg condition of ill being is causally related to his February 2, 2010, fall while working for Respondent.

With respect to (G.) What were the Petitioner's earnings, the Arbitrator finds as follows:

The parties stipulated that Petitioner's earnings while working for Respondent were $2,922.50, which produced an agreed average weekly wage, from Respondent's earnings only, of $76.90. (RX 1) The parties also agreed that the corporate income from F & B On Ice , Petitioner's private company, were $84,455.00 for the year prior to his February 2, 2010 accident.

Petitioner argues that the corporate income of F & B On Ice should be considered wages earned through concurrent income, and therefore included in the average weekly wage calculation. The Arbitrator disagrees. The Appellate Court of Illinois has ruled unambiguously that net profits from corporate income are not included in the average weekly wage calculation. *Paoletti v. Industrial Commission*, 279 Ill.App.3d 988 (1996).

The Arbitrator looks to the Appellate Court's decision in *Mansfield v. Illinois Workers' Compensation Commission* for further guidance. In that case, the claimant worked part-time as a piano teacher for Naperville Park District. In addition, she taught piano lessons out of her home. When the claimant was injured working for the Naperville Park District, she argued her average weekly wage should be calculated using both her earnings with the park district and the income from the self-employment business of teaching lessons out of her home. In *Mansfield,* the Appellate Court held that the self-employment business income was not paid to her as wages from an employer, and therefore could not be included in the average weekly wage calculation. *Mansfield v. Illinois Workers' Compensation Commission*, 2013 Ill.App.(2d) 120909WC.

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Based on the above, the Arbitrator calculates Petitioner's average weekly wage using solely the wages paid to Petitioner by Respondent in the 52 weeks prior to the accident. The income of F & B On Ice will not be included in the calculation.

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Sec. 10 of the Act dictates that earnings "shall be divided by the weeks and parts thereof" actually worked by the claimant. The Appellate Court of Illinois has ruled that when the claimant's employment is less than full-time, earnings are divided by an entire workweek even if the claimant only worked a portion of the week. *Ricketts v. Industrial Commission et al.*, 251 Ill.App.3d 809 (1993).

In the case at hand, Petitioner testified that he was a part-time employee at Park District of Highland Park as an ice skating instructor. Petitioner worked during 38 of the 52 weeks prior to the accident. The wage statement admitted into evidence as Respondent's Exhibit 1 reveals Petitioner earned $2,922.50 working as an ice skating instructor for Park District of Highland Park during those 38 weeks. Therefore, dividing the $2,922.50 earned over the 38 weeks actually worked yields an average weekly wage of $76.90.

Based on the above, the Arbitrator finds Petitioner's earnings during the year preceding the injury were $2,922.50 and his average weekly wage, calculated pursuant to Section 10 of the Illinois Workers' Compensation Act, was $76.90.

With respect to (K.) What temporary benefits (TTD) are in dispute, the Arbitrator finds as follows:

The parties agree that Petitioner was at a minimum temporarily and totally disabled from work for the period of February 2, 2010 through March 5, 2012. Petitioner request additional temporary total disability benefits through July 15, 2012.

Medical documentation submitted and Petitioner's testimony demonstrates that he last saw Dr. Hill on March 5, 2012. At that time Petitioner reported he was improving. Dr. Hill continued physical therapy. Petitioner testified that he never returned to the doctor for another visit. Although Petitioner did not return to Dr. Hill after March 5, 2012, documents submitted show Dr. Hill referred Petitioner for a second Functional Capacity Evaluation. The evaluation took place on June 18, 2012 and was deemed valid indicating Petitioner was capable of performing at a "medium level and with some modifications a heavy physical demand level when done occasionally." Petitioner testified that he returned to skating instruction for Respondent in July 2012, "the 24th or 25th." Respondent paid Petitioner temporary total disability benefits from February 2, 2010, through July 15, 2012, or $21,822.54 over said period.

In summation, Petitioner last saw Dr. Hill on March 5, 2012. Pursuant to Dr. Hill's referral, Petitioner underwent a valid Functional Capacity Evaluation on June 18, 2012. Respondent paid temporary total disability through July 15, 2012, or $21,822.54; and lastly, Petitioner testified that he returned to skating instruction for Respondent in July 2012, "the 24th or 25th."

Taking all the above into consideration, the Arbitrator awards temporary total disability benefits from February 2, 2010 through July 15, 2012, a period of 125-2/7ths weeks. Respondent is entitled to a credit for TTD benefits paid.

With respect to issue (L.) What is the nature and extent of the injury, the Arbitrator finds as follows:

In determining the level of permanent partial disability for injuries incurred on or after September 1, 2011, the Commission shall base its determination on the following factors: (i) the reported level of impairment pursuant to the most current edition of the AMA's "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; (v) evidence of disability corroborated by the treating medical records. (820 ILCS 305/8.1b)

No single enumerated factor shall be the sole determinant of disability. 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)

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no opinion comporting with the specific requirements of §8.1b(a) was submitted into evidence. The Arbitrator gives no weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes Petitioner was employed as an ice skating instructor at the time of the accident. In June 2012, Petitioner underwent a FCE finding Petitioner was capable of performing at a "medium level and with some modifications a heavy physical demand level when done occasionally." Petitioner testified that due to his restrictions, he can only teach up to the fourth, of thirty-seven total levels of ice dancing, and now has to refer any higher level instruction to outside ice dancing instructors. Further he can no longer engage in many of the on ice activities that he once was able to perform. That said, Petitioner is currently employed in the same course of employment as before the accident. Petitioner still maintains his business as an ice skating instructor. He continues to maintain his certification to teach ice skating of all levels of competition and identifies himself as a national and international level coach for professional figure skating on the LinkedIn webpage he maintains. The Arbitrator gives weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner is 38 years old at the time of the accident. As Petitioner is a younger individual who has to live with his permanent partial disability for longer period than that of an older individual, the Arbitrator therefore gives greater weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator again notes Petitioner is currently employed as an ice skating instructor and still maintains his business as an ice skating instructor. He continues to maintain his certification to teach ice skating of all levels of competition and identifies himself as a national and international level coach for professional figure skating on the LinkedIn webpage he maintains. Petitioner testified that the annual income of F & B On Ice fluctuates each year based on a number of different factors, none of which were identified as the work injury on February 2, 2010. He also testified that he charges the same hourly rate for ice skating lessons of every skill level. There was no evidence presented to show Petitioner suffered a decrease in earning capability as a result of the injury. Because there is no impairment to future earnings, the Arbitrator therefore gives no weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes Petitioner underwent two surgeries that being a left patellar open repair surgery with Dr. Lettvin on February 5, 2010 and a left knee arthroscopy with debridement of synovium and plica performed by Dr. Hill on April 15, 2011. During his last documented visit with Dr. Hill on March 2, 2012, Petitioner reported that he was improving. His gait was normal. He had full range of motion of his knee. There was 2 cm of atrophy of the left thigh and he had crepitus on flexion and extension of the knee. Pursuant to Dr. Hill's referral, Petitioner underwent a valid Functional Capacity Evaluation on June 18, 2012. Petitioner demonstrated that he was capable of performing at a "medium level and with some modifications a heavy physical demand level when done occasionally." The evaluator noted Petitioner was able to carry, push and pull at the heavy physical demand tolerance. Petitioner demonstrated limitations with walking or standing completing greater than 2-1/2 hours of repetitive standing and walking. Petitioner also demonstrated single leg balance equally between legs with eyes open and closed. He further performed single leg balanced activity with safe form and without loss of balance. Lastly, the evaluator stated, "[Petitioner] does have the physical strength and stability in his left knee to perform and be on the ice close to his students, but he will have difficulty

performing demonstrations that require deep knee bending or lifting. If he can be assisted with this he may be able to return to his job as a figure skating instructor." Petitioner testified that he is in constant pain. He indicated that he has difficulty with ice dancing instruction. He can only instruct up to the most basic levels both for Respondent and at his own private lessons. He testified that many times he only instructs from off ice, and that when he attempts to skate on ice he suffers from instability and pain, which prevents him from skating as a partner with any of his students, or from doing any activities which require him to bend his left leg at all. He stated he constantly has to take pain medications and ice his leg. The Arbitrator gives some weight to this factor.

Based on all the above, the Arbitrator finds that as a result of the accidental injury, Petitioner sustained 32-1/2% loss of use of the left leg under Section 8(e) of the Act.

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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

MICHELLE REAGAN,

Petitioner,

vs. NO: 17 WC 13278

TIFFANY and COMPANY,

Respondent.

20IWCC0026

DECISION AND OPINION ON REVIEW

Timely Petition for Review under Section 19(b) of the Act having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses, prospective medical care, temporary benefits, 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. Indus. Comm'n*, 78 Ill. 2d 327 (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 Commission has considered all the testimony, exhibits, pleadings, and arguments submitted by the parties. The Commission is not bound by the Arbitrator's findings. Our Supreme Court has long held that it is the Commission's province "to assess the credibility of witnesses, resolve conflicts in the evidence, assign weight to be accorded the evidence, and draw reasonable inferences from the evidence." *City of Springfield v. Indus. Comm'n*, 291 Ill. App. 3d 734, 740 (1997) (citing *Kirkwood v. Indus. Comm'n*, 84 Ill. 2d 14, 20 (1981)). Interpretation of medical testimony is particularly within the province of the Commission. *A. O. Smith Corp. v. Indus. Comm'n,* 51 Ill. 2d 533, 536-37 (1972).

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The Commission affirms the Arbitrator's award of $10,000.00 for Section 19(l) penalties. However, the Commission vacates the Arbitrator's award for Section 19(k) penalties and Section 16 attorney's fees.

The Commission agrees with the Arbitrator's findings and conclusions that Respondent failed to present any evidence to rebut the presumption of unreasonable delay pursuant to Section 19(l) of the Act. Respondent failed to respond to Petitioner's demand for payment of benefits within 14 days as required under Section 19(l) of the Act, and Respondent also did not comply with the Commission's Rule 9110.70, which required written explanation for denial of medical care or payment of temporary benefits.

However, the Commission disagrees with the Arbitrator relative to the award of Section 19(k) penalties and Section 16 fees as the Commission finds that the evidence did not demonstrate that Respondent's actions rose to the level of vexatious conduct. The Commission finds merit in Respondent's position that the delay in payment was in part caused by issues with calculating the correct amount owed in temporary benefits as demonstrated by the irregular and fluctuating hours and payment information contained in Petitioner's Exhibits 1 and 8. The Commission further finds that a legitimate dispute existed as to causal connection for Petitioner's bilateral hip condition and that Respondent had relied on its Section 12 examiner to deny payment of medical benefits. Thus, while the Commission affirms the Arbitrator's award of $10,000.00 for Section 19(l) penalties, the Commission vacates the Arbitrator's award for Section 19(k) penalties and Section 16 attorney's fees.

The remainder of the Arbitrator's Decision is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator, filed March 1, 2019, is hereby modified as stated above, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner temporary total disability benefits of $773.57 per week for 23 weeks, commencing July 5, 2017 through December 12, 2017, that being the period of temporary total incapacity for work under Section 8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner temporary partial disability benefits totaling $24,910.51 for the period commencing December 13, 2017 through January 11, 2019 as provided in Section 8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay $90,141.09 in reasonable and necessary medical services pursuant to Section 8(a) of the Act and to be adjusted in accord with the medical fee schedule provided in Section 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner is entitled to prospective medical treatment as ordered by Dr. Domb including physical therapy, massage and

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myofascial release for the right hip as well as an updated left hip MRI arthrogram and pre-operative and post-operative care related to left hip surgery.

IT IS FURTHER ORDERED BY THE COMMISSION that the Arbitrator's award for Section 19(k) penalties and Section 16 attorney's fees be and is hereby vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay penalties pursuant to Section 19(l) of the Act in the amount of $10,000.00.

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

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

IT IS FURTHER ORDERED BY THE COMMISSION that 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 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 the Circuit Court.

DATED: JAN 15 2020

D. Douglas McCarthy

DDM/pm
O: 12-18-19
052

Stephen J. Mathis

L. Elizabeth Coppoletti

SOTHCC0058

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

REAGAN, MICHELLE
Employee/Petitioner

Case# **17WC013278**

TIFFANY AND COMPANY
Employer/Respondent

20IWCC0026

On 3/1/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.45% 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:

4788 HETHERINGTON KARPEL BOBBER
PETER C BOBBER
120 N LASALLE ST SUITE 2810
CHICAGO, IL 60602

5391 LEWIS BRISBOIS
MICHALEL A PAULETTO
550 W ADAMS ST SUITE 300
CHICAGO, IL 60661

SO LACG0058

20IWCC0026

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

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

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

Michelle Reagan
Employee/Petitioner

v.

Tiffany and Company
Employer/Respondent

Case # **17** WC **13278**

Consolidated cases: **N/A**

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An *Application for Adjustment 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 **January 11, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, October 15, 2016, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $60,338.20; the average weekly wage was $1,160.35.

On the date of accident, Petitioner was 49 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.*

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As agreed by the parties, Respondent is entitled to a credit for any temporary total disability[1] and temporary partial disability[2] payments that have been paid. *See* AX1.

ORDER

Temporary Total Disability and Temporary Partial Disability Benefits

As agreed by the parties, Respondent shall pay Petitioner temporary total disability benefits of $773.57/week for 23 weeks, commencing July 5, 2017 through December 12, 2017,and temporary partial disability benefits totaling $24,910.51[3] for the period commencing December 13, 2017 through January 11, 2019, and ongoing, as provided in Section 8(b) of the Act. Respondent shall be entitled to a credit for any temporary total disability and temporary partial disability payments that have been made.

Medical Bills

Respondent shall pay Petitioner $90,141.09 for reasonable and necessary medical bills as provided in Sections 8(a) and 8.2 of the Act.

Prospective Medical Treatment

As explained in the Arbitration Decision Addendum, the Arbitrator finds that Petitioner is entitled to prospective medical treatment as ordered by Dr. Domb including physical therapy, massage and myofascial release for the right hip as well as an updated left hip MRI arthrogram and pre-operative and post-operative care related to left hip surgery to include a labral repair vs. reconstruction, acetabuloplasty, femoroplasty, endoscopic versus open gluteus medius repair, with possible microfracture and iliopsoas fractional lengthening.

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[1] The parties stipulate that Petitioner is entitled to temporary total disability benefits from July 5, 2017 through December 12, 2017. AX1.

[2] The parties stipulate that Petitioner is entitled to temporary partial disability benefits from December 13, 2017 through January 11, 2019. AX1.

[3] *See* PX1.

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Penalties

As explained in the Arbitration Decision Addendum, Respondent shall pay Petitioner penalties pursuant to Sections 19(l) in the amount of $10,000.00; penalties pursuant to Section 19(k) in the amount of $55,870.46; and Fees pursuant to Section 16 in the amount of $17,174.09.

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

February 28, 2019
Date

ICArbDec19(b) p.3

MAR 1 - 2019

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

Michelle Reagan
Employee/Petitioner

v.

Tiffany and Company
Employer/Respondent

Case # **17** WC **13278**

Consolidated cases: **N/A**

FINDINGS OF FACT

A hearing was held in the above-captioned case on January 11, 2019. Arbitrator's Exhibit[4] ("AX") 1. The issues in dispute include causal connection, Respondent's liability for certain unpaid medical bills, whether Petitioner is entitled to prospective medical care to the right and left hips as ordered by Dr. Domb, and whether Respondent is liable for penalties and attorney's fees pursuant to Sections 16, 19(k) and 19(l) of the Act. AX1. The parties have stipulated to all other issues. *Id.*

Background

Michelle Regan (Petitioner) testified that she was employed by Tiffany and Company (Respondent) as a Sales Associate at the time of her undisputed accident at work. In this position, she sold fine jewelry to customers and received hourly wages in addition to commission. Petitioner explained that she was required to stand for long periods of time as well as bend and squat often to obtain merchandise below the showcases. Additionally, Petitioner testified that she was required to hurry to the customers and make first contact with them to obtain any commission related to those merchandise sales. Petitioner further testified that the position required her to wear professional attire and maintain a well-groomed physical appearance.

Petitioner testified that she was asymptomatic in her hips and did not require medical treatment to either hip or time off work as a result of any hip condition prior to October 15, 2016. The medical records corroborate Petitioner's testimony in this regard.

October 15, 2016

On October 15, 2016, Petitioner testified that she was wearing a skirt with pump-style dress shoes at work. She was coming from her mailbox at the back of the store carrying papers and traversing through a hallway when she slipped and fell on water left by the maintenance person who recently had mopped the floor. Specifically, she explained that her right foot slipped forward and she felt a pop or tear in her right hip. Petitioner then attempted to regain her balance but her left foot slipped to the left of her. Ultimately, she fell forward landing on her hands and knees. Immediately after the occurrence, Petitioner felt pain in her hips, knees and hands. She also felt embarrassed and noticed her knees, hands and papers, which were wet and strewn about the floor as a result of the fall.

[4] 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.

Despite her pain, Petitioner continued working and she was permitted to sit in the back of the store and conduct customer follow up using a computer. During the ensuing days, Petitioner noticed she was in a lot of pain; she took Ibuprofen and hoped to get better. Petitioner did not seek medical treatment immediately following the accident as she believed she could take care of herself, but her work performance suffered dramatically as her ability to be on the sales floor was limited due to her pain. Petitioner's managers allowed her to sit in the back of the store and work on the computer as needed.

Medical Treatment

Due to the persistence of pain and increasing symptoms in her right hip, Petitioner first sought professional care from Dr. Andreano, a chiropractor, on November 2, 2016. Dr. Andreano's evidence deposition was taken and admitted into evidence at the hearing. RX3. By then, Petitioner explained that her hands and knees were still achy, but improving. She also testified that Dr. Andreano performed bilateral blocking treatment which temporarily improved the hip pain.

Respondent's workers' compensation insurance carrier then referred Petitioner for orthopedic care with Dr. Domb in early in 2017. PX3. Petitioner was first seen at Dr. Domb's office on January 18, 2017. *Id.* At that time, a consistent history of the fall at work was noted. PX3 at 99. The right hip MRI revealed tears of the superior and anterior superior labrum and gluteus minimus with a 1 cm retraction of the distal tendon stump and a partial tear of the gluteus medius. *Id.*, at 155. Dr. Domb initially recommended therapy and injections for the right hip as Petitioner hoped to avoid surgery. *Id.*, at 98.

While undergoing therapy, Petitioner reported pain and weakness in her left hip as well. PX3 at 152. She first reported pain in her left hip during therapy on February 22, 2017. *Id.* Petitioner also experienced swelling in both hips, right greater than left, as a result of therapy. PX3.

On July 5, 2017, Dr. Domb performed surgery to the right hip after conservative treatment had failed. PX3 at 68-71. The surgery included over nine specific procedures including an open repair of the gluteus medius, labral repair and loose body removal. *Id.*

Petitioner noted that the surgery was intended to be arthroscopic, but due to the damage, an open procedure was required which necessitated an incision approximately 12 inches in length. Post-operatively, Petitioner could not walk for eight weeks and explained that she had to learn how to walk again thereafter. She was on crutches and used her left leg to compensate for the right and the left hip was becoming more and more symptomatic including pain and weakness.

The medical records reflect that Petitioner then underwent a course of postoperative physical therapy through October 6, 2017. PX3 at 57-61. She underwent another course of physical therapy from October 17, 2017 through December 7, 2017. PX4.

In December of 2017, Dr. Domb recommended surgery to the left hip. PX3 at 55. Specifically, Dr. Domb opined that Petitioner's left hip symptoms worsened over time due to compensation for the right hip problems. *Id.*, at 50. Petitioner testified that she has not undergone the left hip surgery to date due to lack of workers' compensation insurance authorization.

In early 2018, Petitioner underwent additional physical therapy for both hips from January 19, 2017 through May 16, 2018, and injections to the left hip. PX5, PX3 at 38-44.

Approximately one year post-operatively from the right hip surgery, Petitioner testified that she experienced swelling and fatigue in the right hip. However, she also noted relief within the joint as a result of the surgery such that she could take a step without painful clicking that she previously experienced. At that time, the left hip pain and swelling was increasing. Due to her pain and symptoms, Petitioner explained that her gait was impacted as she could not take a full stride due to the left hip. To accommodate the symptoms, Petitioner testified that she limited standing and walking. Further, she often utilizes a tennis ball under the hip while laying down to help relieve the pressure on the hip.

Section 12 Examination – Dr. Cannestra

On October 3, 2018, Petitioner submitted to a one-time medical evaluation with Dr. Cannestra at Respondent's request. RX1-RX2. Dr. Cannestra took a history from Petitioner, performed a physical examination, reviewed various treatment records, and rendered opinions regarding the relatedness, if any, of Petitioner's bilateral hip condition to her accident at work. RX1.

Dr. Cannestra opined that Petitioner sustained a work-related injury to her right hip limited to a right hip gluteus medius tendon rupture or tear. RX1. He opined that reasonable and necessary treatment for this condition was limited to physical therapy, oral anti-inflamatories, x-rays, MRI scans, surgical repair and bracing. *Id.* He specifically found that the platelet-rich plasma injections are considered experimental and were not reasonable and necessary. *Id.* Additionally, Dr. Cannestra opined that Petitioner suffered from a preexisting degenerative condition called femoral acetabular impingement and labral tear. *Id.* He opined that this condition was not caused by or aggravated by the fall. *Id.* Thus, Dr. Cannestra concluded that the treatment for this condition including the arthroscopic acetabuloplasty, iliopsoas fractional lengthening, femoroplasty, capsular plication, endoscopic trochanteric bursectomy and debridement, and iliotibial band tendon release were not indicated or necessitated by her work-related injury. *Id.*

With respect to the left hip, Dr. Cannestra opined that Petitioner's left hip condition was not caused or aggravated by the fall at work. RX1. He based his opinion, in part, on the fact that Petitioner did not complain of left hip pain for over four months after the accident. *Id.* Dr. Cannestra also opined that there was no evidence of a gluteus medius tendon rupture on the left hip MRI scan. *Id.* Rather he opined that the scan showed only degeneration of the tendon which was a preexisting disorder. *Id.*

At the hearing. Petitioner characterized Dr. Cannestra's examination as "quick" and "rough."

Continued Medical Treatment

Petitioner most recently saw Dr. Domb on December 17, 2018. PX3 at 4. Regarding the left hip, he continued recommending surgery and an updated left hip MRI. *Id.* Petitioner wishes to undergo this care because she hopes to recover and live pain free, but testified that the workers' compensation carrier has not authorized this care. Regarding the right hip, Dr. Domb recommends soft tissue therapy, massage and myofascial release, which Petitioner is undergoing at New Life Holistic. *Id.* As a result of that treatment, Petitioner testified that she notices definite relief and improvement in the texture and "lumpiness" of the right hip. She also noted that although the relief is temporary, she does feel right hip improvement.

Work Restrictions

The medical records reflect that Petitioner was placed off work after her right hip surgery from July 5, 2017 through December 12, 2017. PX3. Petitioner testified that she received temporary total disability benefits regularly during this time. Thereafter, she returned to restricted duty work per Dr. Domb from December 13, 2017 through the present. Petitioner's current restrictions include limited lifting, no prolonged walking or sitting with rest as needed, standing as tolerated and no more than four hours of work per day, three days a week. *Id.*, at 6. These restrictions have increased over time due to swelling and increased symptoms with increased activity.

Petitioner testified that for the temporary partial disability period beginning on December 13, 2017 through the present, Respondent has not paid her temporary partial disability benefits with any regularity. At times, Petitioner explained that such benefits were paid two or more months behind. PX8. Petitioner testified that the irregularity of these payments has caused her financial and emotional hardship, including having to borrow money and necessitating her to rent out her house because she could not keep up with the bills. She was also forced to rent a lower cost attic apartment with no kitchen in which to live herself. Additionally, the lack of financial stability has caused her to end participation in extra-curricular activities as well as modify personal habits like buying at-home hair color products and press-on nails, rather than obtaining professional hair and manicure services as she did prior to her accident.

Petitioner testified that she attempted to address the issue of irregular temporary partial disability payments with her managers, human resources personnel, and Joni Shepard, the workers' compensation insurance claim adjustor. Petitioner expressed concern about making such reports as they might alter the light in which she is viewed by Respondent. In the past, Petitioner explained that she was seen as a "performer" whereas she is now seen as a "complainer." Petitioner expressed distress and worry about her job stability.

Additional Information

Regarding her current condition of ill-being, Petitioner has difficulty sleeping due to the symptoms in her hips. She used hike, which was one of her favorite activities, but she can no longer do so due to too much pain in her hips. Additionally, due to hip pain, she stopped working out with weights twice a week and doing yoga three times a week. As a result of the limited activity, Petitioner has gained 20 pounds since the accident. She restricts her activities after work because she must go to bed to recover from the pain and swelling in her hips that work exacerbated. Petitioner explained that if she sits for a prolonged period, it is painful to then stand and once she rises from a seated position, she must stand still momentarily to allow her hips to loosen up before she can start walking. Petitioner testified that her injuries also prevent her from being able to bend or squat normally, so she has to modify her activities. For example, Petitioner testified that when she retrieves merchandise from below the showcases at work, she now kneels on the floor to access the merchandise rather than bending over or squatting to obtain it. Petitioner explained that kneeling proves to be awkward and embarrassing as customers watch her in this task, and co-workers must step over her legs as she is kneeling.

Petitioner testified that before the October 15, 2016 accident at work, she always exceeded expectations in her job reviews, but she is now falling below expectations—even with a modified goal—due to the limitations resulting from her bilateral hip condition which limits her ability to get to the customers first. She cannot walk fast, and she has to take a break every two hours which removes her from the sales floor reducing her commission prospects further.

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 the hearing 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:

Based on the totality of the evidence, the Arbitrator finds that Petitioner's current condition of ill-being in the bilateral hips is causally related to the accident on October 15, 2016. In so concluding, the Arbitrator finds the opinions of Petitioner's treating physician, Dr. Domb, to be more persuasive than those of Respondent's Section 12 examiner, Dr. Cannestra, in this case.

As an initial matter, the Arbitrator finds Petitioner's testimony at the hearing to be credible. Petitioner's testimony is corroborated by the medical records and other documentary evidence submitted at the hearing. Petitioner was asymptomatic in both hips prior to her fall at work. She had no prior treatment to either hip and lost no time from work due to any degenerative or pre-existing condition in either hip. Petitioner then sustained an undisputed slip-and-fall accident at work traversing a wet floor while engaged in her duties as a sales associate. Petitioner underwent a course of conservative medical treatment with a chiropractor that she regularly saw for treatment unrelated to either hip, but obtained no relief from her initial symptoms.

Petitioner then saw Dr. Domb on referral from Respondent. Dr. Domb evaluated Petitioner for her right hip complaints, which were not alleviated with further conservative treatment resulting in a right hip surgery. Petitioner later complained of left hip pain and symptoms. After evaluation and treatment by Dr. Domb, he concluded that Petitioner's left hip condition was due to compensation for the right hip.

While Petitioner had bilateral hip pain and symptoms immediately after her fall at work, the medical records reflect that Petitioner complained primarily of right hip pain and symptoms. Indeed, Dr. Domb and Petitioner's physical therapists focused on the right hip condition throughout her initial course of medical treatment. Dr. Cannestra, Respondent's Section 12 examiner, maintains that the lack of notation relating to left hip complaints for several months in the medical records supports his conclusion that Petitioner's left hip complaints were wholly unrelated to the fall at work. Dr. Cannestra also opined that Petitioner's right hip condition, with immediate complaints of pain and symptoms, is also unrelated to her accident at work. Rather, he contends that Petitioner's right and left hip conditions are wholly unrelated to the accident at work and are due to either pre-existing conditions or non-occupational sources. It is notable that Petitioner was asymptomatic in both hips prior to her accident at work. Moreover, Dr. Cannestra's credentials, while impressive, are also not as extensive as those of Dr. Domb who had the benefit of evaluating Petitioner throughout many months of medical treatment compared to Dr. Cannestra who only had the opportunity to see her once. Respondent offered the deposition testimony of Dr. Andreano, Petitioner's chiropractor, into evidence and his records were reviewed by Dr. Cannestra. While Dr. Cannestra would have expected Petitioner to report immediate left hip complaints after her accident, and he disagrees with Dr. Domb that Petitioner's possible left hip tear as noted in her MRI was aggravated by the accident at work or its *sequelae*, he fails to address how a previously asymptomatic 49-year-old patient who is expected to have degeneration throughout the body would only begin to experience left hip pain and symptoms after an altered gait over many months following a slip and fall injury at work in which her right lower extremity slipped forward resulting in a pop or tear in the right hip prompting medical treatment. Dr. Domb's opinions are consistent with Petitioner's credible testimony and treatment records.

Based on the totality of the record, the Arbitrator finds the opinions of Dr. Domb in this case to be persuasive and reflective of a more informed view of the cause of Petitioner's right and left hip conditions after the October 15, 2016 accident—namely, a traumatic injury to an asymptomatic right hip causing overcompensation by the left hip resulting in an onset of pain and symptoms due to the aggravation of a pre-existing, but asymptomatic, left hip condition. Thus, the Arbitrator finds that Petitioner's present conditions of ill-being in her right and left hips are casually related to her October 15, 2016 accident at work.

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

Petitioner claims entitlement to payment of reasonable and necessary medical bills from medical providers that administered care after her accident at work. As explained above, the Arbitrator finds that Petitioner has established a causal connection between her current bilateral hip condition of ill-being and accident at work. Given the consistency between all treating medical records, the persuasiveness of Dr. Domb's opinions, the lack of credible medical evidence to the contrary, and Petitioner's credible testimony, the Arbitrator finds that all of the medical care rendered to Petitioner after October 15, 2016 to address the bilateral hips is reflective of reasonable and necessary medical treatment to diagnose and treat Petitioner because of the effects of the accident at work.

Thus, Respondent shall pay the following reasonable and necessary medical services as reflected in Petitioner's Exhibits for medical bills that remain unpaid reduced pursuant to the medical fee schedule as provided in Sections 8(a) and 8.2 of the Act. The records reflect unpaid bills from Hinsdale Orthopaedic Services and Petitioner's fee schedule calculation of $90,141.09. PX7; PX11. Respondent shall be given a credit of for any medical benefits that have been paid, if any, as agreed 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 relating to Issue (K), Petitioner's entitlement to prospective medical care, the Arbitrator finds the following:

As explained above, the Arbitrator finds that Petitioner has established a causal connection between her current bilateral hip condition of ill-being and accident at work. Based on the totality of the record, the Arbitrator finds that the recommended right and left hip treatment by Dr. Domb is necessary to alleviate Petitioner from the effects of her injury at work. Dr. Domb has recommended physical therapy including massage and myofascial release for the right hip as well as an updated left hip MRI arthrogram and left hip surgery to include a labral repair vs. reconstruction, acetabuloplasty, femoroplasty, endoscopic versus open gluteus medius repair, with possible microfracture and iliopsoas fractional lengthening.

In support of the Arbitrator's decision relating to Issue (M), whether penalties or fees should be imposed upon Respondent, the Arbitrator finds the following:

The Arbitrator finds that additional compensation is due to Petitioner and shall be imposed upon the Respondent pursuant to Sections 19(l), 19(k) and 16 of the Act. In so concluding, Section 19(k) of the Act provides in pertinent part:

> In case where there has been any unreasonable or vexatious delay of payment 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 the Act equal to 50% of the amount payable at the time of such award. Failure to pay compensation in accordance with the provisions of Section 8, paragraph (b) of this Act, shall be considered unreasonable delay. 820 ILCS 305/19(k) (Lexis 2010).

Section 19(l) provides in pertinent part:

> If the employee has made written demand for payment of benefits under Section 8(a) or Section 8(b), the employer shall have 14 days after receipt of the demand to set forth in writing the reason for the delay. In the case of demand for payment of medical benefits under Section 8(a), the time for the employer to respond shall not commence until the expiration of the allotted 30 days specified under Section 8.2(d). In case the employer or his or her insurance carrier shall without good and just cause fail, neglect, refuse, or unreasonably delay the payment of benefits under Section 8(a) or Section 8(b), the Arbitrator or the Commission shall allow to the employee additional compensation in the sum of $30 per day for each day that the benefits under Section 8(a) or Section 8(b) have been so withheld or refused, not to exceed $10,000. A delay in payment of 14 days or more shall create a rebuttable presumption of unreasonable delay. 820 ILCS 305/19(l) (Lexis 2010).

Also, Section 16 of the Act provides for an award of attorney fees where an employer, its agent, or insurance carrier "has been guilty of delay or unfairness towards an employee in the adjustment, settlement or payment of benefits due such employee… 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." 820 ILCS 305/16 (Lexis 2010).

The employer has the burden to show that any delay in paying benefits is reasonable. *Electro-Motive Division v. Industrial Comm.*, 250 Ill. App. 3d 432, 436, 621 N.E.2d 145 (1993); *Cook County v. Industrial Comm.*, 160 Ill. App. 3d 825, 830, 513 N.E.2d 870 (1987). It is insufficient for an employer to merely assert its belief that "the employee's claim is invalid or that his award is not supported by the evidence; the employer's belief is 'honest' only if the facts which a reasonable person in the employer's position would have would justify it." *Cook County*, 160 Ill. App. 3d at 830 (*citation omitted*).

In this case, no reasonable basis is evident from the record on which Respondent could consistently delay payment of Petitioner's outstanding temporary partial disability benefits without explanation as it did. Petitioner's Exhibit 8 reflects that Respondent's workers' compensation insurer initially paid TPD benefits to Petitioner weekly. These nine weekly TPD checks encompassed December 14, 2017 through February 10, 2018. PX8 at 1-9. Thereafter, despite Petitioner's counsel's demands for payment of further TPD payments, payments became sporadic including the next check issued since February 10, 2018 not being issued until after June 30, 2018. PX10 at 7-22. The following check encompassed most of July and the check thereafter, covering July 28, 2018 through August 28, 2018, was not issued until October 5, 2018. *Id.*, at 11-12. The next check covering August 29, 2018 through October 6, 2018 was not issued until October 30, 2018. *Id.*, at 13. Lastly, Allianz did not issue the check covering the period of October 7, 2018 through November 17, 2018 until

December 5, 2018. *Id.*, at 14. Moreover, no evidence was submitted that Respondent paid Petitioner any temporary partial disability benefits for any period after November 17, 2018.

Petitioner's counsel included correspondence dated March 19, 2018 and March 30, 2018 requesting a possible explanation for some delay, namely questioning whether Respondent maintained a dispute regarding Petitioner's entitlement to temporary partial disability benefits on some basis. Respondent did not offer any evidence of a response and no additional explanation was offered regarding Petitioner's regular pay. Moreover, Respondent provided no evidence that it complied with Commission rule 9110.70 requiring written explanation for denial of medical care or payment of temporary benefits. While Respondent ultimately paid further benefits and stipulated to Petitioner's entitlement to the same, no reasonable basis for the delay was offered. *See* AX1. An assertion at the time of the hearing that Petitioner's temporary partial disability payments were difficult to calculate given the nature of her compensation fails to cure Respondent's lack of explanation during the temporary partial disability payment period and failure to provide a reasonable, or any, explanation for its delays then.

Based on the foregoing, and in the absence of evidence to the contrary, the Arbitrator finds Respondent's delay in tendering temporary partial disability benefit payments from February 11, 2018 through the present amounts to an unreasonable and vexatious delay in the payment of these benefits to which Respondent has stipulated Petitioner's entitlement. The Arbitrator notes the temporary partial disability benefits due Petitioner, $24,910.51, less payments made for periods prior to February 11, 2018 ($3,310.70 *see* PX8 at 1-9), totals $21,599.81 in temporary partial disability benefits due to Petitioner for which the delay in said payments has been unreasonable and vexatious.

Petitioner asserts that Respondent is liable for penalties and attorney's fees related to the delay in authorization of medical treatment, which is not indicated. *Hollywood Casino-Aurora, Inc. v. Illinois Workers' Compensation Comm'n*, 2012 IL App (2d) 110426WC, 967 N.E.2d 848 (2nd Dist. 2012). However, Petitioner also contends that Respondent is liable for penalties and fees related to the delay in payment of authorized medical treatment related to the right hip and failure to pay bills related to the left hip. As with Petitioner's temporary partial disability benefit payments, Respondent offered no evidence regarding its reasoning for its failure to pay Petitioner's medical bills despite inquiries by Petitioner's counsel regarding the same.

Dr. Domb offered an opinion causally relating Petitioner's left hip condition to her accident at work or its *sequelae* as early as June 8, 2017. PX3 at 72. Petitioner initially made a demand for authorization of left hip surgery in Dr. Domb's December 11, 2017 office note and at every office visit thereafter. PX6 at 8; PX3 at 6, 12, 16, 21, 26, 31, 36, 44, 48. Petitioner's counsel made further demand on May 1, 2018. PX6 at 15-22. Respondent offered no response or basis on which to deny treatment or pay Petitioner's medical bills related to either hip stemming from the undisputed accident at work. Respondent inexplicably delayed until October 3, 2018 when it first sent Petitioner to a Section 12 examination with Dr. Cannestra. Moreover, many of the charges presently outstanding are for services including surgery to the right hip which Respondent authorized. Petitioner's counsel has demanded that Respondent satisfy said charges to no avail. PX10 at 61-75. Respondent's unexplained decision to wait almost fourteen months to obtain a Section 12 examination to address causation to either the right or left hip and failure to respond to Petitioner's demand for payment of medical bills for treatment of an accepted injury constitutes unreasonable and vexatious delay.

Based on the totality of the record, the Arbitrator awards penalties and fees as follows:

- Section 19(l) – $10,000 - $30 per day from February 11, 2018 through January 11, 2019, the date of hearing, totaling 334 days or $10,020.00 subject to the maximum of $10,000.00 for the delay in payment of TPD benefits;
- Section 19(k) - $10,799.91 representing 50% of the TPD benefits for which there was/is an unreasonable/vexatious delay in payment thereof ($21,599.81 x 50%= $10,799.91);
- Section 19(k) - $45,070.55 representing 50% of the outstanding medical pursuant to the Fee Schedule for which there has been an unreasonable, vexatious delay in the payment of same $90,141.09 x 50% = $45,070.55); and
- Section 16 - $11,174.09 representing 20% of the Section 19k penalties ($10,799.91 + $45,070.55 = $55,870.46 x 20% = $11,174.09).

STATE OF ILLINOIS)
) SS.
COUNTY OF)
JEFFERSON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jamie Deadmond,

Petitioner,

vs. NO: 16 WC 31956

State of Illinois/Murray Developmental Center,

20IWCC0027

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of causation, medical expenses, temporary total disability, and prospective medical treatment, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for 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).

The Commission corrects a scrivener error in the Arbitrator's decision at p.4, first full paragraph, third sentence, to show that Petitioner's low back surgery was performed "by" (not "on") Dr. Kovalsky.

All else otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision dated 1/22/19 is affirmed and adopted with changes as stated herein.

50 LECCIONES

20IWCC0027

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $614.29 per week for a period of 6-4/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner reasonable and necessary medical expenses in the amount of $4,413.81, pursuant to §8(a) and §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall authorize and pay for the treatment prescribed by Dr. Gornet, including surgery in the form of anterior cervical disc replacement at C3-4, pursuant to §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 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: JAN 16 2020
o:12/3/19
TJT/pmo
51

Thomas J. Tyrrell

Maria E. Portela

Kathryn A. Doerries

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

DEADMOND, JAMIE
Employee/Petitioner

Case# **16WC031956**

SOI/MURRAY DEVELOPMENTAL CENTER
Employer/Respondent

20IWCC0027

On 1/22/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.46% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1459 LEVENHAGEN LAW FIRM PC
T FRITZ LEVENHAGEN
216 W POINTE DR SUITE B
SWANSEA, IL 62226

0558 ASSISTANT ATTORNEY GENERAL
NATALIE N SHASTEEN
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CARBONDALE, IL 62901

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

1745 DEPT OF HUMAN SERVICES
BUREAU OF RISK MANAGEMENT
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

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

JAN 22 2019

Brendan O'Rourke, Assistant Secretary
Illinois Workers' Compensation Commission

20 I W C C 0 0 2 7

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)

Jamie Deadmond ,
Employee/Petitioner

v.

State of Illinois/Murray Developmental Center ,
Employer/Respondent

Case # 16 WC 31956

Consolidated cases: N/A

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Mt. Vernon**, on **December 5, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ 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, **September 8, 2016,** Respondent *was* operating under and subject 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.

Per stipulation of the parties, in the year preceding the injury, Petitioner earned **$47,914.30**; the average weekly wage was **$921.43**.

On the date of accident, Petitioner was **38** years of age, ***single*** with 3 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 **$614.29**/week for **6-4/7** weeks, commencing **12/28/2017** through **02/11/2018**, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services of $4,413.81, as set forth in Petitioner's Exhibit 1, as provided in Sections 8(a) and 8.2 of the Act.

Pursuant to the agreement of the parties, all medical bills awarded shall be paid directly to the medical providers. Respondent shall be given a credit 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 shall also authorize and pay for prospective medical treatment as recommended by Dr. Gornet including, but not limited to, the recommended anterior cervical disc replacement at C3-4, 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.

Edward Lee
Signature of Arbitrator

1/21/19
Date

ICArbDec19(b)

JAN 22 2019

STATE OF ILLINOIS)
) SS
COUNTY OF JEFFERSON)

20 I W C C 0 0 2 7

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

JAMIE DEADMOND,
Employee/Petitioner

v.

Case # 16 WC 31956

STATE OF ILLINOIS /
MURRAY DEVELOPMENTAL CENTER,
Employer/Respondent

Consolidated cases: N/A

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner, a 40-year-old Mental Health Tech II, testified that she has been continuously employed with the State of Illinois/Murray Developmental Center since January 6, 2003. Her job duties required that she provide care for mentally and physically disabled individuals including feeding, bathing, clothing, showering, and transferring. Petitioner testified that she was physically capable of performing all of her job duties as a Mental Health Tech II leading up to her injury of September 8, 2016. Petitioner testified that on September 8, 2016, she put herself between two individuals and one of them were in a wheelchair. She put her arm on the back of his wheelchair and he swung around and hyperextended her left arm backwards. Her left shoulder popped, and she felt an immediate onset of pain. She notified her employer regarding the incident that same day and completed an Employee's Notice of Injury.

That same day, Petitioner was seen at St. Mary's Convenient Care in Centralia, Illinois where x-rays were performed on her left shoulder and restrictions were imposed on her job duties. Petitioner continued to follow-up at St. Mary's Convenient Care and underwent an MR arthrogram of her left shoulder. Michelle Hartke at St. Mary's Convenient Care referred Petitioner to Mark Miller, M.D., a shoulder surgeon in St. Louis. On November 21, 2016, Dr. Miller saw the Petitioner and prescribed physical therapy. He also recommended the injection of her left shoulder joint. Petitioner underwent physical therapy at St. Mary's Hospital in Centralia at Dr. Miller's request. On January 17, 2017, Dr. Miller performed a left shoulder surgery at the Orthopedic Ambulatory Surgery Center in Chesterfield, Missouri. Petitioner continued to follow-up with Dr. Miller following her surgery and on May 4, 2017, Dr. Miller referred her to Dr. Gornet, a spine surgeon. On May 4, 2017, Petitioner saw Dr. Gornet who ordered an MRI scan of Petitioner's neck. Dr. Gornet referred Petitioner to Dr. Boutwell for injections in her neck. Petitioner testified that the injections did not provide any long term relief, but she had a very short amount of relief immediately thereafter. Petitioner continued to follow-up with Dr. Miller concerning her shoulder while continuing to treat with Dr. Gornet for her neck pain. Dr. Gornet recommended that Petitioner undergo a cervical disc replacement at C3-4. Thereafter, on December 5, 2017, Petitioner saw David Robson, M.D. for a Section 12 examination. Petitioner testified that she only saw Dr. Robson for a few minutes. Dr. Robson asked Petitioner about the injections and Petitioner indicated that she couldn't tell if there was any relief because her shoulder was still aching from her previous surgery and her

neck pain overlapped with her shoulder pain. Petitioner testified that by the time she got through traffic and a 2-hour drive home, she had a headache following the injections and laid down. Petitioner testified that she has not underwent the cervical disc replacement at C3-4 because it has not been authorized by the workers' compensation carrier. Petitioner testified that she is requesting that an order be issued requiring the Respondent to authorize and pay for the surgery recommended for her by Dr. Gornet. Petitioner testified that she wants to have the neck surgery because she has pain every day and it is difficult for her to do her job and daily activities at home because of her neck pain. At work, her neck pain causes her problems when showering individuals and helping them with grooming and bathing. Petitioner testified that she has a hard time sleeping because of her neck pain causing her to sometimes sleep in a recliner. She testified that her neck pain increases whenever she has to drive any type of long distance because of the turning of her head. Petitioner testified that the check stubs admitted into evidence reflected her earnings for the State of Illinois from August 21, 2015 through September 15, 2016. Petitioner testified that she was performing her full job duties as a Mental Health Tech II for the entire year preceding her injury of September 8, 2016. When Petitioner saw Dr. Robson on December 5, 2017 she was off from work receiving TTD. Petitioner testified that prior to December 26, 2017, she was paid temporary total disability benefits. After Petitioner saw Dr. Robson on December 5, 2017, she was notified that her workers' comp benefits were terminated on December 26, 2017. On December 28, 2017 Petitioner saw Kendra Bowen who kept Petitioner off from work until she saw Dr. Gornet. After that, Dr. Gornet kept the Petitioner off from work from January 5, 2018 until February 11, 2018 when Petitioner requested that Dr. Gornet release her to return on a full duty basis. Petitioner testified that she asked Dr. Gornet to return her to work on a full duty basis because of financial reasons - she is a single mother of three and had no income. Financially she needed to go back to work. Petitioner is requesting temporary total disability from December 28, 2017 until February 11, 2018. Petitioner testified that the medical bills marked as Petitioner's Exhibit 1 were incurred by her for the treatment of her shoulder and neck. Petitioner testified that she had no injuries to her neck or left shoulder either before or after September 8, 2016. Petitioner did have one other worker's compensation claim for an injury to her right shoulder, but that case was settled.

On cross-examination, Petitioner testified that she was currently experiencing neck pain that travels across her left shoulder and down to her left elbow. She is currently working full duty since November 23, 2018 after being off following a low back surgery which was not work-related. Her low back surgery was performed on Dr. Kovalsky and Petitioner testified that she was still treating with Dr. Kovalsky for her nonwork-related low back surgery. Petitioner testified that in 2006, one of the discs in her low back was fractured and, after years of conservative treatment, she decided to have low back surgery since her oldest daughter had just turned 18 and she needed a legal driver and someone to watch the siblings because the Petitioner would be in the hospital for 3 days. Petitioner testified that she sustained the herniated disc in her low back due to an injury in 2006 that was neither work-related nor due to a car accident. She testified that she has been treating for her lumbar spine condition since 2006 and Dr. Kovalsky was her original doctor. When asked if the Petitioner informed Dr. Robson concerning her low back condition, Petitioner indicated she thought she had written that down in the paperwork. Petitioner does not currently have any restrictions for her low back condition. She is not currently treating for her left shoulder. With regard to her cervical spine condition, Petitioner testified that her last appointment was in March 2018 and she is still waiting for the cervical spine surgery to be performed. She is still working without any restrictions currently and is not undergoing any physical therapy. She is taking over-the-counter medications and some medications as prescribed for her lower back surgery in the form of Flexeril and Percocet. She does not wear any type of protective device. With regard to her current job performance, Petitioner indicated that her employer has been aware of her injury to her neck and it was documented. When asked if she has informed her supervisor of any of the difficulties, she is having performing her job tasks currently, Petitioner indicated that they are aware of it. Petitioner testified that the medical records admitted into evidence accurately reflect her symptoms at the time of her treatment and that she was honest with her healthcare providers concerning the symptoms she was having at the time of

treatment. After the incident on September 8, 2016, Petitioner was seen at the Convenient Care Clinic in Centralia and had pain in her shoulder and heard popping. Petitioner testified that the day of her injury, her shoulder hurt so bad that she didn't recall her neck itself hurting, but it was hurting all the way up at least into the side and all of the way across the top down into her arm. When asked if she noticed any pain down her arm, at the time or any neck pain, Petitioner testified that she was in so much pain she doesn't remember exactly. However, the healthcare providers asked her where her main pain source was, and she indicated her shoulder was where her predominant pain was located. She had an MR arthrogram of her left shoulder and followed up with Dr. Miller through January 2017 when he performed surgery. When asked if she had complaints of pain in her cervical area or radicular symptoms down her arm with burning up until that point, Petitioner indicated that in October 2016 she called her doctor at Michelle Hartke's office and reported it. She indicated she did not believe they wrote it down; however, there was a prescription called in on one of the phone calls. In her physical therapy sessions, she indicated that her complaints were limited to her left shoulder injury and decreased range of motion in her left shoulder she would not dispute that fact. After undergoing surgery on January 17, 2017, Petitioner had an initial follow-up on January 31, 2017 and the records did not mention any neck pain. When asked if she would dispute that fact, Petitioner indicated that she was on quite of bit of pain medication because of the surgery but did notify her case manager and also telephoned Dr. Miller's office and was informed that they would follow-up on it at her next appointment. When she returned to Dr. Miller, he noted burning neck pain which traveled down into her left arm. At that time, Petitioner was referred to Dr. Gornet and was seen the same day. When asked if Dr. Gornet was aware of her lumbar spine condition, Petitioner indicated that he knew because she had seen him for a second opinion in 2009 concerning her lumbar spine. When asked if Dr. Gornet was aware of her lumbar spine operation with Dr. Kovalsky, Petitioner indicated that she has not seen Dr. Gornet since she had the lumbar spine surgery performed. Petitioner testified that she was not aware of any MRI's or image testing of her cervical spine prior to her injury date of September 8, 2016. Petitioner testified that she probably spent less than 5 minutes with Dr. Robson, but she had seen his assistant first. She indicated that the assistant performed the physical examination. Petitioner testified she had restrictions from December 27, 2017 through February 2018 at which time she asked Dr. Gornet to release her to full duty work. She did apply for non-occupational disability benefits at that time, in February 2018. She did receive one check for non-occupational disability but did not receive it until June 2018. This money was taken from her State Retirement System Benefits as non-occupational disability which she believes comes out of her retirement.

The medical bills exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibit 1.

The transcript of the deposition of Matthew F. Gornet, M.D. was entered into evidence at the time of arbitration as Petitioner's Exhibit 2. Dr. Gornet testified that he is an orthopedic surgeon whose practice is devoted to spine surgery.

Dr. Gornet testified that the first time he saw the Petitioner following her injury of September 8, 2016 was on May 4, 2017. Dr. Gornet testified that Petitioner was referred to him by his partner, Mark Miller, M.D. Her main complaint was left trapezial and left shoulder pain, but the pain also radiated at times down her left arm into her forearm and hand with numbness and tingling. Petitioner told him that she did have a component of neck pain, but her trapezial and shoulder pain were the greatest issue for her. She felt that her problem began on or about September 8, 2016 while she was working at Murray Center and involved in an altercation. Her arm was essentially pulled and then pushed backwards. She saw Dr. Miller who diagnosed her as having a frozen shoulder and labral tear. She told Dr. Gornet that after Dr. Miller performed left shoulder surgery, a portion of her symptoms improved, but she still had symptoms in her trapezius, shoulder, forearm, and hand as well as her neck and those had not completely resolved. Petitioner told Dr. Gornet that she did not recall any previous problems of significance with her neck or shoulder. When she first saw Dr. Gornet, she was

working light duty with a 20-pound limit and no overhead work. Dr. Gornet conducted a physical examination which revealed objective findings of some mild decrease in her biceps on the left at 4 over 5. Her sensation was normal. He ordered an MRI scan on that day which showed a disc herniation at C3-4. He noted that it was bilateral but in foraminal view on the left side and that correlated with her trapezial and shoulder pain. He first recommended an injection at C3-4 for her trapezial and shoulder pain and recommended a second injection at C5-6 which fit more with her symptoms down into her forearm and hand. He discussed an overlap between her shoulder and cervical spine condition with her and told her this is a common occurrence that you can have pathology in your neck that causes shoulder pain and you can have pathology in your shoulder which causes neck pain. It is not unusual to have this overlapping symptom. He noted that it was Dr. Miller who picked up on the fact that she may have another origin of her pain which prompted his evaluation with plain x-rays as well as the ordering of an MRI and sending her to see Dr. Gornet. Attached to Dr. Gornet's deposition were his treatment notes from May 4, 2017 through March 12, 2018. Also attached to Dr. Gornet's deposition was an image from Petitioner's MRI scan which Dr. Gornet alluded to in his note of May 4, 2017. On that image, Dr. Gornet identified the C3-4 level which he described as showing disc material coming out into the neural foramen. He testified that this foraminal herniation correlates with the Petitioner's trapezial and shoulder pain. Dr. Gornet discussed conservative care initially and recommended the injections that were performed by Dr. Boutwell initially on May 18, 2017 at C3-4 and on June 7, 2017 at C5-6. Dr. Gornet testified that those injections did not give her any long term or permanent sustained relief. Thereafter, Dr. Gornet recommended cervical disc replacement as her best option to cure and relieve the effects of her work injury. Dr. Gornet discussed the risks and benefits with the Petitioner. Dr. Gornet opined that Petitioner's shoulder and trapezius symptoms were the result of her work injury that occurred on September 8, 2016. Petitioner tried and failed conservative measures. Although the Petitioner was working full duty when he last saw her on March 12, 2018, her symptoms were affecting her quality of life. At the time of her last visit, she was having shoulder discomfort and some of this discomfort may be related to her neck and some may be in her shoulder. For the most part, Dr. Gornet believes that her neck is playing a role in her current shoulder complaints. Dr. Gornet testified that Petitioner's cervical disc herniation at C3-4 is causally related to the injury that she described to him as occurring on September 8, 2016. Dr. Gornet testified that he has had success in alleviating patients' symptoms by performing anterior cervical disc replacement for this type of condition. He testified that the treatments he recommended and provided for the Petitioner were reasonable and necessary in an attempt to cure or relieve the symptoms she experienced from the conditions he diagnosed. He further testified that the limitations and restrictions that he imposed upon her as reflected in his medical records were reasonable and necessary in his effort to alleviate her symptoms from the conditions he diagnosed.

Dr. Gornet testified that he believes that cervical spine surgery would reduce Petitioner's symptoms because she has objective pathology in her cervical spine which correlates with her subjective complaints. Dr. Gornet testified that even her shoulder surgeon who evaluated her for her shoulder does not believe her symptoms are coming from her shoulder anymore. Dr. Gornet testified that Petitioner's complaints are consistent with the condition he diagnosed in her cervical spine. He testified that the charges for the treatments he recommended and provided for her were reasonable, necessary and related to the injury she sustained to her cervical spine on September 8, 2016.

On cross-examination Dr. Gornet testified he treated the Petitioner previously for her low back. He treated her low back conservatively and told her that although she may have a problem with her low back, given her young age he told her, her best option was to try to live with the pain and he recommended against narcotics. His last visit with her for her low back was October 15, 2009. With regard to her low back condition, in reviewing his notes from 2009, he found no complaints of neck pain and no cervical complaints on her pain diagram. When questioned about the mechanism of Petitioner's injury of September 8, 2016, Dr. Gornet indicated that she was involved in an altercation and her arm was essentially pulled with a force being applied

to her arm which affected her left shoulder and cervical spine. He indicated that is why there is often an overlap because you get a shoulder injury and a neck injury with the same mechanism of action. When asked about Dr. Miller's records, Dr. Gornet found the first reference to neck pain occurring on March 1, 2017 after her shoulder surgery on January 17, 2017, where Dr. Miller noted increasing pain after her shoulder surgery. In addition to her shoulder pain, Dr. Miller noted pain down her arm and into her fingers as well as neck pain, arm pain, periscapular pain, and chest pain. In further review of Dr. Miller's notes, Dr. Gornet stated on December 15, 2016, Dr. Miller did not mention anything in her neck or arm at all. However, he did describe scapular pain. Dr. Gornet testified that a C3-4 disc herniation can cause scapular pain and it can also cause shoulder pain. He testified that this is why there is an overlap - they can refer back and forth.

The medical records of SSM Health Medical Group were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The records reflect that Petitioner was seen on September 8, 2016 with complaints of left shoulder pain. Petitioner provided a history of trying to stop two clients from having an altercation and as she was pulling the wheelchair of one away, the client turned the wheelchair she was holding onto, twisting her left arm backwards and there was an audible pop. X-rays of her left shoulder were taken and Flexeril was prescribed. Restrictions of no use of her left arm were imposed. The Petitioner returned on September 13, 2016 with complaints of left shoulder pain due to a work injury that occurred on September 8, 2016. Petitioner indicated that she had her arm on one of the resident's wheelchairs and they moved it, causing her arm to hyperflex. Petitioner had limited range of motion secondary to pain. Petitioner was to continue on one-handed duty and return in one week. Petitioner was seen again on September 20, 2016. Petitioner indicated her pain was getting worse. Due to the mechanism of injury and worsening of symptoms, an MR arthrogram of the left shoulder was ordered. Petitioner was to continue on one-handed duty. On October 7, 2016, a note was made concerning the Petitioner contacting the office requesting pain medications. On November 11, 2016, the MR arthrogram was reviewed, and a labral tear was found. Petitioner was referred to Dr. Mark Miller in St. Louis.

The records of Kendra Bowen, PA-C were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. The records reveal that on October 3, 2017, Petitioner was seen for pre-op clearance for a cervical disc replacement with Dr. Matthew Gornet with the surgery date to be determined based upon the pre-op workup. Petitioner was having neck pain and was seen for a pre-op general, physical examination and a comprehensive metabolic panel with urinalysis was ordered. Petitioner was instructed to hold Mobic for one week prior to surgery.

Petitioner returned on December 28, 2017 reporting continued neck and shoulder problems. The record indicates that Petitioner was cleared for neck surgery, but states at the last-minute work comp denied the surgery and sent her to another provider for a second opinion. Thereafter, she received a letter from work indicating that she was released to full duty. Petitioner complained of neck and shoulder pain and indicated that she was out of her Mobic and Flexeril and was in more pain without her medications. An off work slip was issued for neck pain indicating Petitioner was to remain off from work from December 28, 2017 until January 5, 2018. Her medications were refilled and was she instructed to follow-up with her orthopedic spine surgeon.

The medical records from St. Mary's Hospital of Centralia were entered into evidence at the time of arbitration as Petitioner's Exhibit 5. The records reflect that on November 23, 2016, Petitioner saw David Toennies, PT with a chief complaint of left shoulder pain and decreased motion. Petitioner provided a history of being seen at PT today due to a left frozen shoulder and labral tear with sudden onset. The patient reported an onset of left shoulder symptoms on September 8, 2016 when she was assisting residents in a confrontation at work with her arm getting pulled back. Petitioner reported receiving an injection into her left shoulder on November 21, 2016 with plans to return to Dr. Miller on December 15, 2016. According to the physical therapy

notes on December 13, 2016, the Petitioner had been seen for six physical therapy sessions since the initiation of physical therapy on November 23, 2016. The therapist noted that her treatment sessions included range of motion, light strengthening, cold pack, and patient education/home instruction. The Petitioner reported that her motion in her left shoulder had improved, but her shoulder pain has been staying the same. At that time, she rated her left shoulder pain at a 5-6/10. She reported an increase in shoulder pain when using her left arm. The therapist noted that the Petitioner showed progress toward her physical therapy goals regarding improving her left shoulder motion, but she had not progressed toward her goals regarding her pain level and regarding reports of increased pain in her shoulder with resistance muscle testing. The therapist noted that the patient was scheduled to return to see Dr. Miller on December 15, 2016. On December 20, 2016, a new order for physical therapy was received indicating that the patient was to continue physical therapy and that she was waiting for surgery on her left shoulder to be approved. On December 30, 2016, the Petitioner indicated that she continued to have difficulty sleeping at night and stated that with the therapy and her own home exercise program, her range of motion had improved. However, she continued to have a crepitation and increased pain with use of her left upper extremity. She indicated that she was still waiting for workers' compensation surgical approval.

On January 19, 2017, the patient reported undergoing left shoulder arthroscopic labral repair surgery on January 17, 2017. She came to physical therapy with her left shoulder immobilized in a sling. The patient reported tenderness with palpation into her left anterior/lateral/posterior shoulder. The Petitioner was to resume physical therapy two times a week for a period of six weeks. On February 27, 2017, the physical therapy progress report noted that the Petitioner had been seen for 12 physical therapy visits since her left shoulder surgery on January 17, 2017. The Petitioner reported movement and range of motion of her left shoulder increases her shoulder pain. She reported that she relied on pain medication to control/decrease her left shoulder and neck pain. The Petitioner rated her neck and left shoulder pain at a 5/10 when she is medicated and an 8-9/10 when her medication wears off. The Petitioner rated her left shoulder/neck pain at 7/10 when performing passive/active assisted left shoulder exercises with medication. The Petitioner also reported she occasionally gets numbness down her left arm. The physical therapist noted that the Petitioner had not progressed toward her PT goals as well as expected indicating that it has been difficult to progress the patient's exercises, per her protocol, because of her reports of neck/shoulder pain. The physical therapist noted that the patient was to return to see Dr. Miller on March 1, 2017.

On April 5, 2017, the physical therapy progress notes indicated that the Petitioner had been seen for 14 physical therapy sessions since her previous progress report on February 27, 2017. Her treatment sessions included range of motion, stabilization, strengthening, and patient education/home instruction. The patient reported that she noticed improvement in her left shoulder motion but still feels limitation is present. She reported that she is able to use her left arm better when doing tasks with her arm down by her side. She reported continuing to be challenged with using her left arm above shoulder height, for such activities as reaching into cupboards. The patient reported that she continues to get shooting pain into her left arm, but not as much numbness. She rated her neck pain at a 4-5/10 and her left shoulder pain at a 2-3/10. The physical therapist noted that the patient showed improvement with her active left shoulder motion and in her left shoulder strength. She continued to have decreased end range of motion in her left shoulder. The therapist noted that improving the function use of the patient's left shoulder and improving pain control of the patient's symptoms continue to be a challenge. The patient was scheduled to return to see Dr. Miller on April 6, 2017 and a further course of physical therapy would be decided following the patient's return visit with Dr. Miller.

On April 20, 2017, the physical therapy progress note indicated that an order was received to continue physical therapy for the patient's left shoulder and to add intervention for diagnosis of cervical degenerative disc disease. The patient rated her pain at a 2-3/10 and reported that her neck pain goes up to a 4-5/10 with

movement of her left shoulder and with certain movements of her neck. She reported that her work duties (light duty) which require her to use her arms at shoulder height, increase her neck pain and increase her sharp pain/sleeping pain/numbness into her left arm. The patient was to continue physical therapy for her left shoulder and add intervention for her neck.

On June 12, 2017, the physical therapy progress note indicated that the Petitioner had a chief complaint of pain in her left shoulder from her neck to her elbow. The patient reported that she is currently being treated for neck pain and receiving injections in her neck. The patient complained of pain which is positional in nature. She reported functional deficits with bathing, grooming and upper extremity dressing. Her pain location was in her left shoulder from her neck to her elbow with a current pain level of a 3 and the worse pain in the last seven days as a 5. The patient described the physical demands of her job as a Mental Health Technician at Murray Center involving assisting clients with getting dressed/bathing/etc. It was noted that the patient does work with residents with behavior issues and the patient was currently working on light duty and had been on light duty since the onset of her symptoms in September 2016. According to the treatment plan, the patient was to be seen three times a week for four weeks. On August 3, 2017, a physical therapy discharge summary was prepared indicating that the patient had been seen for 58 physical therapy visits from January 19, 2017 to August 1, 2017. The patient noted a significant improvement in her symptoms with physical therapy. However, overhead lifting was discontinued due to increased neck pain and it was noted that the patient had some persistent pain in the left shoulder radiating into the clavicle. The pain ratings were between a 3-4. The patient was discharged from physical therapy and a home exercise program was given to the patient.

The medical records of Mark Miller, M.D. were entered into evidence at the time of arbitration as Petitioner's Exhibit 6. The Petitioner initially saw Dr. Miller on November 21, 2016 and provided a history of being injured two and a half months ago on September 8, 2016. She told Dr. Miller that she was trying to keep two guys from fighting. One gentleman was in a wheelchair and as she tried to separate the individuals, one of the gentlemen "got my arm and flung it." She demonstrated an abduction external rotation movement. She felt her shoulder pop. Dr. Miller noted that her pain was primarily anterior, and that abduction was painful. Petitioner denied any prior problems with her left shoulder. Dr. Miller conducted a physical examination and reviewed the MRI arthrogram that was performed at SSM Health Good Samaritan in Mt. Vernon, Illinois on November 9, 2016. In his report, Dr. Miller states that the patient's MRI has the appearance of a Bankart tear, possibly extending a bit superiorly. However, she developed a post-traumatic frozen shoulder. Dr. Miller indicated that the Petitioner had not had any therapy since the injury which was now two and a half months ago. She developed a fairly dense posttraumatic frozen shoulder. He recommended a cortisone injection and physical therapy three times per week. He imposed restrictions of strictly one-handed work with the uninjured upper extremity and scheduled a follow-up appointment to see the Petitioner on December 15, 2016.

When Petitioner returned to see Dr. Miller on December 15, 2016. He noted that the Petitioner had made progress in physical therapy. He recommended additional physical therapy 2-3 times a week for two weeks. He also recommended left shoulder surgery to repair the labrum and the perform a Bankart repair. He imposed restrictions of no overhead lifting, no repetitive pushing or pulling, and no lifting more than 20 pounds with the left arm. On January 17, 2017, Dr. Miller performed a left shoulder arthroscopic labral repair with four PushLock anchors and a left shoulder subacromial bursectomy. Post-surgically, Dr. Miller ordered an abduction sling with pillow, a cold therapy unit, and CPM machine to be used on Petitioner's left shoulder for 8 days. Dr. Miller also recommended physical therapy two times a week for six weeks and scheduled a follow-up appointment. When Petitioner saw Dr. Miller on January 30, 2017, he noted that he was pleased with her progress with the use of the CPM machine and the physical therapy. He noted that she had been using the CPM machine for about 4 hours per day. He updated his prescription for pain medication and imposed restrictions on the Petitioner of single arm duties only with no client contact at Murray Center and no pushing,

pulling, or lifting.

On March 1, 2017, Dr. Miller noted that the Petitioner was having increased pain with numbness going down to her fingers. He also noted that she was having neck pain, arm pain, periscapular pain, and chest pain. She described a lot of burning. The patient told Dr. Miller that she was having quite a bit of neck pain and burning after the injury of being involved with trying to break up a fight. Dr. Miller that the patient had a combination of symptoms currently that are suggestive of cervical pathology as well as glenohumeral pathology. Neck x-rays were abnormal, and she had symptoms suggestive of a radiculopathy. He prescribed a Medrol Dosepak and incorporated therapy with her neck to help resolve some of her symptoms. He increased her physical therapy to three times per week and again imposed restrictions of no repetitive pushing and pulling, and no lifting with her left upper extremity. When Petitioner returned to see Dr. Miller on April 6, 2017, she indicated that her shoulder motion was improving. She also indicated that she was still having quite a bit of neck pain and feels as though her neck symptoms are more problematic than the shoulder. Dr. Miller recommended continuing with physical therapy three times per week and noted that the patient was having as much or more pain with her neck than her shoulder. He indicated that he would recommend a referral to a cervical spine specialist to identify pathology/causation. On May 4, 2017, Dr. Miller noted that the patient was making slow, but definable progress. He noted that the patient continued to complain of pain radiating down her upper extremity and that at his last appointment he recommended a spine referral. However, that had not been done. Dr. Miller referred the Petitioner to see Matthew Gornet, M.D. regarding her neck symptoms. Dr. Miller recommended continued physical therapy three times a week for four weeks and imposed restrictions of no lifting greater than 20 pounds and no overhead work with her affected extremity.

On June 1, 2017, Dr. Miller noted that she was making slow but gradual progress with the range of motion in her left shoulder. He also noted that she was having some anterior pain which was likely tightness of the pectoralis minor. He noted that the patient had six physical therapy sessions since her last visit despite having issues with her range of motion. He noted a peer-to-peer review was performed that denied further visits, concentrating on a home exercise program. His report also noted that the Petitioner had an epidural injection at her last appointment through Dr. Gornet and that she was scheduled to have another injection on June 8, 2017. If that injection was unsuccessful, Dr. Gornet has discussed the subject of a disc replacement at C3-4. Dr. Miller recommended a work conditioning program and imposed restrictions of no overhead lifting or lifting up to 20-30 pounds with her left upper extremity. Petitioner returned to see Dr. Miller on August 2, 2017 who noted that the Petitioner was six and a half months postoperatively following the four anchor capsulolabral reconstruction on January 17, 2017. He also noted that she continued to have issues with her neck and was undergoing epidural injections under the care and treatment of Dr. Matthew Gornet. Because of the neck issues, she struggled with the work conditioning program. He also noted that since her last appointment she underwent a corticosteroid injection that was performed on July 17, 2017 under fluoroscopy to address some of her residual irritability. The Petitioner indicated that the last cortisone injection within the joint did not make any difference in her pain pattern. She continued to have numbness and tingling into her fourth and fifth digits. He noted that she was still having neck pain and upper extremity pain. The patient provided a note from Dr. Gornet indicating his strong recommendation of doing a C3-4 disc replacement that was currently being scheduled. Dr. Miller found the Petitioner to be at maximum medical improvement with regard to her left shoulder. He noted that she has overlapping issues with her neck that was causing symptomology. He did not believe further therapy would be productive at this time. He released the Petitioner with no restrictions and no follow-up appointment. He indicated Dr. Gornet's restrictions will supersede his if any are present.

Petitioner's paycheck stubs reflecting her earnings from August 31, 2015 through September 15, 2016 were entered into evidence at the time of arbitration as Petitioner's Exhibit 7.

The Workers' Compensation Employee's Notice of Injury which was completed and signed by the Petitioner on September 8, 2016 was entered into evidence at the time of arbitration as Petitioner's Exhibit 8.

The medical records of Kaylea Boutwell, M.D. were entered into evidence at the time of arbitration as Petitioner's Exhibit 9. On May 18, 2017, Dr. Boutwell performed a C3-C4 epidural steroid injection. The records indicate that Petitioner's pre-procedure pain level was a 4-6 on the left side of her neck and shoulder down her arm and between her shoulder blades. Petitioner's post-procedure pain was a 3-4. On June 7, 2017, Dr. Boutwell performed a C5-C6 epidural steroid injection. Petitioner's pre-procedure pain was a 3-4 and her post-procedure pain was 2.

The transcript of the deposition of David Robson, M.D. was entered into evidence at the time of arbitration as Respondent's Exhibit 4. Dr. Robson testified that he is an orthopedic spine surgeon. He saw the Petitioner for an independent medical examination on December 5, 2017. His examination was limited to the cervical spine. Dr. Robson testified that he reviewed Petitioner's medical records from SSM Health Care Group, Dr. Miller, Dr. Gornet, Imaging Partners of Missouri, Orthopedic Ambulatory Center of Chesterfield epidural injection reports from May and June of 2017, MRI Partners, MRI dated May 4, 2017. In addition, he reviewed the films personally as well. Dr. Robson testified that Petitioner provided him with a history of working for Murry Center trying to separate two individuals who were fighting over an object. Her left arm was outstretched and pulled behind her. She began having immediate shoulder pain and some radiating pain into the neck. She sought treatment shortly thereafter. She had treatment in the form of physical therapy for the shoulder and neck. She ultimately underwent shoulder surgery which was performed by Dr. Miller in January of 2017 and had residual neck pain and had treatments with physical therapy and injections prior to seeing him. Dr. Robson testified that based upon his review of her diagnostic imaging of her cervical spine, he found that she had a small disc protrusion or bulge at the C3-4, C4-5, and C5-6 levels. He found no significant stenosis present. He testified that she did have an annular tear of the C3-4 space which could be consistent with an acute injury. During his physical examination, he noted that the Petitioner had tenderness in the left side of the neck and trapezius muscle when palpated. She was asked to perform a range of motion in her neck and all planes, and indicated that it caused increased pain. She had a normal neurologic examination. She did have some limitation in range of motion and tenderness when touched or asked to move her neck. Dr. Robson found no active radiculopathy in his examination. Based upon Dr. Robson's review of her medical records, he testified that she underwent two injections into her cervical spine with no short-term or sustained relief or long-term improvement noted. Dr. Robson testified that short-term improvement is more of a diagnostic tool and since neither of the cervical spine injections provided Petitioner with relief of her symptoms, this points to the fact that they necessarily weren't causing her symptoms. Dr. Robson testified that at the time of his examination, Petitioner had complaints of neck pain and pain in the left trapezius and shoulder region. He further testified that her complaints were supported by the objective findings and possibly related to her shoulder. He further testified that the majority of her pain came from her shoulder, but she may have had some contribution from her neck. He testified that Petitioner had a cervical strain which was treated with physical therapy and injections and he did not feel that she had a significant enough finding in her neck to warrant a surgical procedure. Dr. Robson testified that Petitioner's cervical strain is related to her work injury of September 8, 2016. Dr. Robson further testified that the treatment Petitioner received was reasonable and necessary and it is the same treatment he would have ordered. When asked if he believe the Petitioner was a surgical candidate, Dr. Robson testified that surgery is always an option but you have to weigh the risk and benefit. He believes that in Petitioner's case due to her BMI of 42.1 when normal is 25 which carries an extra risk for people who have above normal weight, he believes that risk outweighs any success that surgery can produce. Dr. Robson further testified that she had a small protrusion, none of which impacted the spinal cord and none of which caused any significant impingement other than mild at one level which Dr. Gornet wasn't even recommending surgery on, that can be improved with the inherent risk of a surgical procedure.

Dr. Robson prepared an Addendum report based upon his review of Dr. Gornet's testimony and an additional MRI scan that was performed. Dr. Robson testified that it was very similar to the previous MRI and he did not see any significant difference. He noted that Dr. Gornet identified a slice that he thought showed a left-sided protrusion at the C3-4 level. Dr. Robson agreed that it was there. He didn't doubt what Dr. Gornet said. Dr. Robson testified that he just felt that it was just a very mild finding and had a mild impact and wasn't worthy of the surgical procedure for all of the reasons he previously stated. In commenting on Dr. Gornet's deposition testimony, Dr. Robson indicated that neither of the cervical spine injections provided Petitioner with any relief would be evidence not in favor of advocating for a surgical procedure which is contrary to what Dr. Gornet testified in a follow-up statement to say that is really doesn't matter. Dr. Robson testified that there may not be long term improvement of symptoms following an injection, but even in a severe finding, a lot of times a patient has resolution of their symptoms for a couple of hours at least. In Dr. Robson's opinion, the findings on the MRI were mild. He testified that the Petitioner is at maximum medical improvement with regard to her cervical spine and he found no structural abnormalities that would cause him to impose any type of work restrictions.

On cross-examination, Dr. Robson testified that the type of trauma the Petitioner sustained on September 8, 2016 could cause a cervical strain and it could have caused a small protrusion as well. Dr. Robson testified that the Petitioner told him that she had no history of neck pain or regular treatment for her neck prior to September 8, 2016. In his review of Petitioner's medical records, he did not find any evidence that would indicate that she had any medical treatment for her neck prior to September 8, 2016. Petitioner told Dr. Robson that she had pain that is worse during exercise and worse during twisting and turning and that her pain is worse at night. She also told Dr. Robson that she had pain that was worse when laying down and worse with work. During his physical examination, Dr. Robson noted that neck pain was elicited by motion which is consistent with a diagnosis of cervical strain. Dr. Robson testified that Petitioner's symptoms could be caused by a herniated disc at C3-4. Dr. Robson testified that Petitioner had tenderness on the left neck and trapezius area. Those symptoms could be caused by a cervical strain or by a herniated disc at C3-4. Dr. Robson also testified that the trauma that Petitioner sustained on September 8, 2016 was sufficient to cause a disc herniation at C3-4. Dr. Robson testified that Petitioner completed a pain diagram indicating that she had burning on the left side of her neck, left trapezius muscle, and left shoulder. He testified that he thought Petitioner's grip strength was good. However, Petitioner testified that her grip strength had decreased. Petitioner also indicated on the pain diagram that she had numbness in the left little finger on her left hand and aching discomfort along her neck going down her left trapezius into her left arm. He indicated that the areas marked on the pain diagram were consistent with what Petitioner told him at the time of the office visit. Dr. Robson testified that based upon his review of the diagnostic films that there is a small foraminal protrusion on Series 10, Image 6 and that the small foraminal protrusion at C3-4 on the left could have been either caused or aggravated by the trauma that Petitioner sustained on September 8, 2016. Dr. Robson stated in his report that it is certainly a community standard to operate on a disc protrusion at C3-4 on the left side at this magnitude but not common in his practice. He does not believe it would be below the standard of care to do an operation on that finding, but he would not recommend it personally. Dr. Robson testified that reasonable minds can differ as to whether a specific patient requires a spine surgery, and within those parameters of reasonableness, he disagrees with Dr. Gornet.

On re-direct examination, Dr. Robson testified that he would not perform surgery on the Petitioner based on certain risk factors including risks inherent in a surgical procedure including infection, spinal fluid leak, nerve damage, paralysis in a cervical operation, difficulty swallowing, damage to recurrent laryngeal nerve, bleeding problems, in addition to Petitioner's increased risk secondary to her obesity. Dr. Robson testified that Dr. Gornet is the second best surgeon he knows. He said Dr. Gornet is very good. But Dr. Robson doesn't believe that it is worth the risk. He doesn't disagree with the diagnoses that have been made and the treatment that she's had, but surgical intervention is not necessarily the approach he would choose on pathology

that she has on her exam and her imaging studies.

On re-cross examination, Dr. Robson testified that Petitioner's complaints of pain going down her arm and her symptoms in her small finger would be inconsistent with a disc herniation at C3-4. However, her neck pain and left side trapezius pain would be consistent with the injury.

CONCLUSIONS OF LAW

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

Respondent agrees that Petitioner's left shoulder condition is causally related to the injury of September 8, 2016.

Respondent disputes causal connection as it pertains to Petitioner's cervical spine based upon the opinions of Respondent's examining orthopedic spine surgeon, Dr. Robson. Dr. Robson opined that the September 8, 2016 injury caused a cervical strain. He agreed that Petitioner had a disc protrusion at C3-4 on the left and that the trauma she sustained on 9/6/2018 could have caused that protrusion. He testified that Petitioner's pain complaints of the trapezius shoulder and neck are consistent with the injury. He opined that the treatments Petitioner received prior to his examination on December 5, 2017 were reasonable and necessary. Dr. Robson stated it is certainly a community standard to operate on a disc protrusion at C3-4 on the left side of this magnitude, but not his common practice. He did not believe that surgical intervention would significantly improve her symptoms. Dr. Robson based this opinion on the fact that Petitioner's disc protrusion at C3-4 was small and she had absolutely no relief from the injection at that level.

Petitioner testified that she told Dr. Robson that it was difficult to tell if the injections provided any relief of her symptoms in her neck because her neck pain and shoulder pain overlapped.

Dr. Boutwell's records indicate that Petitioner did have some reduction in her pain level following the injection at C3-4.

Petitioner's treating orthopedic spine surgeon, Dr. Gornet, opined that her cervical disc herniation at C3-4 is causally related to the injury on September 8, 2016. Dr. Gornet testified that Petitioner continues to have pain and symptoms. He noted that she has tried and failed conservative measures. Dr. Gornet testified that the Petitioner has objective pathology on her MRI scan which correlates with her subjective complaints. He has recommended disc replacement. He further testified that he believes that he can help her with this treatment and he has had success in alleviating a patient's symptoms by performing an anterior cervical disc replacement at C3-4 for this type of condition.

At arbitration, Petitioner testified in a direct and forthright manner. She testified that she wants to have the neck surgery because she has neck pain every day. Her neck pain causes her difficulty sleeping and affects her activities both at home and at work.

Based upon the foregoing and the record taken as a whole, the arbitrator finds that Petitioner's current condition of ill-being relative to her cervical spine is causally related to the work accident of September 8, 2016.

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?**

Based upon the aforementioned conclusions with regard to Issue F, which are incorporated herein by reference, as well as the record taken as a whole, the Arbitrator finds Respondent is liable for the medical expenses outlined in Petitioner's Exhibit 1, totaling $4,413.81, and orders Respondent to pay these expenses as provided in Sections 8(a) and 8.2 of the Act. Pursuant to the agreement of the parties, all medical bills awarded shall be paid directly to the medical providers. 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.

With respect to prospective medical treatment, the Arbitrator finds the reasoning of Dr. Gornet more persuasive than that of Dr. Robson, and finds that the testimony and the medical evidence, as a whole, supports the need for the cervical disc replacement at C3-4 as recommended by Dr. Gornet. The Arbitrator finds that the prospective treatment recommended for Petitioner by Dr. Gornet is reasonable, necessary, and causally related to Petitioner's work injury.

Issue (L): **What temporary benefits are in dispute?**

Petitioner testified that she received all of her temporary total disability benefits prior to December 26, 2017. She received notification that her temporary total disability benefits were terminated effective December 26, 2017. On December 28, 2017, Petitioner saw Kendra Bowen who kept her off from work until she could see her treating spine surgeon. Contained within Dr. Gornet's medical records is a Physician's Statement signed by Dr. Gornet on January 5, 2018 keeping Petitioner off from work until February 11, 2018.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds that Petitioner has met her burden of proving that she is entitled to temporary total disability benefits for the period of time from December 28, 2017 through February 11, 2018.

Respondent shall pay Petitioner temporary total disability of $614.29 per week for 6-4/7 weeks, commencing December 28, 2017 through February 11, 2018.

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.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Deteasia Enoch Collins,

Petitioner,

vs.

NO: 17 WC 18126

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Help at Home,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by Petitioner and Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical treatment and expenses, prospective medical treatment, temporary total disability ("TTD"), and penalties, and being advised of the facts and law, modifies the Decision of the Arbitrator. The Commission affirms the Arbitrator's conclusion that Petitioner's current condition of ill-being regarding the right labral tear, acromioclavicular joint pathology, and recommended right shoulder surgery is not causally related to the work accident. The Commission further finds Petitioner's current condition of ill-being regarding her right sternoclavicular joint is not related to the 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).

Findings of Facts

Petitioner worked for Respondent as a home health aid. She began working for Respondent approximately two years before the date of accident. On January 20, 2017, Petitioner sustained an injury while helping a client out of bed and into a wheelchair. Petitioner testified that she "pulled a muscle" and felt pain in her right shoulder after lifting the client. She immediately felt throbbing and tingling in her right arm. She testified that the pain was throughout her shoulder, particularly in her clavicle. Petitioner testified that her symptoms have remained unchanged since the date of accident. She would like to proceed with the right shoulder surgery recommended by Dr. Giannoulias. She rated her pain at 6.5/10.

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Under cross-examination, Petitioner testified that she never had pain in her right shoulder prior to the work accident. She testified that the symptoms she felt immediately after her accident were about the same as they currently are—neither better nor worse. Petitioner agreed that on her Application for Adjustment of Claim she identified only her right collarbone as the affected body part.

Dr. DelosSantos, Petitioner's primary care physician, examined Petitioner on January 28, 2017.1 (PX 3). The physical examination revealed tenderness in the subclavicular area and slightly limited right shoulder range of motion. The doctor diagnosed a sprain of an unspecified site of the shoulder and upper arm. Petitioner visited Concentra on February 6, 2017, with complaints of right shoulder and neck pain. (PX 2). Petitioner complained of pain in the right anterior neck and right lateral neck that was constant and rated a 10/10. The pain also radiated to the right trapezius. The physical exam revealed right medial clavicle tenderness. X-rays of the cervical spine and the right clavicle showed no obvious signs of fracture. The doctor diagnosed a neck strain and prescribed physical therapy and medication. On February 16, 2017, Petitioner returned to Concentra and reported improving pain in the right anterior neck. Petitioner returned to Concentra on March 24, 2017, with complaints of unchanged symptoms located in the anterior chest bilaterally and radiating to the right shoulder. The exam revealed tenderness of the right trapezius muscle but no cervical pain and tenderness of the anterior chest up to the right shoulder. The doctor also noted swelling and parasternal tenderness of the sternum. The doctor diagnosed a neck sprain and strain, sternum pain, and soft tissue swelling of the chest wall.

Dr. Cohen first examined Petitioner on April 4, 2017. Petitioner complained of pain in the anterolateral shoulder region, but later noted most of her pain was around her clavicle, the anterolateral base of her neck on the right, and her sternoclavicular region into the sternal region. Dr. Cohen wrote that Petitioner tended to exhibit significant pain behavior. Petitioner was especially tender at the acromioclavicular ("AC") joint and sternoclavicular ("SC") joint. The doctor observed swelling at the SC joint on the right side. Due to her marked pain behavior and difficulty he had examining her, Dr. Cohen recommended an MRI of the right shoulder and a CAT scan of the right SC joint. He believed most of Petitioner's symptoms were coming from the SC joint. On April 10, 2017, Petitioner returned to Dr. DelosSantos and complained of right shoulder pain. She reported fracturing her clavicle in a work accident. Dr. DelosSantos noted the right shoulder was locally tender with adequate range of motion. A CT scan of the right arm had the following impression: 1) no evidence of acute traumatic injury to the right SC joint; 2) multiple foci of subchondral bony reabsorption of the clavicular head with benign-appearing periosteal reaction and a probable small SC joint effusion; and 3) a constellation of findings most consistent with a seronegative arthritis or low-grade repetitive trauma. A right shoulder MRI had the impression of a tear of the superior labrum with associated paralabral cyst extending into the suprascapular notch. There was no evidence of edema in the supraspinatus or infraspinatus muscles to suggest nerve impingement or denervation.

On April 25, 2017, Dr. Cohen wrote that while Petitioner's right shoulder felt better, she still had severe pain in the region of her SC joint on the right. His physical examination revealed no shoulder tenderness, but Petitioner was acutely tender at the right SC joint. Her shoulder

1 There is some confusion regarding the correct spelling of Dr. DelosSantos' name. The Commission is using the spelling found in the medical records from Dr. DelosSantos' office.

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movement was limited with guarding secondary to pain at the sternoclavicular region. Dr. Cohen agreed that the MRI showed changes consistent with a superior labral tear; however, he opined these were old changes that were no longer symptomatic. He performed a steroid injection into the right SC joint. On May 16, 2017, Dr. Cohen again noted that Petitioner's pain was located at the right SC joint. He also noted continued swelling and tenderness at the joint. He interpreted the recent CT scan of the right arm as showing somewhat destructive changes of Petitioner's medial clavicle at the sternoclavicular joint. Dr. Cohen ordered an MRI of the right sternoclavicular joint due to his concern that some of the changes found on the scan could be the result of a tumor. Petitioner never obtained the MRI and did not seek further treatment with Dr. Cohen.

Dr. Murtaza first examined Petitioner on June 20, 2017. (PX 1). Petitioner began treatment with Dr. Murtaza at the recommendation of her attorney. She reported feeling acute pain in her right shoulder and into the collarbone after lifting a patient. Dr. Murtaza interpreted the MRI as showing a superior labrum tear with a paralabral cyst as well as AC joint arthropathy. He prescribed pain medication and aggressive physical therapy. He was concerned that Petitioner may have developed frozen shoulder. Dr. Giannoulias, a colleague of Dr. Murtaza, examined Petitioner on July 12, 2017. Petitioner reported lifting a patient and feeling sharp and sudden stabbing pain in the right shoulder, collarbone, and AC joint. The doctor determined the results of Petitioner's examination were consistent with marked AC joint pain with no impingement sign. He diagnosed a right labral tear and significant AC joint pathology; additionally, Dr. Giannoulias recommended an arthroscopic labral repair and evaluation of the AC joint. Petitioner returned to Dr. Murtaza on October 26, 2017. In the corresponding office visit note, Dr. Murtaza wrote that the work injury caused a superior labral tear with biceps tenosynovitis and severe AC joint arthropathy causing impingement. On December 12, 2017, Dr. Murtaza authored a follow in which he opined that the mechanism of injury described by Petitioner is consistent with her current condition and requires surgery. (PX 1a).

Expert Opinion

Dr. Steven Mash — Respondent Section 12 Examiner

Dr. Mash examined Petitioner on September 8, 2017, at Respondent's request. (RX 3). Petitioner complained of discomfort to palpation and with breathing at the right SC joint only. Dr. Mash noted significant tenderness without swelling to palpation around the SC joint on the right. Petitioner had no complaints over the spinal glenoid notch. Dr. Mash diagnosed sternoclavicular arthropathy. He opined that Petitioner's current symptoms relate to the SC joint and believed Dr. Cohen's evaluations and the diagnostic exams objectively correlate with this diagnosis. Dr. Mash believed the abnormality demonstrated on the diagnostic study about the SC joint was preexisting and was likely exacerbated temporarily by the work incident. He opined that the loss of range of motion evident during Petitioner's physical examination is most likely attributable to the SC joint, not any of the AC joint or labral pathology seen on the right shoulder MRI. Dr. Mash did not believe Petitioner was a surgical candidate for shoulder surgery or surgery relating to the SC joint.

Dr. Mash opined, "The claimant has an unusual problem that likely relates to some underlying systemic disease process leading to the sternoclavicular complaint." Future treatment should focus on this problem; however, he did not believe any additional treatment would be

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related to the work injury. He agreed the treatment recommended by Dr. Cohen, including further diagnostic tests, is appropriate. Dr. Mash opined that Petitioner is at MMI for the temporary aggravation to her preexisting SC joint condition caused by the work incident.

Dr. Mash later reviewed films of the CT scan of the right clavicle and the right shoulder MRI. In a February 2018 addendum report, he agreed with the radiologists' findings on both exams, and clarified that Petitioner's major complaints during his examination and during her visits with Dr. Cohen focused completely around the SC joint, not the AC joint. (RX 4). He believed that while the limited range of motion about the right shoulder may relate to the SC joint, it did not relate to Petitioner's AC joint. He opined, "Just because the claimant has a positive finding on MRI in and of itself does not meet the prerequisite to consider surgery."

Conclusions of Law

Petitioner bears the burden of proving each element of her case by a preponderance of the evidence. *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill. 2d 193, 203 (2003). When a claimant suffers from a preexisting condition, the claimant must show that a work-related accidental injury aggravated or accelerated the preexisting condition "...such that the [claimant'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." *Id.* at 204. The Commission agrees with the Arbitrator's conclusion that Petitioner sustained an accident that arose out of and in the course of her employment on January 20, 2017. However, after carefully weighing the totality of the evidence, the Commission finds Petitioner failed to prove by a preponderance of the evidence that her current condition of ill-being relating to her AC and SC joints is causally related to the January 20, 2017, work accident.

After carefully considering all the credible evidence, the Commission affirms the Arbitrator's conclusion that Petitioner failed to prove by a preponderance of the evidence that her current condition regarding the right shoulder pathology evident on the April 2017 MRI is causally related to the January 20, 2017, work incident. The medical records show that while Petitioner's earliest complaints referred generally to right shoulder pain, the physical examinations of her treating physicians revealed notable tenderness at the SC joint and neck. Dr. Cohen, Petitioner's initial orthopedic doctor, agreed that the April 2017 right shoulder MRI revealed a labral tear and AC joint pathology. However, he determined that there was no objective evidence that the MRI findings are symptomatic. Instead, Dr. Cohen relied on his objective findings of tenderness and swelling in the area of the SC joint as well as Petitioner's complaints of pain in the region of her clavicle. Dr. Cohen interpreted the April 2017 CT scan of Petitioner's right arm as showing somewhat destructive changes of the medial clavicle at the SC joint. The doctor worried these changes were due to a tumor. Respondent's Section 12 examiner, Dr. Mash, noted that Petitioner did not raise any complaints during his examination relating to her right shoulder. Instead, Petitioner solely complained of discomfort to palpation and with breathing at the SC joint. After examining Petitioner and the relevant medical records, Dr. Mash agreed with Dr. Cohen's opinion that Petitioner's complaints are unrelated to the right shoulder pathology seen on the April 2017 MRI.

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The Commission agrees with the Arbitrator's conclusion that the opinions and treatment recommendations given by Drs. Murtaza and Giannoulias are not credible given the totality of the evidence. Petitioner received treatment from several doctors, including her primary care physician and Dr. Cohen prior to beginning treatment with Dr. Murtaza in June 20, 2017. Dr. Murtaza opined that Petitioner's complaints are due to the pathology evident in the April 2017 right shoulder MRI. He referred Petitioner to Dr. Giannoulias, who examined Petitioner in July 2017 and wrote that the results of Petitioner's physical examination were consistent with marked AC joint pain. Dr. Giannoulias diagnosed Petitioner with a right labral tear with significant AC joint pathology and recommended surgical intervention. Dr. Murtaza later agreed with the surgical recommendation and opined Petitioner's current condition of ill-being regarding her right shoulder and the recommended surgery are causally related to Petitioner's work accident. The Commission finds the Arbitrator correctly assessed the evidence and properly denied a causal connection between the findings evident on the April 2017 right shoulder MRI and the work incident. There is no credible explanation in evidence accounting for the marked difference in objective findings and subjective complaints relating to Petitioner's right shoulder noted by Drs. Murtaza and Giannoulias compared to her consistent history of complaints to all her prior treating doctors. The opinions of Drs. Murtaza and Giannoulias differ significantly from those of Petitioner's earlier treating doctors. Their opinions also differ greatly from the very credible opinion of both Drs. Cohen and Mash that Petitioner's right shoulder pathology is asymptomatic and is not related to the work accident. Drs. Cohen and Mash agree that Petitioner's ongoing complaints are most likely related to her SC joint. For these reasons, the Commission affirms the Arbitrator's denial of a causal connection between Petitioner's right shoulder complaints and the findings revealed on the April 2017 MRI and the January 20, 2017, work accident.

While the Commission agrees with the Arbitrator's denial of causation regarding Petitioner's right shoulder, it reverses the Arbitrator's conclusion that the March 8, 2018, 19(b) hearing only addressed the causal connection of the right labral tear, AC joint pathology, and surgical intervention recommended by Drs. Giannoulias and Murtaza. The Arbitrator wrote, "Petitioner did not present evidence that her current condition was causally related to an aggravation of a pre-existing sternoclavicular joint condition, and, as such, the Arbitrator's decision does not address that issue nor whether Petitioner is entitled to TTD benefits or prospective medical treatment related to an aggravation of a pre-existing condition." The Commission respectfully disagrees with this statement.

When parties proceed to hearing pursuant to Section 19(b) of the Act, the Commission is tasked with determining all issues in dispute through the date of hearing. Occasionally, an Arbitrator may allow the parties to agree to reserve a specific disputed issue for subsequent litigation. For example, in this matter the parties agreed to reserve the issue of outstanding medical bills for future determination. However, there was no agreement limiting the 19(b) hearing solely to the question of whether Petitioner's current condition of ill-being regarding only her right shoulder pathology and recommended surgery. Instead, the issues in dispute included the causal connection of Petitioner's current condition of ill-being as well as disputed TTD. Petitioner also identified the shoulder surgery proposed by Dr. Giannoulias as a disputed issue.

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After reviewing the record, the Commission finds that the all-encompassing issue of the causal relation of Petitioner's current condition of ill-being to the work incident was in dispute during the hearing. Petitioner made a strategic decision to only present evidence she believed supported her theory of the case that the right shoulder pathology and related surgical recommendation are causally related to the work accident. However, it was no secret that Respondent's theory of the case is that Petitioner's shoulder pathology is asymptomatic and unrelated to the work accident. It was also no secret that Respondent disputed the causal relation of Petitioner's overall condition of ill-being to the work accident. This included the symptoms relating to Petitioner's SC joint identified by Drs. Cohen and Mash. Dr. Mash's opinion expressly denies the causal connection of Petitioner's current SC joint condition and complaints to the work accident. Petitioner failed to submit sufficient evidence rebutting the opinions of Drs. Cohen and Mash that Petitioner's ongoing complaints involved only her SC joint. Furthermore, Petitioner failed to submit any evidence that her current condition relating to her SC joint is causally connected to the work accident. No doctor opined that Petitioner's current condition regarding her right SC joint is related to the work accident.

When a Petitioner proceeds to a hearing on the merits, the Commission weighs the evidence submitted by each party. The Commission does not, and should not, effectively give Petitioner a "do over" because she failed to submit any evidence rebutting a key element of Respondent's defense. After closely reviewing the totality of the evidence, the Commission finds Petitioner failed to prove her current condition of ill-being is causally related to the January 20, 2017, work accident. Petitioner failed to present credible evidence that any of her complaints or conditions, including those regarding the findings of the April 2017 right shoulder MRI and her ongoing complaints regarding her right SC joint, are related to the work accident.

Finally, the Commission corrects certain scrivener's errors in the Decision of the Arbitrator. First, on page one (1) of the Decision, the Arbitrator mistakenly wrote that Petitioner saw her primary care physician for a **routing** follow up involving unrelated treatment. On page two (2) of the Decision the Arbitrator mistakenly refers to a date of accident of January **30**, 2017. On page three (3) of the Decision, the Arbitrator wrote Dr. Murtaza **proscribed** physical therapy. In the same paragraph, the Arbitrator refers to Illinois Orthopedic **network**. The Arbitrator also mistakenly refers to "Dr. **Murtaza** examination." The Commission hereby modifies the above-referenced sentences to read as follows:

> On January 28, 2017, Petitioner saw Dr. DelosSantos, a primary care physician, for a **routine** follow up involving unrelated treatment. (pg. 1 of the Decision)
>
> On February 1, 2017, Petitioner's supervisor, Keisha Jefferson, completed a Supervisor Incident Statement Form which acknowledged that Petitioner reported injuring her right shoulder and collar bone while transporting a patient from a bed to a wheelchair on January **20**, 2017. (pg. 2 of the Decision)
>
> On June 20, 2017, Petitioner presented to Dr. Sajjad Murtaza of Illinois Orthopedic **Network**. (pg. 3 of the Decision)

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> Dr. **Murtaza's** examination showed reduced range of motion for both active and passive flexion abduction. (pg. 3 of the Decision)
>
> Dr. Murtaza assessed an early frozen shoulder and **prescribed** physical therapy, Valium, menthyl patches and he took Petitioner off work because the employer was not following the work guidelines. (pg. 3 of the Decision)

The Commission otherwise affirms and adopts the Decision of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on May 22, 2018, is modified as stated herein.

IT IS FURTHER ORDERED that Petitioner's current condition of ill-being is not causally related to the January 20, 2017, work accident. Petitioner failed to prove her current conditions regarding her right labral tear and AC joint pathology and her right sternoclavicular joint are causally related to the work accident.

IT IS FURTHER ORDERED that the right shoulder surgery recommended by Dr. Giannoulias is hereby denied.

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

IT IS FURTHER ORDERED 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 that Respondent pay to Petitioner interest pursuant to §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: JAN 16 2020
o: 11/19/19
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Thomas J. Tyrrell

Maria E. Portela

Kathryn A. Doerries

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

COLLINS, DETEASIA ENOCH
Employee/Petitioner

Case# **17WC018126**

HELP AT HOME
Employer/Respondent

20IWCC0028

On 5/22/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.08% 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:

0243 JAMES ELLIS GUMBINER & ASSOC
CHRISTOPHER COOPER
180 N MICHIGAN AVE SUITE 2100
CHICAGO, IL 60601

0766 HENNESSY & ROACH PC
QUINN BRENAN
140 S DEARBORN ST SUITE 700
CHICAGO, IL 60603

20IWCC0028

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)

DETEASIA ENOCH COLLINS
Employee/Petitioner

v.

HELP AT HOME
Employer/Respondent

Case # **17** WC **18126**

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 **Frank Soto**, Arbitrator of the Commission, in the city of **Chicago**, on **March 8, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

20IWCC0028

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FINDINGS

On the date of accident, **January 20, 2017**, Respondent *was* operating under and subject 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 **$5,060.37**; the average weekly wage was **$133.17**.

On the date of accident, Petitioner was **19** 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

Has proven by the preponderance of the evidence that she sustained an accidental injury that course of her employment by Respondent on January 20, 2017.

Petitioner has failed to prove by the preponderance of the credible evidence that her current condition involving the right labral tear and AC joint pathology is causally related to Petitioner's alleged work accident of January 20, 2017.

In light of the Arbitrator's determination that Petitioner failed to establish that her current condition of ill-being, consisting of the right labral tear and AC joint pathology, was causally related to her injury of January 20, 2017, the remaining issues of Respondent's liability are moot and need not be reached by this Arbitrator. Accordingly, those benefits are hereby 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

5/18/2018
Date

ICArbDec19(b)

MAY 22 2018

PROCEDURAL HISTORY

This matter was tried before Arbitrator Frank J. Soto on March 8, 2018. Petitioner filed an Application For Adjustment Of Claim alleging that she sustained an injury to her right collarbone on January 20, 2017. A Petitioner for an Immediate hearing was not attached to the Application For Adjustment Of Claim. (RX 7). On March 8, 2018, the Parties submitted a Request For Hearing pursuant to Sections 19(b) and 8(a) of the Act. The disputed issues involve whether Petitioner sustained an accidental injury that arose out of and in the course of employment, whether the Petitioner's current condition of ill-being is causally connected to the injury and whether Petitioner is entitled prospective medical treatment and TTD benefits. Petitioner is seeking prospective medical treatment consisting of right shoulder arthroscopic labral repair surgery recommended by Dr. Giannulias. Petitioner filed a petition for penalties and attorney's fees pursuant to Section 16(k) and 19(l) of the Act. The Parties stipulated to reserve issues regarding whether Respondent is liable for unpaid medical bills. (Arb. Ex. 1).

FINDINGS OF FACT

Deteasia Enoch Collings (hereinafter referred as "Petitioner") testified that she was employed by Help At Home (hereinafter referred as "Respondent") as a homecare aid and her job duties consisted of cleaning, washing patients, assisting patients to use the bathroom, lifting garbage cans and boxes. Petitioner testified that prior to January 20, 2017, she did not participate in lifting patients.

Petitioner first testified that she pulled a muscle in her right shoulder while lifting a patient out of a bed to place the patient in a wheelchair on January 20. Petitioner later testified that her clavicle hurt more. Petitioner also testified that she notified her supervisor the day of the incident.

On January 28, 2017, Petitioner saw Dr. Delos Santos, a primary care physician, for a routing follow up involving unrelated treatment. At that appointment, Petitioner reported a muscle strain, of the left shoulder, after lifting a patient at home. Dr. Delos Santos examination noted that that Petitioner had slightly limited range of motion in the right shoulder. Petitioner was assessed with a sprain of unspecified site of shoulder an upper arm and proscribed cyclobenzaprine and Lidocaine Ointment. (PX 3, RX 5).

On February 1, 2017, Petitioner's supervisor, Keisha Jefferson, completed a Supervisor Incident Statement Form which acknowledged that Petitioner reported injuring her right shoulder and collar bone while transporting a patient from a bed to a wheelchair on January 30, 2017. (RX 1). Petitioner also completed an Employee Incident Statement on February 1, 2017 which stated the she injured her collar bone while lifting a patient from a bed to a chair. (RX 2).

On February 11, 2017, Petitioner returned to Dr. Delos Santos for a routine follow-up examination and prescription refill. At that visit, Petitioner returned for chronic asthma, recurrent anxiety, coughing and occasional shortness of breath. The medical records do not indicate that Petitioner complained of shoulder or sternum area pain nor was any associated treatment proscribed. (PX 3, RX 5). Petitioner returned to Dr. Delos Santos on February 27, 2017 and March 11, 2017, complaining of low back pain in addition to her asthma and occasional shortness of breath. (PX 3, RX 5).

On March 10, 2017, Petitioner returned to Dr. Delos Santos complaining of right shoulder pain and that she fractured her clavicle in a job-related injury. Dr. Delos Santos assessed pain in joint involving the shoulder region. On May 8, 2017 and June 5, 2017, Petitioner returned to Dr. Delos Santos complaining of low back pain in addition to issues related to asthma and anxiety. (PX 3, RX 5).

On April 4, 2017, Petitioner presented to Dr. James Cohen at the Illinois Bone & Joint Institute. At that time, Petitioner completed a Medical History Form stating the reason for her visit was due to a right shoulder injury, on January 20, 2017, while at work. Petitioner also indicated that she had swelling in her neck and collar bone. (PX 2).

During the examination Petitioner reported while lifting a bed ridden woman, with the assistance of the woman's daughter, she felt a sharp pain in her right shoulder. Dr. Cohen noted that Petitioner initially described the pain in the region of the anterolateral shoulder but subsequently noted that the most of her pain was in her sternal region. Petitioner rated her pain as 10 out of 10 and denied prior shoulder or neck problems. Dr. Cohen indicated that he believed the Petitioner's pain complaints were emanating from her sternoclavicular joint and he ordered a MRI of the right shoulder and CT scan of the sternoclavicular joint. (PX 2).

April 10, 2017, Petitioner underwent both a CT scan of her upper extremity on the right without contrast, and an MRI of the right shoulder without contrast. The CT showed multiple foci of subchondral bony reabsorption of the clavicular head with benign appearing periosteal reaction

and probable small sternoclavicular joint diffusion. The CT diagnosed was seronegative arthritis. It was also noted on the CT scan that correlation with laboratory values and clinical history of arthritis is recommended. The MRI of the right shoulder showed a tear of the superior labrum with associated parolabral cyst extending into some super scapular notch. There was no evidence of edema in the supraspinatus or infraspinatus muscles to suggest nerve impingement or denervation. (PX 2).

On April 25, 2017, Petitioner returned to Dr. Cohen and reported that her right shoulder region was feeling much better, but, that she had "rather severe pain in the region of her sternoclavicular joint on the right side." Dr. Cohen reviewed the MRI and agreed that there were *"changes consistent with the superior labral tear, but there appeared to be a large paralabral cyst that was extending into the bone with some bone sclerosis around it. This had the appearance of an old change and she is no longer having symptoms there."* Dr. Cohen agreed with the CT scan radiologist's findings as being of seronegative arthritis and gave Petitioner a sternoclavicular joint injection. Dr. Cohn issued work restrictions of no use of the upper extremity and to refrain from physical therapy. (PX 2).

On May 16, 2017, Petitioner returned to Dr. Cohen reporting that the injection helped "somewhat." Dr. Cohen was concerned that some of the "cystic changes [were] somewhat lytic and could indeed be due to a neoplasm." Dr. Cohen ordered an MRI of the sternoclavicular joint without gadolinium due to concerns involving the possible tumor. (PX 2).

On June 20, 2017, Petitioner presented to Dr. Sajjad Murtaza of Illinois Orthopedic network. Petitioner testified that she was directed to this clinic by her attorney. At that visit, Petitioner reported acute pain in the right shoulder and collarbone after lifting a client. Petitioner reported her pain level as 6 out of 10. Dr. Murtaza examination showed reduced range of motion for both active and passive flexion abduction. Dr. Murtaza also noted that Petitioner's AC joint was tender to palpation, pain with internal rotation and during the abduction and impingement maneuvers. Dr. Murtaza assessed an early frozen shoulder and proscribed physical therapy, Valium, menthyl patches and he took Petitioner off work because the employer was not following the work guidelines. (PX. 1).

On July 12, 2017, Petitioner was evaluated by Dr. Christos Giannoulias, who is also with Illinois Orthopedic Network. During that visit, Petitioner reported a sharp sudden stabbing pain in the shoulder, collarbone and the AC joint after lifting a client on January 25, 2017. Dr.

Giannoulias diagnosed a labral tear and significant AC joint pathology and recommended arthroscopic labral repair with evaluation of the AC joint. (PX 1).

On September 8, 2017, Petitioner underwent an independent medical examination with Dr. Steven Mash at the request of Respondent. Dr. Mash reviewed the medial records leading up to the date of this exam. During the visit, Petitioner reported that her current major complaints involve the right sternoclavicular joint only. Dr. Mash's examination found limited range of motion about the cervical spine, tenderness without swelling about the sternoclavicular joint on the right. Petitioner did not have any complaints of discomfort over the spinal glenoid notch on the right. The shoulder examination revealed dramatic limitation in range of motion which was limited secondary to pain. (RX 3).

Dr. Mash diagnosed sternoclavicular arthropathy. In his report dated September 18, 2017, which was entered into evidence without objection, Dr. Mash indicated the Petitioner's current issues were related to the sternoclavicular joint. Dr. Mash noted that Dr. Cohen's evaluation also focused primarily on the sternoclavicular joint and is consistent and the findings objectively correlate to the sternoclavicular joint. Dr. Mash opined the abnormality demonstrated on the diagnostic study about the sternoclavicular joint was pre-existing and likely temporarily exacerbated. Dr. Mash further opined that exacerbation to have been four (4) to six (6) weeks in length and that Petitioner's current condition is due to the pre-existing underlying condition.

Dr. Mash stated Petitioner's loss of range of motion and other complaints are entirely related to the FCE joint, not to the acromioclavicular joint or labral issues identified on the MRI. Dr. Mash opined that Petitioner's current problem is entirely pre-existing and any additional medical treatment would be due to the pre-existing condition. (RX 3).

Dr. Mash disagrees with Dr. Giannoulias' recommendation for arthroscopic evaluation of the right shoulder. Dr. Mash opined that the Petitioner is not a candidate for surgical intervention in the glenohumeral or acromioclavicular joint because Petitioner's current symptoms are associated with the sternoclavicular joint problem. Dr. Mash further opines that Petitioner suffers from an unusual sternoclavicular joint problem and she should seek additional treatment with an orthopedic surgeon, who focuses on that type of problem, and associated care at the direction of a rheumatologist to address the abnormalities noted in the sternoclavicular joint. (RX 3).

On October 26, 2017, Petitioner returned to Dr. Murtaza who opined that Petitioners' right shoulder condition is related to a superior labral tear with biceps tenosynovitis and severe AC joint

arthropathy. Dr. Murtaza further opines that Petitioner loss of range of motion and strength is secondary to the superior labrum tear with AC joint arthropathy. (PX 1).

On December 12, 2017, Petitioner returned to Dr. Murtaza for the purpose of obtaining a more detailed history of how Petitioner injured her shoulder. At that time Petitioner reported that the patient was on a sheet when she lifted the sheet to move the patient out of the bed and into a chair. Dr. Murtaza opined the mechanism of injury was consistent with the Petitioner's condition and she requires surgical intervention. (PX 1A).

On February 12, 2018, Dr. Mash authored an addendum report, which was admitted into evidence without objection. In that report, Dr. Mash opines that Drs. Giannoulias' focus upon the MRI study was inappropriate when recommending surgery even though the MRI showed an abnormality. Dr. Mash indicated that Petitioner's major complaints involve the sternoclavicular joint and the evaluation and CT study were positive. Dr. Mash opined the surgery would not address Petitioner's problems which involve the sternoclavicular joint. Dr. Mash noted that Petitioner's complaints in his office and during her treatment with Dr. Cohen focused upon the sternoclavicular joint and not the AC joint. Dr. Mash opined that just because one has a positive finding on an MRI, in and of itself, does not meet the prerequisite to consider surgery. (RX 4).

At trial Petitioner testified, that she would like to have the right shoulder surgery recommend by Dr. Giannulias. Petitioner testified that she continues to suffer from throbbing pain which is at the same level as the day of the accident. Petitioner testified that her current pain level is 6 ½ out of 10 and she is unable to do her hair, cook and lifting pots.

Petitioner testified that she is not currently working and she has not worked since July 12, 2017. Petitioner further testified that she has not made any attempts to find work other than with Respondent. Petitioner does not recall the dates she contacted Respondent.

Petitioner testified her last doctor's appointment was on December 17, 2017 with Illinois Orthopedic Network. The Illinois Orthopedic Network records indicate that Petitioner met with Dr. Murtaza for the purpose of obtaining a more detailed history of the injury but that no treatment was given on that date. The last date Petitioner received medical treatment was on October 26, 2017 with Dr. Murtaza. (PX 1, PX 2).

Sheena Callazo, the risk management coordinator for Respondent, was called as a witness. Ms. Callazo testified that Petitioner returned to work light duty and was given office work to do and that she left work complaining of chest pain. After that incident, Petitioner returned to work and

continued to work light duty until July 23, 2017. Ms. Callazo testified that work is available for Petitioner but she needs to complete in-service training to obtain her active status, which Petitioner has not attempted to do.

Patricia McCoy testified for Respondent. Ms. McCoy was a branch manager. Ms. McCoy testified that Petitioner needs to complete the in-service educational requirements to be considered active and the training is offered every quarter. Ms. McCoy testified to keep your active status, employees must complete four (4) hours of training per quarter and sixteen hours (16) each year, which is outlined in the employee handbook and available to Petitioner.

CONCLUSIONS OF LAW

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

The claimant bears the burden of proving every aspect of her claim by a preponderance of the evidence. *Hutson v. Industrial Commission*, 223 Ill App. 3d 706 (1992). To obtain compensation under the Act, the claimant bears the burden of showing by a preponderance of the evidence, he suffered a disabling injury which arose out of, and in the course of his employment. *Baggett v. Industrial Commission*, 201, Ill 2d. 187, 266 Ill. Dec. 836, 775 N.E. 2d 908 (2002). Preponderance of the evidence means greater weight of the evidence in merit and worth that which has more evidence for it than against it. *Spankroy v. Alesky*, 45 Ill. App.3d 432 (1st Dist. 1977). 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 to create a causal connection between the employment and the accidental injury. *Caterpillar Tractor Co. vs. Industrial Commission*, 129 Ill. 2d, 52, 133 Ill. Dec. 454, 541 N. E. 2d. 665 (1989). Accidental injury need not be the sole causative factor, not even the primary causative factor, as long as it was a causative factor in resulting condition of ill-being. *Rock Road Construction Co. v. Industrial Commission*, 37, Ill. 2d. 123, 227 N.E. 2d. 65 (1967). "Liability under the Workmen's Compensation Act may not be based on imagination, speculation, or conjecture, but must have a foundation of facts established by a preponderance of the evidence..." *Shell Petroleum Corp. v. Industrial Commission*, 10 N.E.2d 352 (1937).

WITH RESPECT TO ISSUE (C) DID PETITIONER SUSTAINED AN ACCIDENT THAT AROSE OUT OF AND IN THE COURSE OF HER EMPLOYMENT, THE ARBITRATOR FINDS AS FOLLOWS:

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). To recover benefits under the Act, a claimant bears the burden of proving by a preponderance of the evidence that his or her injury "arose out of" and "in the course of" the employment. *First Cash Financial Services v. Industrial Comm'n*, 367 Ill. App. 3d 102, 105 (2006). Both elements must be present at the time of the claimant's injury to justify compensation. *Illinois Bell Telephone Co. v. Industrial Comm'n*, 131 Ill. 2d 478 (1989). An injury "arises out of" one's employment if its origin is in some risk connected with or incident to the employment, so that there is a causal connection between the employment and the accidental injury. *Jewel Cos. V. Industrial Comm'n*, 57 Ill.2d 38, 310 N.E.2d 12 (1974). An injury is accidental within the meaning of the Act when it is traceable to a definite time, place, and cause and occurs in the course of employment, unexpectedly and without affirmative act or design of the employee. *Mathiessen & Hegeler Zinc Co. v. Industrial Board*, 284 Ill. 378 (1918). A claimant's injury "arises out of" employment if it "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." *Sisbro, Inc. v. Industrial Comm'n*, 2017 Ill. 2d 193, 203 (2003).

The Arbitrator has carefully reviewed and considered all medical evidence along with all testimony. The Arbitrator concludes that Petitioner has proven by the preponderance of the evidence that she sustained an accidental injury that arose out of and in the course of her employment by Respondent on January 20, 2017, as more fully described below.

Petitioner testified that she sustained an injury, on January 20, 2017, while relocating a patient from a bed to a wheelchair. Petitioner testified that she told her supervisor the day of the incident. The Supervisor Incident Statement shows that the Petitioner's supervisor, Keisha Jefferson, acknowledged being notified of the injury on January 30, 2017. The Report contains a similar description of the incident Petitioner reported to Dr. Delos Santos on January 28, 2017. The Arbitrator also notes that Petitioner provided a similar description of the injury to Drs. Cohen, Murtaza, Giannulias and Mash.

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

In preexisting conditions cases, recovery will depend on the employee's ability to show that a work-related accidental injury aggravated or accelerated the preexisting disease such that the employee's current condition of ill-being can be said to have been casually-connected to the work-related injury and not simply the result of a normal degenerative process of a preexisting condition. *Caterpillar Tractor Co. v. Industrial Comm'n*, 92 Ill2d 30, 36-37. When a workers' physical structures, diseased or not, give way under the stress of their usual tasks, the law views it as an accident arising out of and in the course of employment. *General Electric Co. v. Industrial Comm'n*, 89 Ill.2d 432, 60 Ill.Dec. 629, 433 N.E.2d 671 (1982). When an employee with a preexisting condition is injured in the course and of his employment 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. *Sisbro, Inc. Industrial Comm'n*, 207 Ill.2d 193, 278 Ill.Dec 70, 797 N.E.2d 665 (2003). 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. Industrial Comm'n*, 129 Ill.2d, 52, 133 Ill. Dec. 454, 541 N.E.2d 665 (1989).

The Arbitrator has carefully reviewed and considered all medical evidence along with all testimony. The Arbitrator concludes that Petitioner has failed to prove by the preponderance of the credible evidence that her current condition involving the right labral tear and AC joint pathology is causally related to Petitioner's alleged work accident of March 8, 2018, as set forth more fully below.

On July 12, 2017, Dr. Giannulias, of Illinois Orthopedic Network, indicated that Petitioner's chief complaint involved her right shoulder and she has marked AC joint pain. Dr. Giannulias records do not indicate that Petitioner had been experiencing significant sternoclavicular joint pain prior to April of 2017 nor does his records contain the CT scan nor address the recommendations and findings of Dr. Cohen and the CT scan radiologist.

On April 4, 2017, Petitioner reported, to Dr. Cohen, most of her pain was around her clavicle and the SC region into her sternal region. Based upon Petitioner's symptoms, Dr. Cohen ordered a

CT scan which showed multiple foci of subchondral bony reabsorption of the clavicula head with benign-appearing periosteal reaction and a probable small sternoclavicular joint effusion. The CT scan radiologist's finding was seronegative arthritis and the radiologist recommended correlation with laboratory values and clinical history of arthritis. On April 25, 2017, Petitioner reported, to Dr. Cohen, that her right shoulder was not symptomatic and the only issue she involved her sternoclavicular joint. At that time Dr. Cohen proscribed sternoclavicular joint injections. On May 16, 2017, Petitioner returned to Dr. Cohen and reported that all her pain was in the right sternoclavicular joint. At that time, Dr. Cohen was concerned that some of the cystic changes were becoming lytic and he ordered an MRI of the sternoclavicular joint. (PX 2).

On September 18, 2017, after Dr. Giannulias' examination, Petitioner reported that her current pain involved the right sternoclavicular joint area. During the examination Dr. Mash found that Petitioner was experiencing significant tenderness without swelling around the sternoclavicular joint and that Petitioner did not report any discomfort over the spinal glenoid notch. (RX 3).

The Arbitrator finds the opinions of Dr. Mash more persuasive then those of Drs. Giannoulias and Murtaza, both who are associated with Illinois Orthopedic Network. Prior to seeing Drs. Murtaza and Giannoulias Petitioner's pain involved the sternoclavicular joint. However, Drs. Murtaza and Giannoulias fail to address or acknowledge the significance of the sternoclavicular joint pain, CT findings or the discrepancies in Petitioner's symptoms reported to Drs. Cohen and Mash with those reported to Drs. Murtaza and Giannoulias. The Arbitrator finds the opinions of Dr. Mash to be consistent with Dr. Cohen's findings, treatment and the CT scan.

Dr. Cohen and Dr. Mash agree the MRI study showed a right labral tear with some AC joint pathology and the MRI findings are not consistent with Petitioner's symptomatology. (RX 4). Dr. Mash noted that a positive MRI finding in and of itself does not meet the prerequisite to consider surgery. Dr. Mash opined that the Petitioner's loss of range of motion is related to the FCE joint, not the acromioclavicular joint or labral issues, and as a result the surgery would not address the Petitioner's complaints.

Petitioner proceeded to hearing to determine whether the Petitioner's current condition of ill-being, consisting of the right labral tear and AC joint pathology, is causally connected to her injury of January 20, 2017. Petitioner requested, in part, perspective medical care consisting of the arthroscopic labral repair surgery recommended by Dr. Giannoulias. Petitioner did not present evidence that her current condition was causally related to an aggravation of a pre-existing

sternoclavicular joint condition and, as such, the Arbitrator's decision does not address that issue nor whether Petitioner is entitled to TTD benefits or prospective medical treatment related to an aggravation of a pre-existing condition.

WITH RESPECT TO ISSUES (K), (L) AND (M) WHETHER PETITIONER IS ENTITLED TO PROSPECTIVE MEDICAL CARE, TTD BENEFITS AND PENALTIES, THE ARBITRATOR FINDS AS FOLLOWS:

In light of the Arbitrator's determination that Petitioner failed to establish that her current condition of ill-being, consisting of the right labral tear and AC joint pathology, was causally related to her injury of January 20, 2017, the remaining issues of Respondent's liability are moot and need not be reached by this Arbitrator. Accordingly, those benefits are hereby denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF MCCLEAN)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Cara Burns,

Petitioner,

vs.

NO: 16 WC 35202

20IWCC0029

Manpower,

Respondent.

DECISION AND OPINION ON REVIEW

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

The Commission clarifies the decision of the Arbitrator to show that Petitioner sustained accidental injuries to her right hand and/or wrist and left knee as a result of the accident on 10/12/16. The Commission notes that the Arbitrator determined Petitioner had sustained accidental injuries involving her right *hand* and left knee in the findings contained on p.2 of his decision, but indicated at p.13 of the analysis section of his decision that Petitioner had sustained accidental injuries to her right *thumb* and left knee. The Commission also wishes to emphasize that Petitioner proved her current conditions of ill-being with respect to her right hand and/or wrist and left knee were causally related to the accident in question, but that Petitioner failed to prove causation with respect to her right knee.

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The Commission also corrects a clerical error in the Arbitrator's decision to show that Petitioner was temporarily totally disabled from 12/20/16 through 5/8/17, or a period of 20 weeks (not 20-1/7 weeks).

All else otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's decision dated 1/29/19 is affirmed and adopted with changes as stated herein.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $240.00 per week for a period of 20 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner reasonable and necessary medical expenses in the amount of $4,413.81, pursuant to §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 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:
o:12/3/19 JAN 16 2020
TJT/pmo
51

Thomas J. Tyrrell

Maria E. Portela

Kathryn A. Doerries

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

BURNS, CARA
Employee/Petitioner

Case# **16WC035202**

MANPOWER
Employer/Respondent

20IWCC0029

On 1/29/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.45% 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:

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

0481 MACIOROWSKI SACKMANN & ULRICH
ALAN MACIOROWSKI
105 W ADAMS ST SUITE 2200
CHICAGO, IL 60603

20IWCC0029

STATE OF ILLINOIS)
)SS.
COUNTY OF MC LEAN)

- [ ] 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)

CARA BURNS
Employee/Petitioner

v.

MANPOWER
Employer/Respondent

Case # **16** WC **35202**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Douglas McCarthy**, Arbitrator of the Commission, in the city of **Bloomington, IL**, on **12/20/18**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of 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] Is Petitioner entitled to any prospective medical care?
L. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

FINDINGS

On the date of accident, **10/12/16**, Respondent was operating under and subject 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 to the right hand and left knee.

Timely notice of this accident was given to Respondent.

Petitioner's current condition of ill-being regarding the right knee is not causally related to the accident. **The petitioner failed to prove a causal connection between the medical care and treatment provided and proposed to the right knee.**

In the year preceding the injury, Petitioner earned $360.00; the average weekly wage was $360.00.

On the date of accident, Petitioner was 41 years of age, single with **0** dependent children.

Respondent has paid all reasonable and necessary charges for all reasonable and necessary medical services for treatment to the right hand and left knee.

Respondent shall be given a credit of $2,168.58 for TTD, $ -0- for TPD, $ -0- for maintenance, and $9,579.69 for other benefits, for a total credit of $11,748.27.

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

ORDER

The petitioner's claim for medical care and treatment to the right knee or for prospective medical care to the right knee is denied based on the failure to show a causal connection between the injury in question and the treatment provided and requested.

The petitioner's average weekly wage is $360.00. See the Conclusions of Law on this issue.

The petitioner is entitled to TTD benefits based upon her injury to the right wrist from December 20, 2016 through May 8, 2017, a period of 20 1/7 weeks.

This decision will not act as a bar on determining the degree of disability, if any, to the petitioner's right hand or left knee.

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.

20IWCC0029

D. Douglas McCarthy

Signature of Arbitrator

1-24-2019
Date

ICArbDec19(b)

JAN 29 2019

CARA BURNS v. MANPOWER
16 WC 35202 – D/A: 10/12/16

20 IWCC0029

STATEMENT OF FACTS

At the time of the injury, the Petitioner was 41 years of age and employed on a temporary basis for Manpower. The Petitioner testified that she was hired to set up a dome for a tennis court. The Petitioner testified that the job was supposed to last for 4 days and she admitted that she was paid $9.00 an hour. The Petitioner testified that the job only took two days to complete.

The Petitioner testified that on October 12, 2016, she was setting up a tennis court dome. The Petitioner testified that she had to lift and pull a tarp to get it stretched out. She testified that it was damp and she fell forward onto her hands. Her legs and stomach also hit the ground. The Petitioner testified that she worked until the end of the day. The Petitioner testified that her knee did not hurt when she fell. She testified that she had aching and swelling but did return to work the next day.

The Petitioner first sought treatment at the St. Joseph Medical Center Emergency Room on October 24, 2016. The records from St. Joseph Medical Center were entered into evidence as Petitioner's Exhibit #2. The Petitioner provided a history of falling backwards onto her outstretched hand on October 11, 2016. Her primary complaint was right thumb pain. She provided an additional history of getting up after the initial fall and then falling again on her left knee. X-rays of the left knee revealed mild degenerative changes. Examination of the right hand revealed mild tenderness over the right snuffbox. The Petitioner made no complaints to the right knee; there was no examination performed or findings made. The diagnosis was right thumb sprain.

On cross-examination the Petitioner testified that she did not report the accident to the respondent until November 17, 2017. Introduced into evidence, as Respondent's Exhibit #7, was a pain diagram. Circled

on the pain diagram was the Petitioner's left knee. When asked to explain why the left knee was circled, the Petitioner testified that she was not facing the same way as the picture. The Petitioner denied signing the pain diagram, testifying that the signature was not as big as how she usually signs her name. The Petitioner admitted to having a prior right knee surgery in 1999 and receiving a workers' compensation settlement for same.

The Petitioner testified that after her initial encounter in the emergency room, she followed up with her primary care physician. PX 4 is a report from the OSF Medical Group showing an office visit on November 2, 2016. The note indicates the Petitioner was there to establish a care relationship. The Petitioner gave a history of her accident, stating that she fell forward and landed on her left knee. The left knee was examined and noted to show mild swelling and tenderness in the area of the patella. There is no mention of the right knee in the notes.

The Petitioner testified that she eventually came under the care of Dr. Lawrence Li. Dr. Li's records were entered into evidence as Petitioner Exhibit #3. The Petitioner was first examined by Dr. Li on December 9, 2016. She provided a history pf putting up a plastic dome tennis court. She slipped and injured both her wrists and knees. The right knee and wrist were the most severe. The left knee and wrist had gotten better. The Petitioner indicated that she went to the emergency room and they provided her with braces. X-rays of the right knee revealed mild osteoarthritis. Physical examination of the right knee revealed mild swelling, pain with palpation, and a positive McMurray's. The diagnosis was right knee meniscal or chondral injury and right wrist possible occult fracture.

An MRI of the right knee was performed on December 12, 2016. The impression was mild MCL sprain, multifocal chondromalacia, mild subtle blunting and fraying along the free edge of the posterior horn of

the medial meniscus, and the possibility of a small ill-defined horizontal tear of the posterior horn of the lateral meniscus.

An MRI of the right wrist was also performed on December 12, 2016. The findings were subtle mild patchy bone marrow edema in the lunate and capitate, edema in the dorsal and volar pericapsular soft tissues along the extrinsic ligaments, and small distal radiolunar joint effusion and small radiocarpal joint effusion.

The Petitioner returned to Dr. Li on December 20, 2016. She was provided with an injection into the right knee. Physical therapy was ordered.

The Petitioner's initial physical therapy session was completed on December 20, 2016. It was noted that the Petitioner was working as a housekeeper at Luther Oaks Nursing Home. The Petitioner also testified that she began to work for Luther Oaks Nursing Home the day after Thanksgiving 2016. The Petitioner testified that she continued to work in the position until Dr. Li placed her off from work.

The Petitioner returned to Dr. Li on January 30, 2017. She reported that the injection in her right knee helped for about a week. The diagnosis was right wrist boney contusions at the lunate and capitate with ligament sprains and right knee medial and lateral meniscus tears. Dr. Li removed the Petitioner from work. The Petitioner continued with therapy.

The Petitioner was examined by Dr. Li on February 27, 2017. She stated that the right wrist was responding to therapy but still had some discomfort. Her right knee was causing her a majority of the pain. Dr. Li recommended proceeding with right arthroscopic knee surgery. Physical therapy continued.

At the request of the Respondent, the Petitioner was examined by Dr. Steven Mash on March 8, 2017. Dr. Mash's report was entered into evidence as Respondent's Exhibit #4. She stated that she worked for Manpower. On October 11, 2016, she slipped and fell while tenting a piece of plastic. She landed on all fours. She originally complained of pain in both knees and wrists, but eventually noted pain in the right wrist and knee. The Petitioner admitted to a prior right knee arthroscopy in in 1999. Examination of both wrists revealed full range of motion. There was some vague tenderness noted over the base of the thumb. Examination of the right knee was completely normal. Dr. Mash reviewed previous medical records and diagnostic studies. The diagnosis was resolved sprain/strain of the right wrist and chondromalacia patella. Dr. Mash causally related the wrist sprain strain to the fall. With regard to the right knee, Dr. Mash opined that the Petitioner experienced a temporary exacerbation of a preexisting underlying condition. The doctor did not recommend any further treatment. He further opined that the Petitioner would be able to return to work without restriction. In his report, Dr. Mash also indicated that while at this office, the Petitioner complained of a limping gait and demonstrated some limp on range of motion. When Dr. Mash observed the Petitioner in the parking lot, she was ambulating without any difficulty at any time.

The Petitioner returned to Dr. Li on April 3. 2017. The right knee continued to be painful with no improvement. It was noted that the knee surgery was denied by the independent examiner. Physical therapy was continued. Dr. Li testified that he did not examine the wrist at that visit because it was improving but that he recommended that she continue to treat it with therapy. (PX 6 at 17)

On April 19, 2017, Dr. Mash issued a supplemental report after reviewing images of the MRI studies. The report was entered into evidence as Respondent's Exhibit #5. Based on a review of the MRI image, the doctor's previous opinion was not changed. He was still of the opinion that the Petitioner's knee

complaint is a temporary aggravation of a preexisting underlying condition and that no further testing or treatment was required.

The Petitioner was examined by Dr. Li on May 8, 2017. Her right wrist was doing well, and she no longer had the discomfort she previously had. The right knee was painful. Physical therapy was once again continued. Dr. Li testified that the right wrist had reached a point of maximum medical improvement as of that date. (Id at 23)

The Petitioner returned to Dr. Li on June 5, 2017. Her right wrist was doing well. She complained of pain in the right knee.

The Petitioner was examined by Dr. Li on August 1, 2017. Her right knee continued to bother her. It was noted that surgery was still pending the outcome of her workers' compensation case.

The Petitioner was last examined by Dr. Li on October 24, 2017. She continued to have pain with her right knee and had difficulty getting out of a chair. She was advised to return once litigation was completed. The Petitioner was to remain off from work.

The Petitioner testified that while she was treating for her knee, she also was diagnosed with breast cancer. The Petitioner testified that she took time off to treat for her breast cancer. She testified that she had not returned to work while treating for breast cancer.

Dr. Li testified via way of evidence deposition on June 22, 2017. Dr. Li testified that he was a board-certified orthopedic surgeon. He testified that he had an opportunity to treat the Petitioner; first examining her on December 9, 2016. At that time, she complained of right wrist and knee pain after

sustaining a fall while working for Manpower. Dr. Li testified that his exam findings were swelling and a positive medial and lateral McMurray's test on the right knee. Examination of the wrist revealed tenderness in the snuff box. Dr. Li testified that he was worried about a possible torn meniscus. Dr. Li testified that he ordered an MRI of the right knee and that it demonstrated that it showed some tearing along the posterior horn of the medial meniscus. He admitted that based on the MRI, he could not tell if the injury was acute or not. The doctor testified that he provided the Petitioner with an injection that provided temporary relief and an injection. Since conservative treatment did not provide any relief, the doctor recommended a right knee arthroscopy. Dr. Li testified that he took the Petitioner off from work beginning on December 20, 2016. Dr. Li testified that by May 8, 2017, her wrist problem had resolved, and he stopped treating her for same. Dr. Li testified that there was a direct causal relationship between the right wrist injuries and right knee injuries and the reported incident that occurred in October of 2016. Dr. Li testified that the Petitioner was not at maximum medical improvement and that the right knee arthroscopy would be causally related to the accident. On cross examination, Dr. Li admitted that the small joint effusion on the MRI could have existed prior to the injury. Dr. Li also admitted that the mucinous degeneration seen in the MRI image was degenerative in nature. Dr. Li admitted that he could not tell how long the chondromalacia was present. Dr. Li further admitted that he could not tell when the right knee lateral and medial meniscus tears occurred. On cross-examination, Dr. Li testified that the right wrist MRI did not reveal any fractures. Dr. Li testified that his opinion on causal connection was based solely on the history provided to him by the Petitioner. Dr. Li admitted that he did not know how the Petitioner fell. He did not know if the Petitioner fell to the ground or if she sustained a twisting injury. Dr. Li did not know what the Petitioner's work at Manpower entailed. On cross-examination, Dr. Li could not provide a specific restriction for the wrist or knee, other than she as to remain off from work. Dr. Li admitted that the December 9, 2016 exam and December 20, 2016 examinations were identical, but he only removed her from work after the December 20, 2016 exam.

Dr. Steven Mash testified by way of evidence deposition on October 12, 2017. Dr. Mash testified that he was a board-certified orthopedic surgeon. He testified that in his practice he treats conditions involving the upper and lower extremities. Dr. Mash testified that he examined the Petitioner on March 8, 2017. The Petitioner provided Dr. Mash a history of slipping and falling when tenting a piece of plastic. She fell forward and landed on all fours. She initially complained of difficulty with both wrists and both knees, but over time noted ongoing discomfort about the right wrist and right knee. The Petitioner admitted to a prior right knee arthroscopy in 1999. Dr. Mash testified that he was able to perform an examination of the right wrist and right knee. With regard to the right wrist, Dr. Mash observed vague tenderness to palpation at the base of the thumb on the right. Examination of the right knee revealed full range of motion, no effusion, intact ligaments, no joint line tenderness or meniscal localizing signs. The only positive finding was some grinding on rage of motion on the patellofemoral joint, which was found in both knees. Dr. Mash testified that the patellofemoral grind was indicative of arthritis. Dr. Mash indicated that the diagnosis was a sprain-strain right wrist resolved and chondromalacia patella both knees. With regard to causal connection, Dr. Mash testified that the wrist strain sprain-strain was related and had resolved. For the knee, it was a temporary aggravation of a preexisting underlying condition. Dr. Mash testified that the Petitioner needed no further treatment for the wrist and knee. Dr. Mash also testified that he had an opportunity to observe the Petitioner's gait walking into his office and walking out of his office. He testified that she walked into the office with a limp. Dr. Mash testified that his workstation overlooked the parking lot and he had an opportunity to watch the Petitioner leave. He testified that the limping gait she demonstrated in the examining room was not present when she left the office and walked back to her crowd. Dr. Mash testified that he does not watch every patient leave his office, but only does so when he suspicious of patient behavior. Dr. Mash testified that arthroscopy surgery would not be causally related. Dr. Mash testified that he issued a supplemental report om April 19, 2017 after reviewing the MRI films of the right knee. He testified that the MRI did not reveal any acute injury and his opinion was not changed in any way.

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

On October 12, 2016, the Petitioner testified that she was employed by Manpower to set up a dome tennis court. She testified that the conditions were slippery, and she fell forward onto her bilateral hands, bilateral knees and stomach. Despite this fall, the Petitioner continued to work the rest of the day. The Petitioner also returned to work the next day.

The Petitioner did not seek medical attention until October 24, 2016; almost two weeks after the fall. When the Petitioner presented to the emergency room, she only complained of right hand and left knee pain. There was no mention of any right knee pain within the emergency treatment record. Furthermore, the history provided to the emergency room physician was of falling backwards and not forwards. The record then details a second fall in which the Petitioner slips and falls directly on her left knee. The diagnosis was limited to a right thumb sprain. A right or left knee examination was not even performed.

When the Petitioner was next seen for care on November 2, 2016, she again complained of left knee pain with no reference to her right knee. She gave a history of falling on her left knee. (PX 4)

The Petitioner did not report the alleged accident to her employer until November 17, 2016. At that time, she filed out a pain diagram circling the left knee and right hand. (RX 7) This is consistent with the emergency room records from October 24, 2016. Again, there were no complaints involving the right knee. The Petitioner also testified that the day after Thanksgiving 2016, she accepted full time

employment as a house keeper for a nursing home. The Petitioner continued to work in that position until Dr. Li removed her from work at the end of 2016.

The Petitioner did eventually come under the care of Dr. Lawrence Li on December 9, 2016. At that time, the Petitioner indicated that the emergency room provided her with braces, but the emergency records do not reflect same. X-rays of the right knee revealed arthritic findings.
The MRI films of the right knee do not conclusively demonstrate a meniscal tear, but merely raise the possibility of same.

After the initial evaluation, the Petitioner underwent a conservative course of treatment that included an injection and therapy. Despite the conservative treatment, the Petitioner continued to complain of pain and a recommendation for right knee surgery was made by Dr. Li.

Dr. Li provided his opinion as to causal connection via evidence deposition. Dr. Li admitted that his opinion as to causal connection was based on the Petitioner's provided history. Dr. Li did not know how the Petitioner fell or if she sustained a twisting injury. Furthermore, Dr. Li admitted that the small joint effusion on the MRI could have predated the accident and that he was unable to determine from the MRI films when the possible meniscal tears occurred. Dr. Li also said that it was his understanding that her pain, including her right knee pain began right after her accident. (PX 6 at 58)

Dr. Mash's right knee examination was completely normal. The observed grinding was evidence of preexisting arthritis that predated the accident. Dr. Mash testified that the MRI films of the right knee did not reveal any acute injury. Importantly, Dr. Mash observed obvious signs of symptom magnification. He noted the Petitioner walked into his office with a noticeable limp but was later observed in the parking lot to be walking without apparent distress.

After the accident, the Petitioner took full time employment as a housekeeper for a nursing home. There was no testimony or evidence presented that the Petitioner's right knee complaints prevented her from working in a full duty capacity. Per the Petitioner's own admission, she continued to work in a full duty capacity until Dr. Li removed her from work.

The Arbitrator finds that the petitioner did sustain accidental injuries to her right thumb and left knee. As to the issue of the right knee, the Arbitrator finds that the petitioner has failed to prove that the right knee was injured in the alleged injury.

In support of this finding, the Arbitrator cites the conflicting histories between the petitioner's testimony of falling forward on both knees and the history in the emergency room of falling backwards with no mention of injuring the right knee or complaints or findings to the right knee; the admissions by Dr. Li that the findings in question could have predated the injury; and lastly, the testimony of Dr. Mash which the Arbitrator found to be more convincing than that of Dr. Li.

G. ☒ What were Petitioner's earnings?

Petitioner's unrebutted testimony was that she was hired to perform a short- term job for $9.00 an hour. The rate is confirmed by the pay records entered into evidence by the Respondent. (RX 1) She testified again without rebuttal that she was to work 8 hours per day. The job was expected to take four days, but in fact only took a day and a half.

Under Section 10 of the Act, this job would be characterized as being short termed in nature. The Arbitrator believes the above evidence establishes that the AWW is $9.00 times 40 or $360.00.

J. ☒ Were 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 all reasonable and necessary medical services related to the wrist. The Arbitrator based on his finding of no causal connection to the right knee finds the issue moot, and therefore, makes no further comment.

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

The Arbitrator finds that based on the above, the Petitioner requires no further care for the right wrist. The Arbitrator based on his finding on no causal connection to the right knee finds the issue moot, and therefore, makes no further comment.

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

The Arbitrator finds that the Petitioner was off work under the care of Dr. Li from December 20, 2016 through May 8, 2017 for his right wrist injury. He was taking physical therapy for that injury until said date. The treatment was reasonable for the injuries diagnosed. The Arbitrator finds the opinions of the treating doctor more persuasive than those of the examining doctor on this issue.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Edward Staples,

Petitioner,

vs.

NO: 17 WC 4007

20IWCC0030

State of Illinois Department of Transportation,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of permanent partial disability, 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 January 24, 2019, 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: JAN 16 2020
TJT:yl
o 1/7/20
51

Thomas J. Tyrrell

Maria E. Portela

Kathryn A. Doerries

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

STAPLES, EDWARD
Employee/Petitioner

Case# **17WC004007**

IL DEPT OF TRANSPORTATION
Employer/Respondent

20IWCC0030

On 1/24/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.45% 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:

1580 BECKER SCHROADER & CHAPMAN PC
TODD SCHROADER
3673 HWY 111 PO BOX 488
GRANITE CITY, IL 62040

0502 STATE EMPLOYEES RETIREMENT
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 FL
CHICAGO, IL 60601-3227

1430 CMS BUREAU OF RISK MANAGEMENT
WORKERS' COMPENSATION MANGER
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

JAN 24 2019

Brendan O'Rourke, Assistant Secretary
Illinois Workers' Compensation Commission

08

20 IWCC0030

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

Edward Staples
Employee/Petitioner

v.

Illinois Department of Transportation
Employer/Respondent

Case # 17 WC 04007

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 William R. Gallagher, Arbitrator of the Commission, in the city of Collinsville, on November 30, 2018. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ 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 24, 2016, Respondent was operating under and subject 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 $66,763.07; the average weekly wage was $1,283.91.

On the date of accident, Petitioner was 49 years of age, married with 1 dependent child(ren).

Petitioner has received all reasonable and necessary medical services.

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

Respondent shall be given a credit of $3,913.00 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $3,913.00.

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 14, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit of amounts paid for medical benefits that have been paid and Respondent shall hold Petitioner harmless from any claims by any providers of 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 $855.94 per week for four and four-sevenths (4 4/7) weeks commencing September 15, 2016, through October 16, 2016, as provided in Section 8(b) of the Act.

Based upon the Arbitrator's Conclusions of Law attached hereto, no permanent partial disability 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.

William R. Gallagher

William R. Gallagher, Arbitrator

January 22, 2019

Date

JAN 24 2019

Petitioner filed an Application for Adjustment of Claim which alleged he sustained an accidental injury arising out of and in the course of his employment by Respondent on August 24, 2016. According to the Application, Petitioner tripped and hurt his left knee (Arbitrator's Exhibit 2). Respondent disputed liability on the basis of accident and causal relationship. In regard to temporary total disability benefits, Petitioner claimed he was entitled to temporary total disability benefits of four and four-sevenths (4 4/7) weeks, commencing September 15, 2016, through October 16, 2016. At trial, Petitioner and Respondent stipulated that Petitioner was totally disabled for that aforestated period of time (Arbitrator's Exhibit 1).

Petitioner worked for Respondent as a highway maintainer. On August 24, 2016, Petitioner was working at the scene of an accident that occurred on I 270. A semi truck was driven through a section of highway retention cable in the median. Petitioner testified he was walking in the median and one of the hooks that held the cable in place was sticking up. Petitioner did not see it because of the grass and he caught it with his left foot. This caused Petitioner stumble forward, but he did not fall to the ground. Petitioner stated another employee, Darion Douglas, was present and witnessed the accident. Douglas did not testify when this case was tried.

August 24, 2016, was a Wednesday and Petitioner was able to work the remainder of that day as well as Thursday, August 25, and Friday, August 26, 2016, without any significant symptoms. Petitioner stated he began to experience left knee swelling on Saturday, August 27, 2016, and took some over-the-counter medication.

Petitioner initially sought medical treatment on August 30, 2016, at the ER of Gateway Regional Medical Center. At that time, Petitioner stated he had left knee and leg pain/swelling since Saturday and advised the symptoms began at home and "...resulted from an unknown cause." It was also described as not being "... a work related injury." Petitioner was diagnosed with either deep vein thrombosis (DVT) or cellulitis. A vascular Doppler ultrasound was performed on Petitioner's left leg which was negative for deep vein thrombosis. Petitioner was given a prescription for antibiotics and discharged (Petitioner's Exhibits 1 and 6).

Petitioner subsequently sought medical treatment at Parkland Health Center in Farmington, Missouri, on September 4, 2016. At trial, Petitioner testified he owned a cabin in the Farmington area. Petitioner testified his left knee had become swollen and when he went to Parkland Health Center, fluid was drained from his left knee.

According to the Parkland record, Petitioner had pain/swelling in the left knee, but did not advise that he had sustained a work-related injury. Fluid was drained from Petitioner's left knee. Another Doppler ultrasound was performed which was also negative for deep vein thrombosis. Petitioner was referred to Dr. Scott VanNess, an orthopedic surgeon (Petitioner's Exhibits 2 and 7).

Dr. VanNess saw Petitioner on September 7, 2016. At that time, Petitioner advised he injured his left leg on August 24, 2016, when his left foot hit a pin coming out of a cable guard. Petitioner stated he did not think much of it at the time it occurred, but then over the next three days, he had

swelling/pain in the left knee/leg. Dr. VanNess opined Petitioner had either internal derangement of the knee or a plantaris injury. He ordered an MRI scan of the left knee (Petitioner's Exhibit 3).

The MRI was performed on September 7, 2016. According to the radiologist, there was small joint effusion and fluid collection within the proximal soleus muscle. The impression was a healing muscle tear of the proximal soleus muscle (Petitioner's Exhibit 10).

Dr. VanNess saw Petitioner on October 12, 2016. At that time, he administered an injection in Petitioner's left knee and recommended physical therapy. Dr. VanNess saw Petitioner on November 9, 2016. Petitioner still had left knee pain, but on examination, the range of motion was full (Petitioner's Exhibit 3).

Dr. VanNess again saw Petitioner on November 30, 2016. At that time, Petitioner continued to complain of pain/swelling in the left knee. Dr. VanNess administered another injection in the left knee. Dr. VanNess last saw Petitioner on December 28, 2016, and noted he was going to refer Petitioner to a physician in Illinois (Petitioner's Exhibit 3).

Petitioner was subsequently evaluated by Dr. Dennis Dusek, an orthopedic surgeon, on June 28, 2017. Petitioner informed Dr. Dusek of a work-related accident, although Dr. Dusek's record noted it had occurred on August 26, 2016. Petitioner complained of intermittent pain/swelling in the left knee. Dr. Dusek's findings on examination were benign and he noted Petitioner had very muscular legs and calves. He opined Petitioner may have sustained a rupture of the plantaris muscle rather than the soleus. He noted Petitioner may have sustained a torn meniscus which may have been missed by the prior MRI scan. He ordered another MRI (Petitioner's Exhibit 4).

The MRI was performed on June 28, 2017. According to the radiologist, it was normal (Petitioner's Exhibit 11).

At the direction of Respondent, Petitioner was examined by Dr. Richard Lehman, an orthopedic surgeon, on January 16, 2018. In connection with his examination of Petitioner, Dr. Lehman reviewed medical records provided to him by Respondent. At that time, Petitioner complained of "...mild popping in the anterior aspect of the knee" but Petitioner had been working without difficulty. Dr. Lehman opined Petitioner had sustained a gastroc-soleus strain, but that it had completely resolved by the time of his examination. He opined Petitioner's "mild popping" of his left knee was not related to the accident of August 24, 2016 (Respondent's Exhibit 1; Deposition Exhibits 2 and 3).

Dr. Dusek was deposed on October 30, 2018, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Dusek's testimony was consistent with his medical record. Dr. Dusek noted that the MRI of June 28, 2017, was negative, but he also testified Petitioner had injured the plantaris tendon, which was a very small tendon below the area where the MRI was performed and probably would not have been revealed because of its small size (Petitioner's Exhibit 13; pp 6-9).

Dr. Dusek described the mechanics of the injury and testified that when Petitioner slammed his foot down was when the tendon popped. In regard to the delay of Petitioner's left knee symptoms, Dr. Dusek described it as a very subtle injury and was not disturbed by the delay in Petitioner having complaints (Petitioner's Exhibit 13; pp 10-11).

Dr. Lehman was deposed on November 29, 2018, and his deposition testimony was received into evidence at trial. Dr. Lehman's deposition testimony was consistent with his medical reports and he reaffirmed the opinions contained therein. Dr. Lehman testified Petitioner sustained a gastroc soleus strain on August 24, 2016, but it had totally resolved by the time of his examination of Petitioner. He also stated that the minor popping Petitioner complained of was not related to the gastroc soleus strain (Respondent's Exhibit 1; pp 15-16, 20).

At trial, Petitioner agreed he was able to return to work to his normal job. He still has complaints of swelling when standing as well as grinding/popping in the left knee.

Conclusions of Law

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

The Arbitrator concludes Petitioner sustained an accidental injury arising out of and in the course of his employment by Respondent on August 24, 2016.

In support of this conclusion the Arbitrator notes the following:

Petitioner's testimony regarding the circumstances of the accident of August 24, 2016, was unrebutted.

Petitioner testified the accident was witnessed by another employee, Darion Douglas. Respondent did not have Douglas testify at trial.

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

The Arbitrator concludes Petitioner's current condition of ill-being is not causally related to the accident of August 24, 2016.

In support of this conclusion the Arbitrator notes the following:

Petitioner did not report having sustained a work-related injury when he sought medical treatment on August 30 and September 4, 2016. It was not until he was evaluated by Dr. VanNess on September 7, 2016, that he attributed his left knee symptoms to the accident of August 24, 2016.

Dr. Dusek opined Petitioner sustained an injury to the plantaris muscle which he described as being very subtle and was not disturbed by the delay in Petitioner's delay of his onset of symptoms.

Respondent's Section 12 examiner, Dr. Lehman, opined Petitioner had sustained a gastroc soleus strain as a result of the accident of August 24, 2016.

Dr. Dusek only saw Petitioner on one occasion, June 28, 2017, and while he opined Petitioner had sustained a plantaris muscle strain, he did not opine as to whether Petitioner would have any ongoing complaints/symptoms thereafter.

Dr. Lehman testified that Petitioner's left knee popping was not related to the gastroc soleus strain he sustained as result of the accident of August 24, 2016. This was the only expert medical opinion in regard to causality of Petitioner's current symptoms.

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

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

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibit 14, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit of amounts paid for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of 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 Petitioner is entitled to temporary total disability benefits of four and four-sevenths (4 4/7) weeks, commencing September 15, 2016, through October 16, 2016.

In support of this conclusion the Arbitrator notes the following:

Petitioner and Respondent stipulated Petitioner was disabled during the aforestated period of time.

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

Based upon the Arbitrator's conclusion of law in disputed issue (F) the Arbitrator concludes Petitioner sustained no permanent partial disability as a result of the accident of August 24, 2016.

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF LASALLE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

LINDA ESTES,

Petitioner,

vs. NO: 12 WC 28133

OWENS ILLINOIS INC.,

Respondent.

20IWCC0031

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 9, 2018, 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.

50 IA.CC003

Pursuant to §19(f)(2) of the Act, no bond for removal of this cause to the Circuit Court by Respondent is required as the Commission entered no award for payment of money. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JAN 16 2020
KAD/mav
O: 11/19/19
42

Kathryn A. Doerries

Thomas J. Tyrrell

Maria E. Portela

50IACC003I

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ESTES, LINDA
Employee/Petitioner

Case# **12WC028133**

11WC032025
13WC005771

OWENS ILLINOIS, INC
Employer/Respondent

20IWCC0031

On 8/9/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.18% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1097 SCHWEICKERT & GANASSIN
SCOTT J GANASSIN
2101 MARQUETTE RD
PERU, IL 61354

0075 POWER & CRONIN LTD
ROBERT LUEDKE
900 COMMERCE DR STE 300
OAK BROOK, IL 60523

STATE OF ILLINOIS)
) SS.
COUNTY OF KANKAKEE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Linda Estes
Employee/Petitioner

v.

Owens Illinois
Employer/Respondent

Case # **12** WC **28133**
(Consolidated cases: **11** WC **32025** & **13** WC **5771**

20IWCC0031

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Christine Ory**, Arbitrator of the Commission, in the city of **Ottawa on September 26, 2016** and closed proofs in **Kankakee on October 26, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

[redacted]IWCC[redacted]

FINDINGS

On **August 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 accidents ***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 $**1,600.00**; the average weekly wage was $**800.00**.

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

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

Respondent ***does not owe*** for all appropriate charges for all reasonable and necessary medical services for which they are liable.

To date, Respondent has paid $ **0** in TTD and/or for maintenance benefits, and is entitled to a credit for any and all amounts paid.

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

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

ORDER

Petitioner failed to prove she sustained accidental injuries to her right wrist that arose out of and in the course of her employment with respondent on august 1, 2012, or at any time.

Petitioner's claim is hereby denied and case is dismissed.

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.

Christine M Ory

Signature of Arbitrator

ICArbDec p. 2

August 8, 2018

Date

AUG 09 2018

12 WC [redacted] Estes v. Owens Illinois

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Linda Estes	)	
Petitioner,	)	
	)	
vs.	)	**No. 12 WC 28133**
	)	
Owens Illinois.	)	
Respondent.	)	
	)	**20IWCC0031**

ADDENDUM TO ARBITRATOR'S DECISION
FINDINGS OF FACTS AND CONCLUSIONS OF LAW

This matter was heard in Ottawa on September 26, 2016 and proofs were closed in Kankakee on October 26, 2016.

[The parties asked for the decision not to be written as they were trying to resolve the case. Finally, in September, 2017, when respondent's counsel was appointed Arbitrator, proposed findings were submitted.]

The parties agree that on August 1, 2012, petitioner and respondent were operating under the provisions of the Illinois Workers' Compensation Act; that petitioner earned $41,600 in the year pre-dating the claimed accident; and her average weekly wage, as calculated pursuant to § 10 of the Act was $800.00

At issue in this case is:

1. Whether the petitioner sustained accidental injuries that arose out of and in the course of her employment with respondent;
2. Whether petitioner gave timely notice of the accident.
3. Whether petitioner's current condition of ill-being is causally connected to the claimed injury.
4. Whether respondent is liable for the unpaid medical bills.
5. Whether petitioner is due temporary total disability.
6. The nature and extent of injury.
7. Whether petitioner is entitled to penalties and attorneys' fees.

STATEMENT OF FACTS

Petitioner, Linda Estes, Testimony

At time of hearing, petitioner had been employed for eight and one-half years for respondent. For the first three years she worked as a bulk operator and carton maker. The last job she performed was relief process checker.

A bulk operator is responsible for the machine that loads glass bottles onto a pallet platform. As each tier of bottles is complete, the bulk operator places a four-foot by five-foot cardboard tier sheet on top of the loaded bottles for the next tier of bottles. This is repeated until

the pallet is fully loaded. The pallet operator secures the pallet with a wood top frame and moves onto a new pallet. Over an eight-hour shift, a bulk operator handles and positions 500 tier sheets and 48 top frames.

A carton maker lifts bundles containing 30 flattened 2" X 4" cardboard boxes into a machine that unfolds and assembles them for packing. This process is done 600 times in an eight-hour day.

Thereafter, for the next four years after bulk operator/carton maker, petitioner was a process checker. At the beginning of each shift, the process checker pulls a "set out" of 20 glass liquor bottles to inspect. The process checker completely examines each bottle, using his or her hands to check for sharp edges. This, according to petitioner, requires 25 hand rotations per bottle for all 20 bottles that were pulled for inspection. This process was done every hour during an eight-hour shift.

The process checker also uses a gage, called a magna mike, to check he thickness and height of the bottle. This requires manipulation with her hands. The process checker grabs four bottles at a time, two in each hand, to check. The process checker checks 24 defective bottles per shift to insure the gauges are accurate.

On April 7, 2011, petitioner was working as a bulk operator in relief of another employee. She had pulled down a number of tier sheets to the floor. As they hit the floor, the bounded back, bending her pinky and ring fingers back, causing pain. She reported the injury to Brian Layman. She asked to go for treatment. She was finally able to get treatment on April 14, 2011, when she went to St. Mary's Hospital. X-rays showed a fracture of the finger. She was put in a splint and placed on light duty. She followed up with Dr. Speca in May, 2011 at St. Mary's Hospital. She was taped and kept on light duty.

Thereafter, she went to Dr. Ortinau with Rezin Orthopedics. Although she was still in a ring and pinky finger splint, she was released to return to full-duty work by Dr. Ortinau. She was sent for a MRI of the right hand in August, 2011. She was then sent by Dr. Ortinau to Dr. Carroll. She was seen by Dr. Carroll in December, 2011.

Petitioner became a full time process checker in October, 2011. On December 20, 2011, petitioner reported her claimed injury to the safety manager.

Petitioner obtained an EMG on February 1, 2012 at the request of Dr. Ricca. She then saw orthopedic surgeon, Dr. Sinha, on March 7, 2012. Petitioner provided a work history to Dr. Sinha. Dr. Sinha performed a release of petitioner's right carpal tunnel syndrome on April 27, 2012.

In August, 2012, petitioner was seen by Dr. Ricca with numbness and tingling in her left hand. She had another EMG by Dr. Garg on September 5, 2012. She was referred by Dr. Ricca to Dr. Blair Rhode, whom she saw on September 24, 2012. She provided a job description to Dr. Rhode. She underwent another EMG to her left elbow, which was by Dr. Trudeau on October 29, 2012. On March 26, 2013, Dr. Rhode performed surgery to petitioner's left elbow. She also underwent a debridement in April, 2013. She was released to return to full duty work on June 28, 2013.

Petitioner continued to have pain and discomfort in her left elbow. On March 4, 2014, petitioner had another EMG by Dr. Trudeau. She underwent a revision of the left elbow surgery and carpal tunnel surgery. This improved her condition.

She was released from Dr. Rhode's care in October, 2014.

Petitioner confirmed she was examined by Dr. Eilers, at her attorney's request. She was cooperative. The exam took a half hour to an hour. She underwent two §12 exams with Dr. Ramsey Ellis; each lasting only15 minutes. She did not give details of her job to Dr. Ellis.

20 IWCC0031

She continues to have occasional pain in her hands.

On cross-examination, she confirmed she use a micrometer to check bottles. She would put the bottles on a cart to transport them to test. She turned the bottles with her thumbs. She occasionally picked up the bottle. She also was a carton maker and bulk operator. None of the jobs required use of power tools or air hammers. She did not push hands against resistance. She also did not use vibrator tools.

Petitioner agreed she was released to full duty work as of June, 2011 after her injury of April 7, 2011.

Petitioner confirmed she was seen by the HSHS Medical Group on January 17, 2014 due to neck pain, but was also having pain in lower left arm and numbness and fingers on left hand. Petitioner confirmed the neck condition was not related to a work accident. She was not sure the cause of the neck condition. She underwent a cervical MRI on December 12, 2013.

On rebuttal, petitioner testified that the video did not accurately depict the work she performed for respondent. She testified she used 8000 or 9000 hand movements per an eight-hour day. She disagreed with the number of bottles checked; she testified she checked 125 bottles per hour.

Jeffrey Donnell Testimony

Jeffrey Donnell, employed by respondent for eight years, testified in behalf of respondent. He is a line leader and presides over one line, which is from batch to forming to packaging to quality control. There are four lines at respondent's location in Streator Illinois.

He had performed the job of processor checker, bulk operator and carton maker. He sees this job performed every day.

Donnell agreed that the video identified as Respondent's Exhibit 8, depicts the job of process checker even though the some of the machines shown in the video were no longer used by respondent. Donnell confirmed petitioner would have to pull 20 bottles per hour to perform the inspection performed in the video. Respondent ran the liquor bottles identified in the photos from Petitioner's Exhibit 15A/16 and 15B/17 for only a year.

Medical Bills (PX.1)

Petitioner claims a total medical bills of $176,850.11 for all three claims, of which $115,015.54 remain outstanding.

St. Mary's Orthopedics Records (PX.2)

Petitioner was first seen by orthopedist, Dr. John M. Speca, on May 13, 2011 for the finger injury. She reportedly hyperextended her fingers when pulling cardboard sheets at work on April 7, 2011. X-rayed showed a nondisplaced fracture at the volar lip of the proximal end of the middle phalanx; this was the diagnosis. She was put on light duty as the fracture had not healed.

Petitioner was seen again on May 27, 2011. The diagnosis was nondisplaced volar lip avulsion fracture of the proximal end of the middle phalanx of the ring finger. She remained on restricted duty.

Rezin Orthopedics Records (PX.3)

Petitioner was first seen by Dr. Eric Ortinau on June 20, 2011 with complaints of left fourth finger pain. The middle phalanx fracture was healed. She was sent for hand therapy and released to return to work full-time; full-duty.

She was seen again on July 18, 2011. She was making good strides. She was to continue OT and continue full-time, full-duty work.

On August 23, 2011, petitioner was noted to have stiffness with contracture at the PIP joint. An MRI was ordered.

The August 29, 2011 MRI showed mild ill-defined bone edema, 2 mm area of subchondral cystic change and a remote sprain of the PIP joint radial collateral ligament.

At the September 6, 2011, petitioner lacked approximately 10 degrees' full extension of the left ring finger. She was referred to Dr. Carroll at her request.

Northwestern Orthopedic Institute/Dr. Charles Carroll Records (PX.4)

Petitioner was first seen by Dr. Carroll for a second opinion on December 12, 2011. Dr. Carroll's diagnosis was a stable PIP injury to the left ring finger. Dr. Carroll determined there was no further testing or further therapy, other than home stretching and use of LMB splint, necessary. Dr. Carroll believe petitioner would reach MMI within two to three months.

Petitioner returned to Dr. Carroll on August 1, 2012. Dr. Carroll reported no provocative testing noted for carpal tunnel syndrome, pronator syndrome, cubital tunnel syndrome or radial nerve compression at elbow or wrist. Diagnosis was stable PIP injury left ring finger, and also ulnar neuritis. She was to return PRN.

ATI Physical Therapy Records (PX.5)

Petitioner received physical therapy to the left fourth finger from June 21, 2011 through August 11, 2011.

St. Mary's Hospital Records (PX.6)

[These records included over hundreds of pages of superfluous and irrelevant documents. The discussion of this exhibit is limited to only the relevant pages that were identified amount the volume of non-relevant documents.]

On April 14, 2011, petitioner was seen by Dr. Amit Garg for the left finger injury. X-rays showed a small avulsion fracture along the ventral based of the left middle fourth phalanx.

Petitioner returned to Dr. Garg for follow up treatment of the left fourth finger on May 2, 2011. X-rays showed non displaced chip fracture along the palmer base of fourth middle phalanx.

On September 21, 2011, petitioner was seen in urgent care by Dr. Amit Garg. She reported she had ongoing pain in the third digit of the left hand. She was instructed to follow up with hand specialist. A referral was made to Dr. Charles Carroll.

Petitioner presented to the emergency department with right wrist numbness on December 20, 2011. Petitioner reported it started at 7:30 that morning at home. A Cat scan of the brain was performed. Diagnosis was paresthesia with peripheral neuropathy of the right hand and wrist.

Petitioner was admitted to the hospital on April 27, 2012 for severe right carpal tunnel release of the right hand. Petitioner had a history of numbness and tingling along the medial nerve distribution of the right hand that had been going on for several months. The EMG showed mild carpal tunnel on the right and none on the left. The surgical order form indicates the right carpal tunnel condition was not related to work.

Dr. Upendra K. Sinha Records (PX.7)

The February 1, 2012 EMG/NCV showed mild carpal tunnel syndrome of the right hand and normal on the left.

On April 27, 2012, Dr. Sinha performed a carpal tunnel release for severe carpal tunnel syndrome of the right hand. According to the history and physical at the time of admission to St. Mary's Hospital on April 27, 2012, petitioner claimed she had tingling and numbness along the median nerve distribution for the last many years; and in the last several months she has had more symptoms.

Petitioner underwent post-operative physical and occupational therapy in May and June, 2012.

Dr. Edward Trudeau Records (PX.8)

The October 29, 2012 EMG/NCV study done by Dr. Edward Trudeau showed ulnar neuropathy at the left elbow (cubital tunnel syndrome). Petitioner related the problem to the April 7, 2011 work injury.

The EMG/NCV study done by Dr. Trudeau on March 4, 2014, showed ulnar neuropathy of the left elbow, which was improved over the previous study of 10/29/2012, median neuropathy of the left wrist (carpal tunnel syndrome) which was new since 10/29/2012 study and mild left medial antebrachial cutaneous neuropathy. Again, petitioner related the condition back to her April 7, 2011 injury.

Parkview Family Practice/Glen L. Ricca Records (PX.9)

The December 20, 2011 ER report from St. Mary's Streator indicate petitioner reported right hand and wrist pain that started that morning at 7:30 AM at home.

On December 28, 2011, petitioner followed up with Dr. Ricca after ER visit of December 22, 2011.

Petitioner obtained an EMG on February 1, 2012 at Dr. Ricca's request for pain in both hands. The EMG/NCV showed mild right carpal tunnel syndrome and none on the left.

Petitioner was seen on August 8, 2012, due to paresthesia tingling left 4th and 5th fingers. She reportedly moved bottles all day while working for respondent.

The September 5, 2012 NCV/EMG report was negative.

On September 11, 2012, petitioner was seen for paresthesia tingling left fourth and fifth finger; symptoms persist even though the nerve conduction study was normal.

On October 3, 2012, petitioner reported to the emergency room with a history of pain in her right hand for two to three days. She reportedly hit her head (sic) on the porch rail at home.

Petitioner followed up with Dr. Ricca on October 9, 2012, after ER visit of October 3, 2012 for right hand trauma after striking it against an object.

Petitioner underwent a pre-op physical on March 20, 2013.

Orland Park Orthopedics Center for Sports Medicine/Dr. Blair Rhode Records (PX.10)

Petitioner first saw Dr. Blair Rhode on September 24, 2012 with the history of suffering a fracture of the left ring finger on April 7, 2011. Diagnosis was hand and elbow pain, cubital tunnel syndrome and closed fracture of distal finger.

She was seen again on September 26, 2012. An MRI of the left ring finger on September 26, 2012 showed chondromalacia involving the ring finger. She returned on September 28, 2012 for hand and elbow pain. She saw Dr. Rhode after the MRI on November 12, 2012. On November 20, 2012, she was given an injection into the cubital tunnel and splinted. On December 8, 2016, she advised the injection only gave her temporary relief. Left cubital tunnel surgery was proposed.

Petitioner underwent left cubital tunnel release on March 28, 2013. She followed up on April 4, 2013 and April 29, 2013.

She had additional surgery on April 30, 2013 for left elbow irrigation and debridement with closure of the wound.

She followed up on May 16, 2013, May 20, 2013 and May 30, 2013. On June 27, 2013, petitioner was released to return to work full duty on a trial basis. On July 24, 2013 petitioner was doing well performing her regular work. She was released from Dr. Rhode's care, having reached MMI.

On January 10, 2014 petitioner returned with significant symptoms in her elbow. The diagnosis was medial epicondylitis. She returned on February 8, 2014 with ongoing symptomology. An EMG was prescribed. She was seen on March 19, 2014, S/P EMG which showed persistent cubital tunnel and carpal tunnel syndrome. On April 17, 2014 a repeat surgery was discussed. On May 2, 2014 and May 15, 2014, additional surgery was proposed.

Petitioner underwent left open carpal tunnel release and cubital tunnel release revision with sub muscular transposition. She received follow up care on June 12, 2014, July 10, 2014, August 7, 2014, September 7, 2014. On October 2, 2014, petitioner was released to full duty work and determined to be at MMI.

Memorial Medical Center Report (PX.11)

The report is also contained in Petitioner's Exhibit 8.

Results Physical Therapy and Fitness Records (PX.12)

Physical therapy records from July and August, 2014.

Physical Medicine and Rehabilitation Associates/Dr. Robert Eilers Report (PX.13)

Dr. Robert Eilers examined petitioner on August 11, 2015. He reviewed treating medical records, including EMGS and operative reports, as well as MRIs. Petitioner provided a history that on April 7, 2011, she was lifting 4 x 5 feet cardboard pieces, she bent her left hand backwards resulting in extension in injury to the fourth digit of her left hand.

On December 20, 2011, petitioner was having numbness and tingling in her hands and was diagnosed with carpal tunnel syndrome by Dr. Garg and referred to Dr. Ricca.

She reportedly worked with respondent as a lab process checker on the line doing various checking of bottles hourly and reporting defects, using gauges, cutting bottles with hot wire and emptying glass into the cullet. She reportedly lifted up to 30 pounds, which she did 10 to 30 times a day.

Dr. Eilers concluded petitioner avulsion fracture of the ventral base of the left mid fourth phalanx as a result of the April 7, 2011 work accident, with some acceleration of degenerative changes at the MCP and PIP joints, and enlargement of the pip joint.

Dr. Eilers concluded petitioner developed carpal tunnel syndrome on December 20, 2011, of the right hand and underwent carpal tunnel surgery on April 27, 2012, as a result of the work activities.

Dr. Eilers also concluded petitioner developed cubital tunnel syndrome on the left as a result of the repetitive activity, which necessitated cubital tunnel release performed on March 26, 2013, as well as additional surgery on April 30, 2013 to reclose the wound dehiscence from the March 26, 2013 surgery. Petitioner also had to undergo revision of the cubital tunnel release and a sub muscular transposition done on May 27, 2014.

In conclusion, Dr. Eilers determined petitioner sustained bilateral carpal tunnel syndrome and left cubital tunnel syndrome, which required surgical releases, and subsequent transposition. She also had some acceleration of her degenerative arthritis from the fracture of the fourth left digit. All of these conditions Dr. Eilers related to petitioner's employment activities with respondent.

Dr. Blair A. Rhode April 13, 2016 Deposition (PX.14)

Dr. Blair Rhode testified in behalf on petitioner via deposition on April 13, 2016. He is board certified in orthopedic surgery, sports medicine and from the American Board of Independent Medical Examiners (5).

Petitioner was first seen by Dr. Rhode on September 24, 2012. She reportedly injured her left ring finger when she was manipulating heavy cardboard on April 7, 2011, causing the finger to snap back resulting in a fracture. She continued to work and her symptoms did not significantly improve. (5-6)

Petitioner advised Dr. Rhode she developed medial-sided elbow pain with numbness and tingling to the ring and little finger on the left. The September 5, 2012 EMG showed no evidence of left-sided cubital tunnel syndrome. Dr. Rhode recommended another MRI. (6-7)

Dr. Rhode confirmed petitioner had not provided him with a history of right carpal tunnel surgery by Dr. Sinha in April, 2012. He had obtained this information from the medical records (7-8).

On November 28, 2012, petitioner related that she was required to pick up and inspect 12-ounce bottles at a rate of 400 to 500 per minute. She advised the cubital tunnel [on the left] symptomology developed in March or April. She developed the symptoms [on the left] from compensating from the right carpal tunnel condition, (9)

Dr. Rhode reported the October 29, 2012 EMG showed a moderately severe cubital tunnel syndrome (10). Eventually Dr. Rhode performed a left cubital tunnel release on March 26, 2013 after a course of conservative treatment (10-11). On April 30, 2013, Dr. Rhode performed an irrigation and debridement procedure at the operation site due to post-operative drainage (11). Petitioner was off work from the date of the surgery of March 26, 2013 until July 24, 2013, at which time Dr. Rhode deemed her to be at MMI (12).

Petitioner returned to Dr. Rhode on January 10, 2014 with continued medial sided-elbow pain; a repeat EMG was ordered and showed persistent cubital tunnel syndrome with evidence also of carpal tunnel syndrome (12-13). Dr. Rhode performed a revision of the left cubital tunnel procedure and a left carpal tunnel release (13-14). Dr. Rhode released petitioner to return to full-time, regular work on a trial basis on September 4, 2014 (14).

On October 4, 2014, petitioner was again released from his care. On that date, Dr. Rhode reported petitioner was doing well, with full range of motion and negative provocative maneuvers for compressive neuropathy both at the wrist and the elbow. Dr. Rhode also indicated petitioner would have some residual medial sided pain given the fact she had three surgeries and returned to work at her previous occupation (14-15).

Dr. Rhode testified he found petitioner's work for respondent was repetitive, but not forceful (15). He confirmed that the job described by petitioner as an inspector was the cause of the carpal and cubital tunnel syndrome [on the left] (16-17).

On cross-examination, Dr. Rhode confirmed petitioner did not perform any heavy lifting (19). Dr. Rhode confirmed petitioner had no pre-disposition, such as diabetes or thyroid problems,

to the condition (21). Dr. Rhode agreed that cubital tunnel and carpal tunnel can be idiopathic (21-22).

Midwest Hand Surgery/Dr. Ramsey Ellis February 13, 2015 Report (PX.15)

Dr. Ellis examined petitioner at respondent's request on February 13, 2015, in order to perform an AMA rating. The only condition Dr. Ellis related to any work accident was the left ring finger injury. Dr. Ramsey found petitioner sustained a 14% digital loss which translates to 1.05 % loss of the upper extremity and a 1% Whole Person Impairment

Photos (PX. 15 A/16 & 15 B/17)

15 A is a photo of the Jim Beam bottle and 15 B is a photo of Smirnoff Vodka bottle.

Dr. Ramsey Ellis March 17, 2015 Deposition (RX.1)

Dr. Ramsey Ellis, board certified plastic and reconstruction, as well as hand, surgeon, testified in behalf of respondent. Dr. Ellis had previously examined petitioner on February 5, 2013 and testified via deposition on November 12, 2013 [which was not introduced into evidence]. He also had issued June 27, 2013 addendum after viewing a job interview.

Dr. Ellis saw petitioner again on February 13, 2015. He reviewed additional medical records. Based upon his review of the video of the job and petitioner's previous interview regarding her job duties, Dr. Ellis concluded petitioner's job did not cause petitioner's cubital or carpal tunnel syndromes. Dr. Ellis noted no evidence of repetitive forceful grasping, flexion and extension of the wrist or prolonged use of hand-held vibratory tools. (9-12)

Dr. Ellis only performed an AMA rating for the left ring finger injury.

Genex Utilization Review October 21, 2014 Report (RX.2)

A utilization review was performed by Dr. Khalid Yousuf in behalf of respondent. Dr. Yousuf non-certified the surgery performed on May 27, 2014 as petitioner had not undergone appropriate conservative treatment before undergoing surgery.

Physical Demands Analysis of Process Checker/Inspector (RX.3)

According to the description, the process checker/inspector checks and inspects a variety of bottles in a variety of different manners.

St. Mary's Hospital Records (RX.4)

Among the voluminous irrelevant or duplicate of Petitioner's Exhibit 6, were records of treatment on May 9, 2011 and May 29, 2011 of petitioner's left finger injury. In addition, these records included treatment to petitioner's cervical spine in 2013 and 2014.

Dr. Charles Carroll Records (RX.5)

These records are duplicate of Petitioner's Exhibit 4, and also supplemental records contained in St. Mary's Hospital Records and Rezin Orthopedics records.

Rezin Orthopedic Records (RX.6)

Petitioner was seen by Dr. Ortinau on June 15, 2006 with complaints of left fifth finger pain after hitting it on the back of the door in the kitchen a few days ago. She suffered a fracture to the middle phalanx of the fifth finger. She was seen in follow up on June 22, 2006 and July 13,

2006. On August 17, 2006, more physical therapy for strengthen was recommended for strengthening; she was released from doctor's care.

Petitioner returned to Dr. Ortinau's office on March 20, 2007 with bilateral had numbness and tingling. The diagnosis was bilateral carpal tunnel syndrome; left greater than right. She was seen again on March 26, 2007 for left greater than right hand pain and numbness. She indicated she was having the pain for years. She was also shown to have possible Raynaud's. She reported the carpal tunnel brace helped.

She returned on April 9, 2007 after an EMG was positive for carpal tunnel syndrome. Carpal tunnel surgery was proposed, at least on the left.

On August 25, 2009, petitioner returned with right elbow pain. She reported it had been going on for a month. She was unsure of the cause. She reported she held off on scheduling the carpal tunnel surgery as her symptoms were not too severe. Diagnosis was stable carpal tunnel syndrome and epicondylitis.

On September 22, 2009 her condition had stabilized and she was released.

The remaining records are duplicate of Petitioner's Exhibit 3.

HSHS Medical Group/Family Medicine Parkview Records (RX.7)

Petitioner was seen by NP Patricia Hess for neck pain November, 2013 through January, 2014. On January 17, 2014 she had neck pain and also having pain in lower left arm and numbness and fingers on left hand. Treatment included physical therapy.

Video of Job of Process Checker Zip Drive (RX.8)

A 47-minute video showing an individual doing the checking job at respondent's.

CONCLUSIONS OF LAW

The Arbitrator adopts the Finding of Facts in support of the Conclusions of Law.

C. With respect to the issue of whether an accident occurred that rose out of and in the course of petitioner's employment with respondent, the Arbitrator makes the following conclusions of law:

The only nexus to the claimed accident date of August 1, 2012, is Dr. Charles Carroll's records from that date wherein Dr. Carroll reported petitioner's PIP injury of the left ring finger was stable. Dr. Carroll also indicated petitioner's testing was negative for carpal tunnel syndrome, pronator syndrome, cubital tunnel syndrome or radial nerve compression at elbow or wrist, although he does mention ulnar neuritis. Dr. Carroll offered no explanation as to the cause of the ulnar neuritis.

The September 5, 2012 EMG/NCV was negative for left cubital tunnel or carpal tunnel syndrome.

On September 28, 2012 petitioner reported to Dr. Blair Rhode that she processed and inspected 400 to 500 12-ounce bottles per day for respondent. This is the size of the bottles depicted on the video of the job, identified as Respondent's Exhibit 8. However, petitioner testified she processed the larger liquor bottles identified as Petitioner's Exhibit 15A/16 and 15B/17.

The October 29, 2012 EMG/NCV study done by Dr. Edward Trudeau showed ulnar neuropathy at the left elbow (cubital tunnel syndrome.) The petitioner related the problem to the April 7, 2011 accidental injury.

Dr. Eilers, who examined petitioner at her behalf, opined petitioner's job as a process checker was the cause of petitioner's bilateral carpal tunnel and left cubital tunnel syndrome. This was based upon petitioner's description of her job. The Arbitrator notes petitioner testified that her job was to inspect the large liquor bottles (PX.15A/16 and 15B/17); and yet, she related to Dr. Rhode on September 28, 2012 that she processed only the 12-ounce bottle, which were depicted in respondent's video (RX.8). The job of process checker, as depicted in the video, was not onerous in regard to repetitive grasping as claimed by petitioner.

In addition, petitioner advised Dr. Rhode in November, 2012, that her left elbow symptoms developed in March or April [2012] from overcompensating for the right carpal tunnel syndrome. [The Arbitrator determined in case 13 WC 5771 that petitioner failed to prove that her right carpal tunnel syndrome was caused by her work activity with respondent.]

Furthermore, Dr. Rhode agreed carpal tunnel syndrome and cubital tunnel syndrome can be idiopathic.

Dr. Ramsey Ellis, who examined petitioner on two occasions in behalf of respondent, and viewed the job video tape, opined petitioner's bilateral carpal tunnel and left cubital tunnel was not caused by the work as a process checker noting the job did not include repetitive forceful grasping, flexion and extension of the wrist, or prolonged use of hand-held vibratory tools. The Arbitrator noted Dr. Rhode agreed that petitioner's job did not include forceful repetitive movement.

Based upon the foregoing, the Arbitrator finds petitioner failed to prove that her left cubital tunnel and left carpal tunnel syndrome was the result of the April 7, 2011 left finger injury, or the claimed repetitive work accident of August 1, 2012, or any other date.

As the Arbitrator determined petitioner was not injured in an accident that arose out of her employment with respondent, the claim is denied and all other issues are moot.

50IACC003I

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

LINDA ESTES,

Petitioner,

vs.

NO: 13 WC 005771

OWENS ILLINOIS INC.,

Respondent.

20IWCC0032

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, employer-employee relationship, benefit rates, medical expenses, occupational disease, temporary total disability and permanent partial disability and being advised of the facts and law, modifies the Decision of the Arbitrator to correct clerical errors and otherwise affirms the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission modifies the Decision of the Arbitrator on page 9 in the ***Conclusions of Law*** section by striking the bracketed language. (Decision of the Arbitrator, p. 9)

The Commission corrects a scrivener's error in the Decision of the Arbitrator on page 10 in the ***Conclusions of Law*** section. The Commission corrects the scrivener's error found in the last sentence of the fourth paragraph on page 10 striking the name "Ramsey" and adding the name "Ellis" so the sentence reads, "Dr. Ellis concluded petitioner's work for respondent did not cause petitioner's right carpal tunnel condition of December 20, 2011." (Decision of the Arbitrator, p. 9)

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 9, 2018, is hereby affirmed as modified.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent pay to

SOIMCC0035

20IWCC0032

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.

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

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

Pursuant to §19(f)(2) of the Act, no bond for removal of this cause to the Circuit Court by Respondent is required as the Commission entered no award for payment of money. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JAN 16 2020
KAD/mav
O: 11/19/19
42

Kathryn A. Doerries

Thomas J. Tyrrell

Maria E. Portela

50IMCC0038

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ESTES, LINDA
Employee/Petitioner

Case# **13WC005771**

11WC032025
12WC028133

OWENS ILLINOIS INC
Employer/Respondent

20IWCC0032

On 8/9/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.18% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1097 SCHWEICKERT & GANASSIN
SCOTT J GANASSIN
2101 MARQUETTE RD
PERU, IL 61354

0075 POWER & CRONIN LTD
ROBERT LUEDKE
900 COMMERCE DR STE 300
OAK BROOK, IL 60523

20IWCC0032

STATE OF ILLINOIS)
) SS.
COUNTY OF KANKAKEE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

19IWCC0186

Linda Estes
Employee/Petitioner

v.

Owens Illinois
Employer/Respondent

Case # **13** WC **5771**
(Consolidated cases: **11** WC **32025** & **12** WC **28133**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Christine Ory**, Arbitrator of the Commission, in the city of **Ottawa on September 26, 2016** and closed proofs in **Kankakee on October 26, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **December 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.

Timely notice of this accidents ***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 **$41,600.00**; the average weekly wage was $**800.00**.

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

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

Respondent ***does not owe*** for all appropriate charges for all reasonable and necessary medical services for which they are liable.

To date, Respondent has paid $ **0** in TTD and/or for maintenance benefits, and is entitled to a credit for any and all amounts paid.

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

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

ORDER

Petitioner failed to prove she sustained accidental injuries to her left wrist, arm, or elbow that arose out of and in the course of her employment with respondent on December 20, 2011, or at any time.

Petitioner's claim is hereby denied and case is dismissed.

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.

Christine W Day

Signature of Arbitrator

ICArbDec p. 2

August 8, 2018

Date

AUG 09 2018

SECOND

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Linda Estes **Petitioner,**	)	
vs.	)	**No. 13 WC 5771**
Owens Illinois. **Respondent.**	)	**20IWCC0032**

ADDENDUM TO ARBITRATOR'S DECISION
FINDINGS OF FACTS AND CONCLUSIONS OF LAW

This matter was heard in Ottawa on September 26, 2016 and proofs were closed in Kankakee on October 26, 2016.

[The parties asked for the decision not to be written as they were trying to resolve the case. Finally, in September, 2017, when respondent's counsel was appointed Arbitrator, proposed findings were submitted.]

The parties agree that on December 20, 2011, petitioner and respondent were operating under the provisions of the Illinois Workers' Compensation Act; that petitioner earned $41,600 in the year pre-dating the claimed accident; and that her average weekly wage, as calculated pursuant to § 10 of the Act was $800.00

At issue in this case is:

1. Whether the petitioner sustained accidental injuries that arose out of and in the course of her employment with respondent;
2. Whether petitioner gave timely notice of the accident.
3. Whether petitioner's current condition of ill-being is causally connected to the claimed injury.
4. Whether respondent is liable for the unpaid medical bills.
5. Whether petitioner is due temporary total disability.
6. What is the nature and extent of injury?
7. Whether petitioner is entitled to penalties and attorneys' fees.

STATEMENT OF FACTS

Petitioner, Linda Estes, Testimony

At time of hearing, petitioner had been employed for eight and one-half years for respondent. For the first three years she worked as a bulk operator and carton maker. The last job she performed was relief process checker.

A bulk operator is responsible for the machine that loads glass bottles onto a pallet platform. As each tier of bottles is complete, the bulk operator places a four-foot by five-foot cardboard tier sheet on top of the loaded bottles for the next tier of bottles. This is repeated until the pallet is fully loaded. The pallet operator secures the pallet with a wood top frame and moves

onto a new pallet. Over an eight-hour shift, a bulk operator handles and positions 500 tier sheets and 48 top frames.

A carton maker lifts bundles containing 30 flattened 2" X 4" cardboard boxes into a machine that unfolds and assembles them for packing. This process is done 600 times in an eight-hour day.

Thereafter, for the next four years after bulk operator/carton maker, petitioner was a process checker. At the beginning of each shift, the process checker pulls a "set out" of 20 glass liquor bottles to inspect. The process checker completely examines each bottle, using his or her hands to check for sharp edges. This, according to petitioner, requires 25 hand rotations per bottle for all 20 bottles that were pulled for inspection. This process was done every hour during an eight-hour shift.

The process checker also uses a gage, called a magna mike, to check he thickness and height of the bottle. This requires manipulation with her hands. The process checker grabs four bottles at a time, two in each hand, to check. The process checker checks 24 defective bottles per shift to insure the gauges are accurate.

On April 7, 2011, petitioner was working as a bulk operator in relief of another employee. She had pulled down a number of tier sheets to the floor. As they hit the floor, the bounded back, bending her pinky and ring fingers back, causing pain. She reported the injury to Brian Layman. She asked to go for treatment. She was finally able to get treatment on April 14, 2011, when she went to St. Mary's Hospital. X-rays showed a fracture of the finger. She was put in a splint and placed on light duty. She followed up with Dr. Speca in May, 2011 at St. Mary's Hospital. She was taped and kept on light duty.

Thereafter, she went to Dr. Ortinau with Rezin Orthopedics. Although she was still in a ring and pinky finger splint, she was released to return to full-duty work by Dr. Ortinau. She was sent for a MRI of the right hand in August, 2011. She was then sent by Dr. Ortinau to Dr. Carroll. She was seen by Dr. Carroll in December, 2011.

Petitioner became a full time process checker in October, 2011. On December 20, 2011, petitioner reported her claimed injury to the safety manager.

Petitioner obtained an EMG on February 1, 2012 at the request of Dr. Ricca. She then saw orthopedic surgeon, Dr. Sinha, on March 7, 2012. Petitioner provided a work history to Dr. Sinha. Dr. Sinha performed a release of petitioner's right carpal tunnel syndrome on April 27, 2012.

In August, 2012, petitioner was seen by Dr. Ricca with numbness and tingling in her left hand. She had another EMG by Dr. Garg on September 5, 2012. She was referred by Dr. Ricca to Dr. Blair Rhode, whom she saw on September 24, 2012. She provided a job description to Dr. Rhode. She underwent another EMG to her left elbow, which was by Dr. Trudeau on October 29, 2012. On March 26, 2013, Dr. Rhode performed surgery to petitioner's left elbow. She also underwent a debridement in April, 2013. She was released to return to full duty work on June 28, 2013.

Petitioner continued to have pain and discomfort in her left elbow. On March 4, 2014, petitioner had another EMG by Dr. Trudeau. She underwent a revision of the left elbow surgery and carpal tunnel surgery. This improved her condition.

She was released from Dr. Rhode's care in October, 2014.

Petitioner confirmed she was examined by Dr. Eilers, at her attorney's request. She was cooperative. The exam took a half hour to an hour. She underwent two §12 exams with Dr. Ramsey Ellis; each lasting only15 minutes. She did not give details of her job to Dr. Ellis.

She continues to have occasional pain in her hands.

On cross-examination, she confirmed she use a micrometer to check bottles. She would put the bottles on a cart to transport them to test. She turned the bottles with her thumbs. She occasionally picked up the bottle. She also was a carton maker and bulk operator. None of the jobs required use of power tools or air hammers. She did not push hands against resistance. She also did not use vibrator tools.

Petitioner agreed she was released to full duty work as of June, 2011 after her injury of April 7, 2011.

Petitioner confirmed she was seen by the HSHS Medical Group on January 17, 2014 due to neck pain, but was also having pain in lower left arm and numbness and fingers on left hand. Petitioner confirmed the neck condition was not related to a work accident. She was not sure the cause of the neck condition. She underwent a cervical MRI on December 12, 2013.

On rebuttal, petitioner testified that the video did not accurately depict the work she performed for respondent. She testified she used 8000 or 9000 hand movements per an eight-hour day. She disagreed with the number of bottles checked; she testified she checked 125 bottles per hour.

Jeffrey Donnell Testimony

Jeffrey Donnell, employed by respondent for eight years, testified in behalf of respondent. He is a line leader and presides over one line, which is from batch to forming to packaging to quality control. There are four lines at respondent's location in Streator Illinois.

He had performed the job of processor checker, bulk operator and carton maker. He sees this job performed every day.

Donnell agreed that the video identified as Respondent's Exhibit 8, depicts the job of process checker even though the some of the machines shown in the video were no longer used by respondent. Donnell confirmed petitioner would have to pull 20 bottles per hour to perform the inspection performed in the video. Respondent ran the liquor bottles identified in the photos from Petitioner's Exhibit 15A/16 and 15B/17 for only a year.

Medical Bills (PX.1)

Petitioner claims a total medical bills of $176,850.11 for all three claims, of which $115,015.54 remain outstanding.

St. Mary's Orthopedics Records (PX.2)

Petitioner was first seen by orthopedist, Dr. John M. Speca, on May 13, 2011 for the finger injury. She reportedly hyperextended her fingers when pulling cardboard sheets at work on April 7, 2011. X-rayed showed a nondisplaced fracture at the volar lip of the proximal end of the middle phalanx; this was the diagnosis. She was put on light duty as the fracture had not healed.

Petitioner was seen again on May 27, 2011. The diagnosis was nondisplaced volar lip avulsion fracture of the proximal end of the middle phalanx of the ring finger. She remained on restricted duty.

Rezin Orthopedics Records (PX.3)

Petitioner was first seen by Dr. Eric Ortinau on June 20, 2011 with complaints of left fourth finger pain. The middle phalanx fracture was healed. She was sent for hand therapy and released to return to work full-time; full-duty.

She was seen again on July 18, 2011. She was making good strides. She was to continue OT and continue full-time, full-duty work.

On August 23, 2011, petitioner was noted to have stiffness with contracture at the PIP joint. An MRI was ordered.

The August 29, 2011 MRI showed mild ill-defined bone edema, 2 mm area of subchondral cystic change and a remote sprain of the PIP joint radial collateral ligament.

At the September 6, 2011, petitioner lacked approximately 10 degrees' full extension of the left ring finger. She was referred to Dr. Carroll at her request.

Northwestern Orthopedic Institute/Dr. Charles Carroll Records (PX.4)

Petitioner was first seen by Dr. Carroll for a second opinion on December 12, 2011. Dr. Carroll's diagnosis was a stable PIP injury to the left ring finger. Dr. Carroll determined there was no further testing or further therapy, other than home stretching and use of LMB splint, necessary. Dr. Carroll believe petitioner would reach MMI within two to three months.

Petitioner returned to Dr. Carroll on August 1, 2012. Dr. Carroll reported no provocative testing noted for carpal tunnel syndrome, pronator syndrome, cubital tunnel syndrome or radial nerve compression at elbow or wrist. Diagnosis was stable PIP injury left ring finger, and also ulnar neuritis. She was to return PRN.

ATI Physical Therapy Records (PX.5)

Petitioner received physical therapy to the left fourth finger from June 21, 2011 through August 11, 2011.

St. Mary's Hospital Records (PX.6)

[These records included over hundreds of pages of superfluous and irrelevant documents. The discussion of this exhibit is limited to only the relevant pages that were identified amount the volume of non-relevant documents.]

On April 14, 2011, petitioner was seen by Dr. Amit Garg for the left finger injury. X-rays showed a small avulsion fracture along the ventral based of the left middle fourth phalanx.

Petitioner returned to Dr. Garg for follow up treatment of the left fourth finger on May 2, 2011. X-rays showed non displaced chip fracture along the palmer base of fourth middle phalanx.

On September 21, 2011, petitioner was seen in urgent care by Dr. Amit Garg. She reported she had ongoing pain in the third digit of the left hand. She was instructed to follow up with hand specialist. A referral was made to Dr. Charles Carroll.

Petitioner presented to the emergency department with right wrist numbness on December 20, 2011. Petitioner reported it started at 7:30 that morning at home. A Cat scan of the brain was performed. Diagnosis was paresthesia with peripheral neuropathy of the right hand and wrist.

Petitioner was admitted to the hospital on April 27, 2012 for severe right carpal tunnel release of the right hand. Petitioner had a history of numbness and tingling along the medial nerve distribution of the right hand that had been going on for several months. The EMG showed mild carpal tunnel on the right and none on the left. The surgical order form indicates the right carpal tunnel condition was not related to work.

Dr. Upendra K. Sinha Records (PX.7)

The February 1, 2012 EMG/NCV showed mild carpal tunnel syndrome of the right hand and normal on the left.

On April 27, 2012, Dr. Sinha performed a carpal tunnel release for severe carpal tunnel syndrome of the right hand. According to the history and physical at the time of admission to St. Mary's Hospital on April 27, 2012, petitioner claimed she had tingling and numbness along the median nerve distribution for the last many years; and in the last several months she has had more symptoms.

Petitioner underwent post-operative physical and occupational therapy in May and June, 2012.

Dr. Edward Trudeau Records (PX.8)

The October 29, 2012 EMG/NCV study done by Dr. Edward Trudeau showed ulnar neuropathy at the left elbow (cubital tunnel syndrome). Petitioner related the problem to the April 7, 2011 work injury.

The EMG/NCV study done by Dr. Trudeau on March 4, 2014, showed ulnar neuropathy of the left elbow, which was improved over the previous study of 10/29/2012, median neuropathy of the left wrist (carpal tunnel syndrome) which was new since 10/29/2012 study and mild left medial antebrachial cutaneous neuropathy. Again, petitioner related the condition back to her April 7, 2011 injury.

Parkview Family Practice/Glen L. Ricca Records (PX.9)

The December 20, 2011 ER report from St. Mary's Streator indicate petitioner reported right hand and wrist pain that started that morning at 7:30 AM at home.

On December 28, 2011, petitioner followed up with Dr. Ricca after ER visit of December 22, 2011.

Petitioner obtained an EMG on February 1, 2012 at Dr. Ricca's request for pain in both hands. The EMG/NCV showed mild right carpal tunnel syndrome and none on the left.

Petitioner was seen on August 8, 2012, due to paresthesia tingling left 4th and 5th fingers. She reportedly moved bottles all day while working for respondent.

The September 5, 2012 NCV/EMG report was negative.

On September 11, 2012, petitioner was seen for paresthesia tingling left fourth and fifth finger; symptoms persist even though the nerve conduction study was normal.

On October 3, 2012, petitioner reported to the emergency room with a history of pain in her right hand for two to three days. She reportedly hit her head (sic) on the porch rail at home.

Petitioner followed up with Dr. Ricca on October 9, 2012, after ER visit of October 3, 2012 for right hand trauma after striking it against an object.

Petitioner underwent a pre-op physical on March 20, 2013.

Orland Park Orthopedics Center for Sports Medicine/Dr. Blair Rhode Records (PX.10)

Petitioner first saw Dr. Blair Rhode on September 24, 2012 with the history of suffering a fracture of the left ring finger on April 7, 2011. Diagnosis was hand and elbow pain, cubital tunnel syndrome and closed fracture of distal finger.

She was seen again on September 26, 2012. An MRI of the left ring finger on September 26, 2012 showed chondromalacia involving the ring finger. She returned on September 28, 2012 for hand and elbow pain. She saw Dr. Rhode after the MRI on November 12, 2012. On November 20, 2012, she was given an injection into the cubital tunnel and splinted. On December 8, 2016, she advised the injection only gave her temporary relief. Left cubital tunnel surgery was proposed.

Petitioner underwent left cubital tunnel release on March 28, 2013. She followed up on April 4, 2013 and April 29, 2013.

She had additional surgery on April 30, 2013 for left elbow irrigation and debridement with closure of the wound.

She followed up on May 16, 2013, May 20, 2013 and May 30, 2013. On June 27, 2013, petitioner was released to return to work full duty on a trial basis. On July 24, 2013 petitioner was doing well performing her regular work. She was released from Dr. Rhode's care, having reached MMI.

On January 10, 2014 petitioner returned with significant symptoms in her elbow. The diagnosis was medial epicondylitis. She returned on February 8, 2014 with ongoing symptomology. An EMG was prescribed. She was seen on March 19, 2014, S/P EMG which showed persistent cubital tunnel and carpal tunnel syndrome. On April 17, 2014 a repeat surgery was discussed. On May 2, 2014 and May 15, 2014, additional surgery was proposed.

Petitioner underwent left open carpal tunnel release and cubital tunnel release revision with sub muscular transposition. She received follow up care on June 12, 2014, July 10, 2014, August 7, 2014, September 7, 2014. On October 2, 2014, petitioner was released to full duty work and determined to be at MMI.

Memorial Medical Center Report (PX.11)

The report is also contained in Petitioner's Exhibit 8.

Results Physical Therapy and Fitness Records (PX.12)

Physical therapy records from July and August, 2014.

Physical Medicine and Rehabilitation Associates/Dr. Robert Eilers Report (PX.13)

Dr. Robert Eilers examined petitioner on August 11, 2015. He reviewed treating medical records, including EMGS and operative reports, as well as MRIs. Petitioner provided a history that on April 7, 2011, she was lifting 4 x 5 feet cardboard pieces, she bent her left hand backwards resulting in extension in injury to the fourth digit of her left hand.

On December 20, 2011, petitioner was having numbness and tingling in her hands and was diagnosed with carpal tunnel syndrome by Dr. Garg and referred to Dr. Ricca.

She reportedly worked with respondent as a lab process checker on the line doing various checking of bottles hourly and reporting defects, using gauges, cutting bottles with hot wire and emptying glass into the cullet. She reportedly lifted up to 30 pounds, which she did 10 to 30 times a day.

Dr. Eilers concluded petitioner avulsion fracture of the ventral base of the left mid fourth phalanx as a result of the April 7, 2011 work accident, with some acceleration of degenerative changes at the MCP and PIP joints, and enlargement of the pip joint.

Dr. Eilers concluded petitioner developed carpal tunnel syndrome on December 20, 2011, of the right hand and underwent carpal tunnel surgery on April 27, 2012, as a result of the work activities.

Dr. Eilers also concluded petitioner developed cubital tunnel syndrome on the left as a result of the repetitive activity, which necessitated cubital tunnel release performed on March 26, 2013, as well as additional surgery on April 30, 2013 to reclose the wound dehiscence from the March 26, 2013 surgery. Petitioner also had to undergo revision of the cubital tunnel release and a sub muscular transposition done on May 27, 2014.

In conclusion, Dr. Eilers determined petitioner sustained bilateral carpal tunnel syndrome and left cubital tunnel syndrome, which required surgical releases, and subsequent transposition. She also had some acceleration of her degenerative arthritis from the fracture of the fourth left digit. All of these conditions Dr. Eilers related to petitioner's employment activities with respondent.

Dr. Blair A. Rhode April 13, 2016 Deposition (PX.14)

Dr. Blair Rhode testified in behalf on petitioner via deposition on April 13, 2016. He is board certified in orthopedic surgery, sports medicine and from the American Board of Independent Medical Examiners (5).

Petitioner was first seen by Dr. Rhode on September 24, 2012. She reportedly injured her left ring finger when she was manipulating heavy cardboard on April 7, 2011, causing the finger to snap back resulting in a fracture. She continued to work and her symptoms did not significantly improve. (5-6)

Petitioner advised Dr. Rhode she developed medial-sided elbow pain with numbness and tingling to the ring and little finger on the left. The September 5, 2012 EMG showed no evidence of left-sided cubital tunnel syndrome. Dr. Rhode recommended another MRI. (6-7)

Dr. Rhode confirmed petitioner had not provided him with a history of right carpal tunnel surgery by Dr. Sinha in April, 2012. He had obtained this information from the medical records (7-8).

On November 28, 2012, petitioner related that she was required to pick up and inspect 12-ounce bottles at a rate of 400 to 500 per minute. She advised the cubital tunnel [on the left] symptomology developed in March or April. She developed the symptoms [on the left] from compensating from the right carpal tunnel condition, (9)

Dr. Rhode reported the October 29, 2012 EMG showed a moderately severe cubital tunnel syndrome (10). Eventually Dr. Rhode performed a left cubital tunnel release on March 26, 2013 after a course of conservative treatment (10-11). On April 30, 2013, Dr. Rhode performed an irrigation and debridement procedure at the operation site due to post-operative drainage (11). Petitioner was off work from the date of the surgery of March 26, 2013 until July 24, 2013, at which time Dr. Rhode deemed her to be at MMI (12).

Petitioner returned to Dr. Rhode on January 10, 2014 with continued medial sided-elbow pain; a repeat EMG was ordered and showed persistent cubital tunnel syndrome with evidence also of carpal tunnel syndrome (12-13). Dr. Rhode performed a revision of the left cubital tunnel procedure and a left carpal tunnel release (13-14). Dr. Rhode released petitioner to return to full-time, regular work on a trial basis on September 4, 2014 (14).

On October 4, 2014, petitioner was again released from his care. On that date, Dr. Rhode reported petitioner was doing well, with full range of motion and negative provocative maneuvers for compressive neuropathy both at the wrist and the elbow. Dr. Rhode also indicated petitioner would have some residual medial sided pain given the fact she had three surgeries and returned to work at her previous occupation (14-15).

Dr. Rhode testified he found petitioner's work for respondent was repetitive, but not forceful (15). He confirmed that the job described by petitioner as an inspector was the cause of the carpal and cubital tunnel syndrome [on the left] (16-17).

On cross-examination, Dr. Rhode confirmed petitioner did not perform any heavy lifting (19). Dr. Rhode confirmed petitioner had no pre-disposition, such as diabetes or thyroid problems,

to the condition (21). Dr. Rhode agreed that cubital tunnel and carpal tunnel can be idiopathic (21-22).

Midwest Hand Surgery/Dr. Ramsey Ellis February 13, 2015 Report (PX.15)

Dr. Ellis examined petitioner at respondent's request on February 13, 2015, in order to perform an AMA rating. The only condition Dr. Ellis related to any work accident was the left ring finger injury. Dr. Ramsey found petitioner sustained a 14% digital loss which translates to 1.05 % loss of the upper extremity and a 1% Whole Person Impairment

Photos (PX. 15 A/16 & 15 B/17)

15 A is a photo of the Jim Beam bottle and 15 B is a photo of Smirnoff Vodka bottle.

Dr. Ramsey Ellis March 17, 2015 Deposition (RX.1)

Dr. Ramsey Ellis, board certified plastic and reconstruction, as well as hand, surgeon, testified in behalf of respondent. Dr. Ellis had previously examined petitioner on February 5, 2013 and testified via deposition on November 12, 2013 [which was not introduced into evidence]. He also had issued June 27, 2013 addendum after viewing a job interview.

Dr. Ellis saw petitioner again on February 13, 2015. He reviewed additional medical records. Based upon his review of the video of the job and petitioner's previous interview regarding her job duties, Dr. Ellis concluded petitioner's job did not cause petitioner's cubital or carpal tunnel syndromes. Dr. Ellis noted no evidence of repetitive forceful grasping, flexion and extension of the wrist or prolonged use of hand-held vibratory tools. (9-12)

Dr. Ellis only performed an AMA rating for the left ring finger injury.

Genex Utilization Review October 21, 2014 Report (RX.2)

A utilization review was performed by Dr. Khalid Yousuf in behalf of respondent. Dr. Yousuf non-certified the surgery performed on May 27, 2014 as petitioner had not undergone appropriate conservative treatment before undergoing surgery.

Physical Demands Analysis of Process Checker/Inspector (RX.3)

According to the description, the process checker/inspector checks and inspects a variety of bottles in a variety of different manners.

St. Mary's Hospital Records (RX.4)

Among the voluminous irrelevant or duplicate of Petitioner's Exhibit 6, were records of treatment on May 9, 2011 and May 29, 2011 of petitioner's left finger injury. In addition, these records included treatment to petitioner's cervical spine in 2013 and 2014.

Dr. Charles Carroll Records (RX.5)

These records are duplicate of Petitioner's Exhibit 4, and also supplemental records contained in St. Mary's Hospital Records and Rezin Orthopedics records.

Rezin Orthopedic Records (RX.6)

Petitioner was seen by Dr. Ortinau on June 15, 2006 with complaints of left fifth finger pain after hitting it on the back of the door in the kitchen a few days ago. She suffered a fracture to the middle phalanx of the fifth finger. She was seen in follow up on June 22, 2006 and July 13,

2006. On August 17, 2006, more physical therapy for strengthen was recommended for strengthening; she was released from doctor's care.

Petitioner returned to Dr. Ortinau's office on March 20, 2007 with bilateral had numbness and tingling. The diagnosis was bilateral carpal tunnel syndrome; left greater than right. She was seen again on March 26, 2007 for left greater than right hand pain and numbness. She indicated she was having the pain for years. She was also shown to have possible Raynaud's. She reported the carpal tunnel brace helped.

She returned on April 9, 2007 after an EMG was positive for carpal tunnel syndrome. Carpal tunnel surgery was proposed, at least on the left.

On August 25, 2009, petitioner returned with right elbow pain. She reported it had been going on for a month. She was unsure of the cause. She reported she held off on scheduling the carpal tunnel surgery as her symptoms were not too severe. Diagnosis was stable carpal tunnel syndrome and epicondylitis.

On September 22, 2009 her condition had stabilized and she was released.

The remaining records are duplicate of Petitioner's Exhibit 3.

HSHS Medical Group/Family Medicine Parkview Records (RX.7)

Petitioner was seen by NP Patricia Hess for neck pain November, 2013 through January, 2014. On January 17, 2014 she had neck pain and also having pain in lower left arm and numbness and fingers on left hand. Treatment included physical therapy.

Video of Job of Process Checker Zip Drive (RX.8)

A 47-minute video showing an individual doing the checking job at respondent's.

CONCLUSIONS OF LAW

The Arbitrator adopts the Finding of Facts in support of the Conclusions of Law.

C. With respect to the issue of whether an accident occurred that rose out of and in the course of petitioner's employment with respondent, the Arbitrator makes the following conclusions of law:

Petitioner claims the injury to her right hand occurred on December 20, 2011. It was on that date petitioner appeared at St. Mary's Hospital emergency department due to right wrist numbness. Petitioner reported it started at 7:30 that morning at home. She underwent an EMG/NCV on February 1, 2012 which showed mild carpal tunnel syndrome of the right hand.

Petitioner then came under the care of Dr. Sinha, whom she first saw on March 7, 2012.

[In respondent's proposed decision, respondent cites to patient information forms signed by petitioner on March 7, 2012 that indicated petitioner had numbness and tingling in the fingers and thumbs that began approximately eight years before, that she had treated with Dr. Jhee eight years before for carpal tunnel, that it occurred from factory work and that factory was now closed. After a diligent and extensive review of this exhibit, the Arbitrator did not find these forms in the St. Mary's Orthopedic North records (PX. 7)]

Dr. Sinha wrote in the history and physical at the time of petitioner's admission to St. Mary's Hospital on April 27, 2012 for the right carpal tunnel released, that petitioner had tingling and numbness along the median nerve distribution for many years. Dr. Sinha did not relate petitioner's right carpal tunnel condition to her employment with respondent.

The complete records of Rezin Orthopedics introduced by respondent as Respondent's Exhibit 6, confirms petitioner had been diagnosed with bilateral carpal tunnel in March, 2007. Petitioner reported she had been having pain for years. Carpal tunnel surgery was proposed on the left more than right. She returned on August 25, 2009 with right elbow pain. She had elected not to go forth with the carpal tunnel surgery as the symptoms were not too severe.

Dr. Rhode provided care and treatment to petitioner beginning on September 24, 2012 to petitioner's left hand and arm. His opinion was limited to petitioner's left hand, wrist and arm. There was no opinion as to petitioner's right carpal tunnel condition. However, Dr. Rhode agreed that cubital tunnel and carpal tunnel can be idiopathic.

On August 11, 2015, Dr. Robert Eilers examined petitioner at her attorney's request. Based upon petitioner's explanation of her job with respondent as lab process checker, without viewing the video tape of the job, Dr. Eilers concluded petitioner's job was repetitive and thus was the cause of petitioner's right carpal tunnel condition.

At respondent's request, Dr. Ramsey Ellis examined petitioner on February 5, 2013 and February 13, 2015 and reviewed the video tape and job description. Dr. Ellis found no evidence of forceful grasping, flexion and extension of prolonged use of hand-held vibratory tools. Dr. Ramsey concluded petitioner's work for respondent did not cause petitioner's right carpal tunnel condition of December 20, 2011.

Based upon the foregoing evidence, the Arbitrator finds petitioner failed to prove by clear and convincing evidence that she developed carpal tunnel condition as a result of a work accident on December 20, 2011, or anytime, with respondent.

As the Arbitrator determined petitioner was not injured in an accident that arose out of her employment with respondent, the claim is denied and all other issues are moot.

20IWCC0035

STATE OF ILLINOIS)
) SS.
COUNTY OF SANGAMON)

- [x] 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

Illinois Workers' Compensation Commission,
Petitioner,

vs.

No. 11 INC 000110,
19 WC 20227

Mark Lemp Home Improvements, Mark Lemp, Individually and Owner,
Respondents.

20IWCC0033

DECISION AND OPINION RE: INSURANCE NON-COMPLIANCE

Petitioner Illinois Workers' Compensation Commission, brings this action by and through the Office of the Illinois Attorney General, against the above-captioned Respondent. Petitioner alleges a violation of Section 4(a) of the Illinois Workers' Compensation Act (the Act), for Respondent's failure to procure mandatory worker's compensation insurance. Proper and timely notice was given to all parties.

Petitioner alleges that Respondent knowingly and willfully lacked workers' compensation insurance for a total of 3,988 days between July 20, 2005 and June 23, 2016. A hearing was held before Commissioner Marc Parker in Collinsville, Illinois, on July 22, 2019. Petitioner appeared and presented the testimony of Investigator Michael Cummins. Respondent, Mark Lemp, appeared *pro se.*

20IWCC0033

The Commission sought the maximum fine allowed under the Act, $500.00 per day for each day Mr. Lemp did business individually and as owner of Mark Lemp Home Improvements and failed to provide coverage for his employees (3,988 days x $500.00 = $1,994,000.00), plus $19,074.92 which the Injured Workers' Benefit Fund paid out to Respondent's injured worker, for a total of $2,013,074.92.

The Commission, after considering the record in its entirety and being advised of the applicable law, finds that Respondent Mark Lemp, individually and as owner of Mark Lemp Home Improvements, knowingly and willingly violated Section 4(a) of the Act during the period in question. As a result, Respondent shall be held liable for non-compliance with the Act and shall pay a penalty in accordance with Section 4(d) of the Act. The Commission hereby assesses the penalty of $250.00 per day for 3,988 days ($997,000.00), plus $19,074.92 for a total of $1,016,074.92.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

1. Investigator Cummins testified he began an investigation of Mark Lemp Home Improvements in 2016 as a result of a workers' compensation claim against the Injured Workers' Benefit Fund. Mark Lemp Home Improvements came under the mandatory insurance clause of the Act, but did not have workers' compensation insurance.

2. Investigator Cummins testified he conducted additional steps in his investigation of Mark Lemp Home Improvements. He searched several databases that indicate employer's revenue and insurance history. Records from the Illinois Department of Revenue indicated that Mark Lemp Home Improvements wasn't reporting payroll taxes. He searched the National Council on Compensation Insurance database which indicated that Respondent was without workers' compensation insurance. He checked with the Office of Self-Insurance and learned that Mark Lemp Home Improvements was not self-insured.

3. Investigator Cummins sent a notice of non-compliance to the business, and when he received no response to that, a hearing was set and notices of hearing were sent to the business and to Mr. Lemp. Mr. Lemp reported to Investigator Cummins his business was no longer in operation, and denied that the Petitioner in the underlying workers' compensation claim had been an employee of his.

4. Petitioner's Exhibit 7 is a certified statement from the Commission's Office of Self-Insurance stating that at no time was Mark Lemp Home Improvements self-insured.

5. Petitioner's Exhibit 8 is a certified statement from the National Council on Compensation Insurance showing that at no time during the period in question did Mark Lemp have a workers' compensation policy.

6. The Commission's records show that the Injured Workers' Benefit Fund paid out $19,074.92 to Respondent's injured worker, Chris Richards, pursuant to the Commission's February 15, 2017 decision in that claim, 09 WC 32064.

20IWCC0033

7. Respondent, Mark Lemp, testified that while his business was in existence, it performed home improvements, including roofing work. He testified that the roofing job on which the underlying claimant was injured was not a job through Mark Lemp Home Improvements, but rather, was a job from another person, who in fact was the one who paid the claimant in the underlying claim for the work he performed. However, he acknowledged owing $19,000.00 in that underlying claim.

8. Respondent, Mark Lemp, admitted that he did not have workers' compensation insurance during the period in question. He did not offer any exhibits into evidence, or present the testimony of other witnesses.

The Commission notes for the record that, immediately after the hearing, the parties were advised to file briefs. To date, Respondents have not filed a brief.

Pursuant to Section 3 of the Act, certain employers and their employees are automatically subject to the provisions of the Act if they engage in specific businesses including: "the erection, maintaining, removing, remodeling, altering or demolishing of any structure" *820 ILCS 305/3(1)*; "construction, excavating or electrical work" *820 ILCS305/3(2)*; and, "any business or enterprise in which electric, gasoline or other power driven equipment is used in the operation thereof." *820 ILCS 305/3(15).*

The Commission finds, based on the work performed by Mark Lemp Home Improvements as disclosed in the testimony of Investigator Cummins and Mark Lemp, that pursuant to Section 3, Respondents were automatically subject to the provisions of the Illinois Workers' Compensation Act and were required to carry workers' compensation insurance.

Regarding the issue of penalties, Section 4(d) of the Act states in part:

> "Upon a finding by the Commission, after reasonable notice and hearing, of the knowing and willful failure or refusal of an employer to comply with any of the provisions of paragraph (a) if this section or the failure or refusal to comply with any order of the Illinois Workers' Compensation Commission pursuant to paragraph (c) of this Section disqualifying him or her to operate as a self insurer and requiring him or her to insure his or her liability, the Commission may assess a civil penalty of up to $500.00 per day for each day of such failure or refusal after the effective date of this amendatory Act of 1989. The minimum penalty under this Section shall be the sum of $10,000.00. Each day of such failure or refusal shall constitute a separate offense." *(820 ILCS 305/4(d).*

Here, Mr. Lemp was the owner of Mark Lemp Home Improvements for the entire time at issue and acknowledged that during the period in question he failed to secure and maintain any workers' compensation insurance coverage despite knowing of the legal requirement to do so. The certification from NCCI shows that Respondent was without workers' compensation insurance from July 20, 2005 through June 23, 2016.

In *State of Illinois v. Murphy Container Service, et al.,* 2007 Ill.Wrk.Comp.LEXIS 1216, the Commission considered the following factors in assessing penalties against an uninsured employer: 1) the length of time the employer had been violating the Act; 2) the number of workers' compensation claims brought against the employer; 3) whether the employer had been made aware of his conduct in the past; 4) the number of employees working for the employer; 5) the employer's ability to secure and pay for workers' compensation coverage; 6) whether the employer had alleged mitigating circumstances; and, 7) the employer's ability to pay the assessed amount.

In the instant case, the Commission finds that the length of time in which the Respondent had been violating the Act in failing to obtain workers' compensation insurance was significant. The Respondent failed to have insurance for 3,988 days. However, the Commission finds there are mitigating factors. Mr. Lemp testified that his business was small and that he did most of the work himself, only occasionally hiring part-time helpers for roofing jobs. Then, he usually hired his son and nephew. The underlying claim by Chris Richards was the first and only workers' compensation claim made against Respondent. The Commission also finds Petitioner's testimony that he is on disability but would be willing to make payments from his disability income, to be a mitigating factor.

The Commission finds that Petitioner has met its burden of proving that Respondent was operating a business in Illinois, and was properly served with notice, was legally required to maintain Workers' Compensation insurance, but conducted business for 3,988 days without Workers' Compensation insurance. The Commission also finds that Petitioner proved that such violation was willful because Mr. Lemp admitted that prior to the period in question, he had workers' compensation insurance for another business. Accordingly, the Commission finds that Respondent is liable for a penalty for failure to comply with Section 4(a) of the Act. The Commission hereby assesses against Respondent a fine totaling $1,016,074.92, for the period of 3,988 days that Respondent was without workers' compensation insurance coverage ($997,000.00), plus the $19,074.92 paid by the Injured Workers' Benefit Fund.

IT IS THEREFORE ORDERED BY THE COMMISSION that Mark Lemp, individually and as owner of Home Improvements, pay to the Illinois Workers' Compensation Commission the sum of $1,014,074.92, as provided in Section 4(d) of the Act.

Pursuant to Commission Rule 9100.90, once the Commission assesses a penalty against an employer in accordance with Section 4(d) of the Act, payment shall be made according to the following procedure: 1) payment of the penalty shall be made by certified check or money order made payable to the Illinois Workers' Compensation Commission; 2) payment shall be mailed or presented within 30 days after the final Order of the Commission or the order of the court on review after final adjudication to:

Workers Compensation Commission,
Insurance Compliance Division
100 West Randolph Street
Suite 8-328
Chicago, Illinois 60601

3) or as otherwise directed by www.iwcc.il.gov.

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 the Circuit Court.

DATED: JAN 16 2020

Marc Parker

Deborah L. Simpson

Barbara N. Flores

mp/mcp
r-07-22-19
68

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Kesha Streater,
Petitioner,

vs. No. 16 WC 15535

20IWCC0034

Bi-State Development Agency,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petitions for Review having been filed by Petitioner and Respondent herein and notice given to all parties, the Commission, after considering the issues of 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 Decision of the Arbitrator, which is attached hereto and made a part hereof.

On April 21, 2016, Petitioner, a bus driver, was involved in a motor vehicle collision while working. Following unsuccessful conservative treatment for her back injuries, Petitioner underwent a two stage fusion with hardware at L5-S1, in March 2017. In her accident, Petitioner also sustained other injuries of lesser severity, including sprains and contusions to her left upper extremity, shoulder and neck. Those injuries had largely resolved by the time of arbitration. Petitioner made a good recovery from her back surgery and was able to return to her usual job with no restrictions.

The Arbitrator found Petitioner had proved that, in addition to her other injuries, her back condition and need for fusion surgery were causally related to her work accident. The Arbitrator awarded Petitioner: the reasonable and necessary medical expenses contained in Petitioner's group exhibit; 37 additional weeks of TTD (February 6, 2017 through October 22, 2017), and 15% body as a whole under §8(d)2 of the Act.

SOIMCC0034

20IWCC0034

Petitioner claims the Arbitrator erred by not granting her a larger permanent partial disability award. Respondent claims the Arbitrator erred by finding that Petitioner's fusion surgery was causally related to her accident. Respondent claims Petitioner attained maximum medical improvement on January 4, 2017, based on the opinion of its Section 12 expert, Dr. Michael Chabot. Respondent disputes the Arbitrator's award of temporary total disability and medical expenses extending beyond January 4, 2017, as well as the award of expenses for an MRI spectroscopy, written reports and interest charged by some of Petitioner's medical providers. Finally, Respondent claims the award for permanent partial disability should be reduced to an amount commensurate with that for a resolved back strain.

With regard to the issue of causal connection, the Commission affirms and adopts the Arbitrator's conclusion that Petitioner's low back condition and need for fusion surgery were causally related to her accident, for the reasons stated in the Arbitrator's decision. The Commission also affirms and adopts the Arbitrator's award of 37 weeks of TTD for the period February 6, 2017 through October 22, 2017, as being causally related to Petitioner's accident.

However, the Commission modifies the Arbitrator's award of medical expenses. The Commission finds that in this case, Petitioner's MRI spectroscopy was not a reasonable or necessary medical expense; her lumbar MRI taken just two months before, revealed her L5-S1 annular disc bulge which contributed to neuroforaminal exit stenosis. Accordingly, the Commission reverses the award of the expense of Petitioner's MRI spectroscopy.

Respondent contends the Arbitrator erred by awarding the interest charges and fees for writing reports, which some medical providers' itemized and included in their bills attached to Petitioner's group exhibit. However, the Arbitrator's award of medical included only the, "reasonable and necessary medical expenses," contained in that group exhibit, pursuant to the fee schedule, as provided in §8(a) and §8.2 of the Act. The providers' charges for interest and for writing reports are not reasonable or necessary to cure or relieve Petitioner from the effects of her accidental injury. Those charges were not awarded by the Arbitrator, and they are not awarded by the Commission.

With regard to the nature and extent of Petitioner's injury, the Commission modifies the Arbitrator's permanent partial disability award, increasing it from 15% to 20% person as a whole under §8(d)2 of the Act. In so doing, the Commission notes that the Petitioner sustained injuries to other body parts which required treatment, including her left upper extremity and neck.

As a result of her accident, Petitioner experienced severe low back pain, left arm pain and tingling in her left elbow and hand. She underwent physical therapy, required medications and received lumbar injections. Petitioner was diagnosed with neck and low back strains, contusions of her left shoulder and abdominal wall, cervical radiculopathy, a left elbow ulnar nerve contusion, cubital tunnel syndrome, tendonitis, lateral epicondylitis, and disc herniations at L4-5 and L5-S1. Petitioner underwent an anterior decompression and fusion at L5-S1, followed by a posterior fusion with instrumentation (which had to be aborted mid-procedure). Petitioner testified that even after her surgery, she still experiences symptoms, including a feeling of pressure in her back which increases with prolonged sitting.

SOIMCC003

20IWCC0034

Finally, the Commission notes that the Arbitrator, in his decision, omitted assigning a weight to subparagraph *(v)* of §8.1b(b), "Evidence of disability corroborated by the treating records." For the reasons stated above, the Commission assigns moderate weight to that factor. With regard to factors *(i)* through *(iv)* of §8.1b(b), the Commission affirms and adopts the Arbitrator's findings, determinations and weights assigned to those factors.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 27, 2018, is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of medical expenses is modified. The Commission reverses the Arbitrator's award of the providers' charges for the MRI spectroscopy. Respondent shall, however, pay all other reasonable and necessary medical expenses contained in Petitioner's group exhibit pursuant to the medical fee schedule, as provided in §8(a) and §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of permanent partial disability benefits is modified, and Respondent shall pay to Petitioner permanent partial disability benefits of $405.56 per week for a period of 100 weeks, as provided in §8(d)2 of the Act, because the injuries sustained caused a 20% loss of person as a whole.

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

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

Bond for 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: JAN 16 2020

Marc Parker

Deborah L. Simpson

Barbara N. Flores

o-12/05/19
mp/mcp
68

50IMCC003

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

STREATER, KESHA
Employee/Petitioner

Case# **16WC015535**

BI-STATE DEVELOPMENT AGENCY
Employer/Respondent

20IWCC0034

On 6/27/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.08% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0969 RICH RICH & COOKSEY PC
THOMAS C RICH
6 EXECUTIVE DR SUITE 3
FAIRVIEW HTS, IL 62208

0180 EVANS & DIXON LLC
SCOTT KELEMTEC
211 N BROADWAY SUITE 2500
ST LOUIS, MO 63102

STATE OF ILLINOIS)
)SS.
COUNTY OF MADISON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

KESHA STREATER
Employee/Petitioner

v.

BI-STATE DEVELOPMENT AGENCY
Employer/Respondent

Case # 16 WC 15535

Consolidated cases: _____

20IWCC0034

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Collinsville**, on **March 27, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **April 21, 2016**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$35,148.92**; the average weekly wage was **$675.94**.

On the date of accident, Petitioner was **40** years of age, ***single*** with **1** dependent child.

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

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

Respondent shall be given a credit of **$4,461.25** for TTD, **$11,476.49** for TPD, $- for maintenance, and $- for other benefits, for a total credit of **$15,937.74**.

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

ORDER

Respondent shall pay all reasonable and necessary medical expenses contained in Petitioner's group exhibit, pursuant to the medical fee schedule, as provided in § 8(a) and § 8.2 of the Act.

Respondent shall be given credit for medical benefits that have been paid through its group carrier, 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 § 8(j) of the Act.

Respondent shall pay Petitioner further additional temporary total disability benefits of **$450.63**/week for **37** weeks, commencing **February 6, 2017**, through **October 22, 2017**, as provided in § 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of **$405.56**/week for **75** weeks, because the injuries sustained caused the **15%** loss of the **body as a whole**, as provided in § 8(d)2 of the Act.

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

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

Signature of Arbitrator

6/23/18
Date

JUN 27 2018

FINDINGS OF FACT

The parties stipulated that Petitioner sustained accidental injuries that arose out of and in the course of her employment as a bus driver for Respondent, Bi-State Development, on April 21, 2016, when she was involved in a motor vehicle accident. (T.9, 11) Petitioner was making a left turn during a green light when a vehicle struck the side of the bus behind her driver's seat. (T.11) Petitioner sustained no injuries and required no treatment to her low back prior to April 21, 2016. (T.10-11) Respondent disputes causal connection and liability for medical expenses and temporary total disability benefits beyond January 2, 2017, and the nature and extent of the injury. (T.4, 27)

Petitioner was taken from the scene via Abbot Ambulance to Belleville Memorial Hospital, where Petitioner reported initially reported left anterior shoulder pain and inability to move the left shoulder. (PX3; PX4) X-rays were negative, and Petitioner was diagnosed with a left shoulder contusion and discharged with pain medication and muscle relaxers. (PX4) By the following morning of April 22, 2016, however, Petitioner had developed severe back pain. (PX5) Petitioner reported to BarnesCare Midtown on April 22, 2016, and complained of left shoulder pain, left upper extremity symptoms, and an onset of severe back pain upon awakening in the morning. (PX5) After the history was taken, physical examination demonstrated reduced grip strength of the left upper extremity, positive Spurling sign with left arm radiculopathy, left shoulder tenderness, positive Hawkins Kennedy test, positive infraspinatus test, and positive painful arc test. *Id.* An "Assessment of Causal Connection" was also included, which stated, "Based on my examination, the patient's history, along with a review of records presented to me, it is my opinion, within a reasonable degree of medical certainty, that the accident is the prevailing factor in causing the patient's medical condition and need for treatment." *Id.* Petitioner was diagnosed with strains of the neck and low back, contusions of the left shoulder and abdominal wall, and cervical radiculopathy. *Id.* Follow-up visits showed that Petitioner continued to have pain and tenderness over her left upper extremity, neck, and back. *Id.* Petitioner was referred for physical therapy at Athletico Physical Therapy. *Id.* Petitioner also obtained chiropractic care with Dr. Derrick Hamilton and Everett at Proficient Chiropractic. (PX8) Petitioner, however, continued to be symptomatic.

Petitioner presented to Dr. Nathan Mall on May 4, 2016, and he noted that Petitioner gained no significant improvement from conservative care and continued to have symptoms. (PX7) His physical examination demonstrated a positive Tinel's and positive flexion compression test of the left elbow, tenderness to palpation of the cervical spine with limited range of motion, left shoulder weakness, and weakness and pain with O'Brien's testing. (PX7, 5/4/16) His assessment was left elbow ulnar nerve contusion and inflammation, left elbow tendonitis and lateral epicondylitis, possible cervical spine disc herniation versus cervical strain, and left shoulder strain. *Id.* He prescribed medication and recommended an MRI of the neck and left upper extremity along with EMG and nerve conduction studies. *Id.* Dr. Mall also noted that

Petitioner continued to have pain and symptoms in her lumbar spine for which he gave a working diagnosis of lumbar strain with possible disc herniations. (PX7, 6/3/16)

Petitioner underwent the recommended EMG and nerve conduction studies and returned to Dr. Mall, at which time he noted the results demonstrating ulnar nerve compression at the left elbow with no evidence of cervical radiculopathy. (PX7, 6/3/16) He recommended an ulnar nerve night brace and continued chiropractic treatment for her spine complaints. *Id.* He also recommended an MRI of Petitioner's lumbar spine and a referral to Dr. Gornet for Petitioner's neck and back complaints. *Id.* On follow-up for her left upper extremity complaints, Dr. Mall noted that Petitioner's left shoulder and elbow were improving. (PX7, 7/7/16) These complaints ultimately subsided with conservative care, and Dr. Mall released Petitioner to Dr. Gornet's care. (PX7, 9/9/16) Petitioner testified at the hearing that her left shoulder is currently fine, and she is not claiming any permanent partial disability for her left shoulder injury. (T.13-14)

Petitioner also saw her family physician, Dr. Ann Nash, who noted Petitioner's complaints of back pain radiating to the buttocks and legs with a constant ache in her lower back rated 8 out of 10. (PX11) Dr. Nash's physical examination noted that Petitioner was ambulating slowly with tenderness and reduced range of motion of the elbow, spasms and tenderness on palpation, and reduced range of motion of the lumbar spine. *Id.*

Petitioner came under the care of Dr. Gornet on July 26, 2016. (PX9, 7/26/16) Dr. Gornet noted that Petitioner presented with a chief complaint of low back pain, left greater than right, that radiated into both hips and particularly the left side and left leg to her thigh. *Id.* He noted that Petitioner had no prior problems of significance with respect to her neck or back. *Id.* Physical examination demonstrated decreased EHL and ankle dorsiflexion on the left. *Id.* Dr. Gornet also made note of a complete absence of any functional overlays. *Id.* Dr. Gornet reviewed the MRIs of Petitioner's cervical and lumbar spine which showed an obvious central herniation obvious disc injury at C4-5 and to a lesser extent at C6-7 as well as an obvious central herniation and annular tear at L5-S1. *Id.* Dr. Gornet recommended a transforaminal steroid injection on the left at L5-S1, which he performed himself, as well as an epidural steroid injection for which he referred Petitioner to Dr. Blake. *Id.* He opined that Petitioner's condition of ill-being was causally related to the motor vehicle accident and placed Petitioner under restrictions. *Id.* Given that her lumbar pathology was more prominent, Dr. Gornet placed treatment of Petitioner's neck on hold. *Id.*

Petitioner returned to Dr. Gornet following the injections, but unfortunately did not obtain significant relief. (PX9, 9/29/16) Petitioner failed conservative treatment and continued to have substantial back pain. *Id.* Dr. Gornet recommended anterior lumber fusion and requested a VMA motion analysis, MRI spectroscopy, and plain CT films. *Id.* Petitioner was also kept under restrictions. *Id.* Petitioner returned on December 15, 2016, and Dr. Gornet noted that the MRI spectroscopy showed 10 out of 10 painful chemicals at the L5-S1 disc. (PX9, 12/15/16) Given

that the motion analysis study did not reveal any overt instability present, Dr. Gornet recommended moving forward with surgery. *Id.*

On March 1, 2017, Dr. Gornet began his staged approach and performed anterior decompression at L5-S1 and anterior lumbar fusion at L5-S1 with LT cages and BMP. (PX13, 3/1/17) Dr. Gornet attempted to finalize the procedure on March 3, 2017 via posterior fusion with instrumentation, but this was aborted due to inability to make pilot holes for pedicle screws. (PX13, 3/3/17) Dr. Gornet noted that this was an unusual situation that he had not encountered and declined to implement an alternative maneuver that would potentially lead to early adjacent level failure, especially given the relief Petitioner obtained following the first portion of the procedure. *Id.* Petitioner testified that she experienced pain relief immediately after surgery. (T.16) Dr. Gornet obtained post-operative CT films which showed good positioning of Petitioner's device with no evidence of lucency. (PX9, 3/20/17) Petitioner was referred for post-operative therapy and gradually improved to the point where she was allowed to return to work full duty on October 16, 2017. (PX9, 6/22/17, 10/5/17)

Petitioner testified that despite the improvement in pain from surgery, she continues to feel pressure in her back that increases with prolonged sitting. (T.18-20) Her symptoms are relieved by moving around; however, Petitioner continued to work her sedentary position as a bus driver. (T.19)

Respondent had Petitioner examined by Dr. Michael Chabot on January 4, 2017. (PX19, p.5) He testified that he took the history of the injury, reviewed Petitioner's records, performed his own physical examination, and reached diagnoses of status post involvement in a motor vehicle, resolved neck strain, left shoulder strain, history of left ulnar nerve neuropathy, back strain, disc degeneration at L5-S1, and depression. *Id.* at 11. He felt that all of the treatment rendered to Petitioner up until the date of his examination was reasonable and necessary; but opined that Petitioner was at maximum medical improvement at the time of his examination, that she required no further treatment, and that she could return to her employment as a bus driver. *Id.* at 12-13. He was later sent additional records to review and his opinion remained unchanged. *Id.* at 14.

Dr. Chabot charged $1,800.00 for Petitioner's independent medical evaluation and $600.00 for his addendum report. *Id.* at 24-25. He performs 4 to 5 examinations per week, and earns on average $270,000.00 a year performing medical/legal examinations alone. *Id.* at 25. He testified that he does not keep a record of for whom he gives depositions. *Id.* at 25. Dr. Chabot, however, acknowledged the existence of a list when counsel for Petitioner presented a list of IMEs from 2010 to 2014 that was provided to him when Dr. Chabot was deposed in a separate matter. *Id.* at 26-27.

Dr. Chabot acknowledged that Petitioner's pain diagram indicated continued low back pain at the time he examined her. *Id.* at 28. He was not aware that Petitioner's duties as a bus

driver involved assisting in the transport of disabled patients; he believed it was classified as a light duty job position. *Id.* at 13, 29-30. He acknowledged that no other physician, none of Petitioner's medical providers believed she was malingering, exaggerating, or had symptoms that didn't correlate with her findings in any way. *Id.* at 31. Dr. Chabot was not provided with the records of Dr. Blake or the records of Proficient Chiropractic. *Id.* at 35. He was not provided with any supplemental records beyond April 13, 2017, and did not have the record of Dr. Gornet from April 17, 2017, or August 3, 2017. *Id.* at 37. He was aware, however, that Petitioner had undergone surgery and improved. *Id.* at 37-38.

On further cross-examination regarding the medical summary in his report, Dr. Chabot admitted that he characterized Petitioner's reduced left upper extremity grip strength as "normal." *Id.* at 38-39. He omitted several positive physical examination findings throughout Petitioner's records, including the Spurling's sign noted in the Barnes Care Midtown records indicating radiculopathy in Petitioner's left arm, positive Hawkins-Kennedy test, and positive Painful Arc test. *Id.* at 39-10. He omitted the fact that Dr. Mall noted a positive O'Brien's test. *Id.* at 41. He omitted the fact that Dr. Gornet noted no prior problems of significance in Petitioner's neck or back. *Id.* at 43-44. He omitted the fact that Dr. Gornet noted no functional overlay. *Id.* at 44. He indicated that Petitioner's first injection was done by Dr. Blake, but it was performed by Dr. Gornet. *Id.* at 44.

Dr. Chabot testified that he disagreed with the interpretation of both the radiologist and Dr. Gornet with respect to the imaging studies, and he admitted that he omitted objective findings in the operative report reflecting a large central annular tear and admitted that this objective finding could cause Petitioner's symptoms. *Id.* at 47-48. He admitted that he had no record of any prior low back complaints, and admitted that at no point following the accident had her back pain returned to baseline. *Id.* at 48-49.

Petitioner's board certified family physician, Dr. Anne Nash, was deposed, and she confirmed that in her records she has kept on treating Petitioner since October of 2012, she has never treated Petitioner for back or neck pain prior to her undisputed accidental work injury on April 21, 2016. (PX20, p.5, 8-9) Following the accident, Petitioner presented to her with complaints of significant low back pain. *Id.* at 9-10. She testified that Petitioner's complaints were entirely consistent with her mechanism of injury and causally related to the motor vehicle accident. *Id.* at 12-15. She testified that there was no evidence of malingering and she found Petitioner to be a credible, forthcoming person. *Id.* at 15. She testified that Petitioner was much better following Dr. Gornet's treatment and corroborated the report of a complete resolution of Petitioner's pain following surgery. *Id.* at 15. Dr. Nash testified that she was not aware of any prior degenerative condition. *Id.* at 16. She also had an independent recollection of Petitioner before and after the accident, and she stated:

> One of the reasons I remember the case with Kesha is because I did know her before. I had seen her, and she appeared to me as a patient to be a different person after the

> accident, not similar affect that I had seen in the patient before. She was a lot more flat, more down, her movements were slowed. That isn't the way she presented to me before. It was clear to me at our first visit after the accident what had an impact, what she related to me was related to the trauma of the accident. *Id.* at 19-20.

Dr. Gornet also testified by way of deposition. (PX18) He is a board certified orthopedic surgeon whose practice is devoted to spine surgery. *Id.* at 3. He sees approximately 100 to 120 patients per week and performs 5 to 10 surgeries per week. *Id.* at 4. He is involved in ongoing clinical research and participates in clinical trials for diagnostics and treatment of neck and low back complaints. *Id.* at 4. He also performs 1 to 2 independent medical evaluations per month, mostly done at the request of the State of Illinois. *Id.* at 6. He testified that when Petitioner presented to him at the referral of Dr. Mall, she reported neck, left shoulder, and low back pain; however, her main and most significant complaint was low back pain radiating to her left lower extremity. *Id.* at 7-8, 11. He testified that Petitioner's films were negative for any significant lumbar spine degeneration. *Id.* at 10. He testified that Petitioner's diagnosis of L5-S1 disc injury was entirely consistent with the mechanism of injury. *Id.* at 10. He testified that Petitioner's current condition of ill-being was directly caused by the motor vehicle accident of April 21, 2016. *Id.* at 11.

Dr. Gornet testified that he recommended restrictions and injections in an effort to reduce the inflammation and pain in Petitioner's spine and resolve her complaints conservatively. *Id.* at 11-12. Petitioner, unfortunately, continued to be symptomatic. *Id.* at 13. He acknowledged that Petitioner continued to have neck pain on that date, but her neck complaints were placed on hold to address her lumbar spine. *Id.* at 13. It was at that point, Dr. Gornet recommended the VMA motion analysis, MRI spectroscopy, and CT films. *Id.* at 13. He testified that MRI spectroscopy is an FDA-approved technique that allows him to evaluate discs and their integrity. *Id.* at 5. He testified that the technique itself is widely available and has its own CPT code given its lengthy existence. *Id.* at 5. He testified that it is a safer diagnostic method than discography, because it is not invasive and carries no risk of infection from needle penetration. *Id.* at 19-20. He also stated that the procedure has been accepted by the North American Spine Society and was given an award for its new application. *Id.* at 28-29. Dr. Gornet stated that the MRI spectroscopy revealed painful chemicals at 10 on a scale of 10 at L5-S1, confirming with 100% certainty that said level was the source of Petitioner's pain. *Id.* at 17-18.

Dr. Gornet testified that the lumbar fusion was the best option for Petitioner, because he felt that removing the disc or part of the disc would only weaken Petitioner's spine and set her up for further structural back pain. *Id.* at 14. He explained:

> If she had significant nerve compression and neurologic symptoms, a decompression may be an option, if you felt that the rest of the disc was relatively stable or she had a sedentary occupation, but in this situation, my experience of commercial drivers and the bouncing and the vibration they have, doing a discectomy on her would not bear fruit.

> And so in prospective randomized clinical trials looking at structural back pain, back pain was significantly improved with anterior lumbar fusion. *Id.* at 14.

Dr. Gornet testified that he recommended surgery, because at that point, Petitioner had already had over 3 to 4 months of chiropractic care plus a further period of conservative care with injections and had exhausted all of her option with no improvement in her symptoms. *Id.* at 14-15. Dr. Gornet recommended the VMA motion analysis to look for subtle instabilities, fine tune the diagnosis, and increase the success rate of the surgery. *Id.* at 15-16.

Dr. Gornet testified that the surgery was a staged procedure, beginning on March 1, 2017, that consisted of anterior and posterior approaches. *Id.* at 23. During the anterior portion of the surgery, Dr. Gornet identified a large central annular tear and a shearing of Petitioner's annulus from the superior inferior endplates directly into the canal that propagated to the left, which correlated with Petitioner's subjective complaints. *Id.* at 23. Dr. Gornet testified that the procedure was uneventful with the exception that he was unable to place screws during the posterior procedure. *Id.* at 23. Dr. Gornet explained, however, that the devices were made to be potentially standalone and still gave Petitioner a good chance of healing without any further hardware placement. *Id.* at 23-24. He testified that Petitioner was markedly improved following the procedure. *Id.* at 24-25. He stated that if Petitioner's neck continued to be symptomatic, he would consider further evaluation and treatment, since the disc injuries visualized in Petitioner's cervical spine at C4-5 and C6-7 can cause persistent neck pain and headaches. *Id.* at 26.

Dr. Gornet testified that Dr. Chabot improperly placed Petitioner at maximum medical improvement at a time when she continued to be symptomatic and Petitioner had not exhausted her treatment options. *Id.* at 27. He testified that there was no evidence that Petitioner returned to a baseline or pre-injury status, and testified that Petitioner at no time exhibited any signs of symptom magnification or malingering. *Id.* at 31-32. He testified that all of Petitioner's medical care was warranted and reasonably necessary to treat her work-related condition of ill-being. *Id.* at 32-33.

CONCLUSIONS OF LAW

Issue (F): Is Petitioner's current condition of ill-being causally related to the injury?
Issue (J): Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
Issue (K): What temporary benefits are in dispute? (TTD)

In addition to or aside from expert medical testimony, circumstantial evidence may also be used to prove a causal nexus between an accident and the resulting injury. *Gano Electric Contracting v. Industrial Comm'n*, 260 Ill.App.3d 92, 631 N.E.2d 724 (4th Dist. 1994); *International Harvester v. Industrial Comm'n*, 442 N.E.2d 908 (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 workers' compensation claimant's injury. *Shafer v. Illinois Workers' Comp. Comm'n*, 2011 IL App (4th) 100505WC, 976 N.E.2d 1 (2011).

The record demonstrates that Petitioner had no prior significant problems with her lumbar spine. Respondent, however, disputes causal connection and liability for medical expenses and temporary total disability benefits beyond January 2, 2017, and the nature and extent of the injury. (T.4, 27) Based upon the clear chain of events and the objective evidence in the medical record, the Arbitrator finds that Petitioner met her burden of proof in establishing that she is entitled to continued benefits beyond the examination of Dr. Chabot.

The Arbitrator does not find Dr. Chabot's opinion credible or persuasive. Dr. Chabot deliberately omitted pertinent positive examination findings from a number of physicians while authoring his report and completely ignored the consistent objecting findings at L5-S1 identified by the radiologist and Dr. Gornet which were confirmed as part of the intraoperative findings. During his cross-examination, Dr. Chabot admitted that he characterized Petitioner's reduced left upper extremity grip strength as "normal." (PX19, p.38-39) He omitted the Spurling's sign noted in the Barnes Care Midtown records indicating radiculopathy in Petitioner's left arm, positive Hawkins-Kennedy test, and positive Painful Arc test. *Id.* at 39-10. He omitted the fact that Dr. Mall noted a positive O'Brien's test. *Id.* at 41. He omitted the fact that Dr. Gornet noted no prior problems of significance in Petitioner's neck or back. *Id.* at 43-44. He omitted the fact that Dr. Gornet noted no functional overlay. *Id.* at 44. He testified that he disagreed with the interpretation of both the radiologist and Dr. Gornet with respect to the imaging studies, and he admitted that he omitted objective findings in the operative report reflecting a large central annular tear and admitted that this objective finding could cause Petitioner's symptoms. *Id.* at 47-48. He admitted that he had no record of any prior low back complaints, and admitted that at no point following the accident had her back pain returned to baseline. *Id.* at 48-49. In light of these weighty admissions, the Arbitrator finds no factual basis for his opinion exists in the record. The

Arbitrator also took notice of the other exhibits introduced which call into question Dr. Chabot's candor in general.

The Arbitrator is persuaded by the opinion of Dr. Gornet, as it is substantiated by the evidence in the record. The Arbitrator also concurs with Dr. Gornet in holding that Petitioner had not reached maximum medical improvement and that the further treatment rendered to Petitioner was reasonable and necessary to relieve her of the effects of her work-related injury. Dr. Gornet testified that Petitioner exhausted conservative care. Despite months of conservative care through medication, physical therapy, and chiropractic care, Petitioner remained symptomatic. Dr. Gornet attempted additional conservative care through injections, but these also failed to bring Petitioner relief. Only after Petitioner exhausted all conservative care did Dr. Gornet recommend and perform surgery. Petitioner testified that Dr. Gornet's surgery completely resolved her symptoms of pain. (T.16, 18-19)

Upon establishing causal connection the reasonableness and the necessity of recommended medical treatment, employers are responsible for necessary prospective medical care required by their employees. *Plantation Mfg. Co. v. Indus. Comm'n*, 294 Ill.App.3d 705, 691 N.E.2d. 13, 229 Ill.Dec. 77 (Ill. 2000). This includes treatment required to diagnose, relieve, or cure the effects of claimant's injury. *F & B Mfg. Co. v. Indus. Comm'n*, 758 N.E.2d 18 (1st Dist. 2001). Respondent is therefore ordered to pay for all the reasonable and necessary medical expenses contained in Petitioner's group exhibit, and shall have credit for any amounts previously paid for which it claims credit, provided that it holds Petitioner harmless from any claims made by any medical providers regarding same.

With regard to the disputed temporary total disability benefits, given the above findings establishing that Petitioner had not reached maximum medical improvement when Respondent terminated benefits, the law in Illinois holds that "[a]n employee is temporarily totally incapacitated from the time an injury incapacitates him for work until such time as he is as far recovered or restored as the permanent character of his injury will permit." *Archer Daniels Midland Co. v. Indus. Comm'n*, 138 Ill.2d 107, 561 N.E.2d 623 (Ill. 1990). The ability to do light or restricted work does not preclude a finding of temporary total disability. *Archer Daniels Midland Co. v. Indus. Comm'n*, 138 Ill.2d 107, 561 N.E.2d 623 (Ill., 1990) citing *Ford Motor Co. v. Industrial Comm'n*, 126 Ill.App.3d 739, 743, 467 N.E.2d 1018, 81 Ill.Dec. 896 (1984). The evidence in the record fully demonstrates that Petitioner had not reached maximum medical improvement at the time of Dr. Chabot's examination. Respondent is therefore also liable for Petitioner's additional period of temporary total disability following her surgical intervention with Dr. Gornet from February 6, 2017, through October 22, 2017.

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

Pursuant to §8.1b of the Act, permanent partial disability from injuries that occur after September 1, 2011 are to be established using the following criteria: (i) the reported level of

impairment pursuant to subsection (a) of the Act; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. 820 ILCS 305/8.1b. The Act provides that, "No single enumerated factor shall be the sole determinant of disability." 820 ILCS 305/8.1b(b)(v).

(i) **Level of Impairment**: Neither Party submitted an AMA rating. Therefore, the Arbitrator gives no weight to this factor.

(ii) **Occupation**: Petitioner continues to work as a bus driver and testified that she notices pressure in her back after she drives all day for Respondent. (T.19) The Arbitrator places greater weight on this factor.

(iii) **Age**: Petitioner was 40 years old at the time of her injury. She must live and work with her disability for a considerable number of years. The Arbitrator gives greater weight to this factor under *Jones v. Southwest Airlines*, 16 I.W.C.C. 0137 (2016) (wherein the Commission concluded that greater weight should have been given to the fact that Petitioner was younger [46 years of age] and would have to work with his disability for an extended period of time).

(iv) **Earning Capacity**: There is no direct evidence of reduced earning capacity. The arbitrator gives no weight to this factor.

(v) **Disability**: As a result of her accident, Petitioner sustained injuries to her left upper extremity, neck and back, with her lumbar injuries being the most prominent. Petitioner sustained left ulnar nerve contusion, shoulder contusion, C4-5 and C6-7 disc injuries which resolved conservatively, and an L5-S1 annular tear which produced radicular pain and required surgery by way of fusion. Petitioner testified that despite the improvement in pain from surgery, she continues to feel pressure in her back that increases with prolonged sitting. (T.18-20) Her symptoms are relieved by moving around; however, Petitioner continued to work her sedentary position as a bus driver. (T.19) The Arbitrator finds Petitioner's complaints supported by the record.

Based upon the foregoing factors, the Arbitrator finds that Petitioner sustained serious and permanent injuries that resulted in the 15% loss of her body as a whole.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Abdulahad Rezko,
Petitioner,

vs. No. 14 WC 29959

20IWCC0035

Walmart,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causal relationship to the injury, temporary total disability, 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 July 10, 2018, is hereby affirmed and adopted.

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

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

50 INCC0032

20IWCC0035

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: JAN 16 2020

Barbara N. Flores

mp-mcp
o-11/21/19
68

Deborah L. Simpson

DISSENT

I respectfully dissent from the decision of the majority affirming and adopting the Arbitrator's decision in this case. I would have found that Petitioner's current conditions of ill-being are causally related to his August 8, 2014 accident.

Petitioner slipped and fell at work, striking his head and back on the floor. He was seen at Physicians Immediate Care on the day of his accident and initially diagnosed with cervicalgia, lumbago and contusions to his face, neck and scalp. He was given lifting restrictions of 5-10 lbs. and ordered to avoid prolonged standing, squatting, bending and twisting. Petitioner reported radiating symptoms within two weeks of his accident.

When Petitioner's symptoms did not improve, he was referred to spine surgeon, Dr. Martin Herman, who examined Petitioner on November 4, 2014. Dr. Herman continued Petitioner's restrictions and ordered cervical and lumbar MRI's. Those tests, performed in August 2015, revealed degenerative changes, disc desiccation and protrusions of both cervical and lumbar discs. Of note, Respondent did not approve the requested diagnostics causing delay in Petitioner's treatment, a result on which the Arbitrator relied heavily in determining that Petitioner had "gaps" in his treatment. At Petitioner's next exam 5 months later, Dr. Herman reported Petitioner had not undergone those MRI's because they had not been approved. Dr. Herman renewed his order for those tests on that date, but it took another 4 months, until August 5, 2015, before Petitioner underwent them.

By July 7, 2016, Petitioner came under the care of orthopedic surgeon Thomas McNally. Petitioner complained of constant neck pain radiating bilaterally to his shoulder and low back pain radiating into his buttocks. Dr. McNally diagnosed him with stenosis, cervical disc displacement, spondylosis and radiculopathy. He continued Petitioner's light duty restrictions and referred him to a pain management specialist. In August 2016, Petitioner underwent an EMG which revealed mild upper cervical radiculopathy and mild to moderate right wrist/palm neuropathy.

SOINCC0032

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At Petitioner's September 8, 2017 visit with Dr. McNally, he complained of neck pain down his upper extremities to his fingers; numbness and tingling in his arms, fingers and legs, and low back pain. Surgery was discussed but Petitioner wished to continue non-surgical treatment. Dr. McNally recommended physical therapy and a Functional Capacity Evaluation.

On September 26, 2017, Petitioner underwent a Functional Capacity Evaluation which revealed valid effort and found Petitioner only able to work only at a light duty level. Thereafter, Dr. McNally placed Petitioner on permanent work restrictions per the FCE, and referred him for further pain management treatment, while also keeping open the possibility of spine surgery. At his deposition, Dr. McNally opined that Petitioner's work accident caused his preexisting cervical and lumbar conditions to become symptomatic and in need of treatment.

Petitioner was examined by Respondent's Section 12 examiner, Dr. Steven Mather, on January 4, 2016 and January 26, 2017. After his examinations and review of Petitioner's medical records, Dr. Mather declared that Petitioner had suffered only cervical and lumbar strains. He concluded Petitioner was a malingerer; and that his EMG, which showed cervical radiculopathy, was invalid. He believed Petitioner's MRI showed only degenerative changes. Dr. Mather's opinions were based, in large part if not entirely, on his belief that Petitioner had no radicular type complaints prior to November of 2014.

I find Dr. McNally's opinions more persuasive than those of Dr. Mather. While Dr. Mather believed Petitioner exhibited positive Waddell's signs, none of Petitioner's other treating physicians reported similar findings. The fact that Petitioner's FCE was found to be valid also supports a conclusion that he was not malingering. Additionally, the fact that Petitioner continued to work for Respondent for more than 2½ years following his accident, until Respondent terminated him, dictates against a conclusion that he was malingering. Furthermore, Dr. Mather's attempt to discredit Petitioner's positive EMG is not persuasive. Finally, Dr. Mather's belief that Petitioner had no radicular symptoms prior to November of 2014 is simply wrong. Even the most cursory review of Petitioner's records reveals numerous instances of radicular complaints, including tingling, numbness and pain radiating into Petitioner's extremities. Dr. Mather is simply not a credible witness and I would not rely on any of his opinions in this case.

Given the evidence in this case, I disagree with the majority and would find that Petitioner's current conditions of ill-being are causally related to his work accident. I would have awarded Petitioner his reasonable and necessary medical expenses, the prospective care prescribed by Dr. Novoseletsky, and temporary total disability benefits between February 24, 2017 and May 8, 2018. Therefore, I respectfully dissent.

Marc Parker

501HCC0032

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

REZKO, ABDULAHAD
Employee/Petitioner

Case# 14WC029959

20IWCC0035

WALMART
Employer/Respondent

On 7/10/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.10% 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:

0019 SEIDMAN MARCULIS & FAIRMAN LLC
RYAN A MARCULIS
30 LAKE COOK RD SUITE 350
DEERFIELD, IL 60015

0560 WEBNER & MCAULIFFE LTD
BROOKE F TORRENGA
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)

Abdulahad Rezko
Employee/Petitioner
v.
Walmart
Employer/Respondent

Case # **14** WC **029959**

20IWCC0035

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 **Thomas L. Ciecko**, Arbitrator of the Commission, in the city of **Chicago**, on **May 8, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ 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 **8(a) medical**

20IWCC0035

FINDINGS

On the date of accident, **8/8/14**, 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 $**13,334.88**; the average weekly wage was $**256.44**.

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

The parties have reserved the liability for payment of 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

Temporary total disability

Petitioner is not entitled to TTD Benefits because any injuries he suffered in the accident of August 8, 2014 no longer impacted his ability to work, or employability when he was terminated from employment with Respondent.

In no instance shall this award be a bar to subsequent hearing and determination of 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

July 10, 2018
Date

ICArbDec19(b)

JUL 10 2018

Preface

The parties proceeded to hearing May 8, 2018, on Petitioner's Petition for an Immediate Hearing Under Section 19(b) of the Act, and Petition Under Section 8(a) Medical. Arbitrator's Exhibit 3. The Request for Hearing indicates the following disputed issues: whether Petitioner's current condition of ill-being is causally connected to this injury; whether Petitioner is entitled to temporary total disability; and whether Petitioner is entitled to prospective medical care in accordance with Section 8(a) of the Act. Arbitrator's Exhibit 1. Neither party ordered a transcript of the proceeding.

Findings of Fact

Abdulahad Rezko (Petitioner), testified at hearing by means of an Arab translator. He testified he does not speak English. Some medical records note: a language barrier (Physicians Immediate Care, 8-8-2014); Petitioner being accompanied by a translator or interpreter (Dr. McNally, 7-7-2016, 1-14-2016, 9-8-2017, 9-16-2017); Patient Registration Form indicates "Patient...speaks only Arabic no translator was available today. He rescheduled to July 7, 2016, and will bring a translator." (Suburban Orthopedics, 6-21-2016); and Petitioner's use of an interpreter (Dr. Mather, 1-14-2016). However, others note: Patient does not need an interpreter (Center for Brain and Spine Surgery, 10-8-2015); and Patient does not require an interpreter (Dr. Novoseletsky, 7-25-2016, 11-20-2017, 2-12-2018). It is also of note, Paul Ayala, the manager at the store where Petitioner worked, testified most conversations with Petitioner were without a translator. He testified he never thought Petitioner could not understand English. Every position Petitioner had with Respondent required him to communicate with others, in person and by using telecommunications equipment. Petitioner's Exhibit 1 (unpaginated); Petitioner's Exhibit 3 (unpaginated); Respondent's Exhibit 4 at 1; Respondent's Exhibit 5 at 1; Respondent's Exhibit 6 at 2.

Prior to beginning work with Respondent, Petitioner testified in 2013 he injured his neck working at K Mart. He said he recovered. An MRI of Petitioner's cervical spine taken November 27, 2013, reveals multilevel degenerative changes including disc protrusions with prominent disc/spur complexes, most marked C3-C4 and C5-C6. Respondent's Exhibit 10.

On August 8, 2014, Petitioner was employed part time with Respondent at its Niles location, as a lawn and garden seasonal sales associate. His position required him, essentially, to maintain the lawn and garden area and merchandise, and to receive and stock merchandise and supplies. Petitioner testified he tried to pull a pallet to a cooler. He said the floor was frozen, his feet stuck and he fell back, his head hit the floor and he hurt his back. Respondent's Exhibit 4 at 1.

Petitioner told two physicians, Dr. McNally and Dr. Novoseletsky, he slipped on water in a receiving area, falling on his back and head. Petitioner's Exhibit 3 (unpaginated). On the day of the accident, Petitioner signed an Associate Incident Report indicating he was injured on the back of the head and face. Although the Report directed the employee to describe what happened, Petitioner did not describe how the injury actually happened. Petitioner testified his manager filled out the report, although the manager's portion of the report is blank. Respondent's Exhibit 2.

Petitioner testified he was sent by Respondent to immediate care. On August 8, 2014, Petitioner was seen at Physicians Immediate Care. He complained of pain to his head, neck, and back. Two x-rays, of his cervical and lumbosacral spine, were taken revealing no fractures, dislocations or abnormalities. Petitioner was diagnosed with contusion to face/scalp/neck, cervicalgia and lumbago and taken off work until the next day. On August 9, 2014, Petitioner returned. His complaints and diagnoses remained the same. He was found fit for duty with restrictions, no: jumping; use of ladders; prolonged standing, squatting, bending over, twisting; no lifting over the shoulder of more than five pounds; no lifting from the waist or below the waist over 10 pounds; and no pulling or pushing over 15 pounds. Petitioner's Exhibit 1 (unpaginated).

Petitioner testified he was treated at Physicians Immediate Care for two months and worked light duty. The records indicate Petitioner had six more visits there, the last being October 4, 2014. The visits followed a repetitive pattern: Petitioner complains of pain in his head, neck and lower back; the diagnoses remained the same; medication is prescribed; and Petitioner is fit for duty with restrictions. Petitioner underwent an MRI of the brain and CT of the lumbar and cervical spine. The MRI of the brain showed no abnormality. The CT of the lumbar spine showed spondylosis and multi-level central canal stenosis. The CT of the cervical spine showed spondylosis. On Petitioner's final visit, October 4, 2014, he was advised to follow up with a spine specialist/neurosurgeon. He was found fit for duty with restrictions and released from care. The findings of the MRI and CT scans were not related to the fall. The notes indicate "He is being put back to full duty upon his request...." The note indicated "He is being released without any residual disability...." Petitioner's Exhibit 1 (unpaginated).

On November 4, 2014, Petitioner first saw Dr. Martin Herman at the center of Brain and Spine Surgery, complaining of neck and low back pain. Herman's examination of Petitioner's systems was negative and the physical exam was normal. Petitioner was assessed with cervicalgia, brachial neuritis or radiculitis and lumbago. A Work Status Note indicated permitted activity to be walking or standing only occasionally, occasional lifting of 10 pounds maximum and/or carrying articles like small tools. Petitioner then saw Herman five months later, April 2, 2015, complaining of neck pain and low back pain. The Work Status Note remained the same, with work restrictions. Petitioner's Exhibit 2 (unpaginated).

Paul Ayala testified Petitioner accepted a position as a People Greeter, which he described as light duty, May 2015. As a Greeter, Petitioner provided customer service and promoting products and services. The physical requirements required carrying up to 10 pounds, fine motor skills, and hand and eye coordination. Respondent's Exhibit 5 at 1.

Two months after changing positions with Respondent, on July 9, 2015, Petitioner again saw Dr. Herman, complaining of neck pain and low back pain. Herman's assessment was cervicalgia and lumbago. Petitioner was taking over the counter medication. Petitioner's Exhibit 2 (unpaginated).

Petitioner underwent an MRI of the cervical and lumbar spine on August 4, 2015, nearly a year after his fall. The cervical spine MRI revealed minor disc degeneration without nerve compression and the lumbar spine MRI showed minimal degenerative changes without signs of nerve root compression. There were no signs of acute trauma in either MRI. Petitioner's Exhibit 6; Respondent's Exhibit 1 at 16.

Petitioner returned to Dr. Herman on October 8, 2015, complaining of low back pain and neck pain. He was referred for physical therapy. As of three months later, Petitioner had not performed physical therapy. At that time, October 8, 2015, a Work Status Note indicated Petitioner was permitted to engage in sedentary work activities, walking or standing only occasionally, lifting 10 pounds maximum and frequent lifting or carrying of objects such as small tools. He was to alternate sitting and standing for one hour periods. Petitioner's Exhibit 2 (unpaginated); Respondent's Exhibit 1 at exhibit 2.

Petitioner submitted to an independent medical examination by Dr. Steven Mather, an orthopaedic spine surgeon, Board Certified in orthopaedic surgery. Mather testified by means of an evidence deposition. He said essentially 100 percent of his practice is devoted to treatment of the spine. He performs between 20 to 30 spine surgeries a month. He is the Chairman of Neuroscience at Good Samaritan Hospital and a team physician for the Chicago White Sox for seven years. Mather examined Petitioner January 4, 2016. Mather said Petitioner was taking no pain medication and had a perception of disability not consistent with the finding of a physical examination. Mather conducted a physical examination of Petitioner, reviewed his imaging, and reviewed the records of immediate care and Dr. Herman. It was Mather's impression Petitioner had a cervical and lumbar strain syndrome and psychogenic pain and function overlay. He testified the cervical and lumbar strain would have resolved themselves. Petitioner's subjective complaints did not correlate with objective findings or the MRI results. Mather found Petitioner at MMI August 4, 2015, needing no further treatment for his cervical or lumbar spine. Mather found Petitioner able to return to work without restrictions. He found Petitioner appeared to have significant symptom magnification. Respondent's Exhibit 1 at 4-6, 10, 15, 17-18; Respondent's Exhibit 1, exhibit 1; Respondent's Exhibit 1, exhibit 2.

Nonetheless, Petitioner returned to Dr. Herman four months later, May 10, 2016. He told Herman he occasionally works as a barber and has pain lifting his arms to cut hair. Petitioner testified he never worked as a barber, simply was in training. He did not know when he stopped. Paul Ayala testified Petitioner had a second job as a barber and had restricted ability not being able to work weekends. He said it was common knowledge at the store that Petitioner had this second job. Petitioner complained of neck pain and lower back pain to Herman. Herman noted Petitioner's pain unchanged in seven months, recording Petitioner has had no injections or physical therapy or any other treatment in six months, taking Advil for pain. Herman was aware of an IME but did not have the report. He referred Petitioner to Dr. Simon Adanin for treatment

of chronic pain and indicated he was "...not recommending surgery at this time." There was no indication of continued work restrictions. Petitioner's Exhibit 2 (unpaginated).

Petitioner testified he was referred to Dr. Thomas McNally by Dr. Herman. However, Petitioner told Dr. Mather he was referred to McNally by his attorney. At the time of his first visit to McNally, this case had been pending since September 2014. Almost two years after the fall, Petitioner first saw Dr. McNally July 7, 2016, complaining of neck and back pain. McNally's notes indicate Petitioner denied any treatment or physical therapy. McNally diagnosed Petitioner with: strain of muscle, facia and tendon of the neck and lower back; lumbar spine stenosis; cervical disc displacement; cervical spine stenosis; and cervical spondylosis. He recommended a cervical MRI, an EMG, physical therapy, and a prescription for Meloxicam. He referred Petitioner to Dr. Dimitri Novoseletsky for pain management. A Work Duty Status of July 7, 2016 noted "Return to work without restrictions." Respondent's Exhibit 1 at 22; Petitioner's Exhibit 3 (unpaginated).

On July 8, 2016, Petitioner accepted a position, of a lateral movement, of Pharmacy Sales Associate. The physical activities necessary to perform the essential functions of the position were virtually identical to Petitioner's position of Lawn and Garden Sales Associate which he held on the day of the fall, with increased communications requirements. Paul Ayala testified the position of Greeter was being eliminated in July 2016 and he told Petitioner he could apply for an open position or take severance. To take an open position, Ayala told Petitioner, he had to be at full duty or request an accommodation. After showing Petitioner what was open, Ayala said Petitioner was interested in Pharmacy Sales and would get his restrictions lifted. Ayala told Petitioner he would need it in writing. Ayala testified Petitioner returned with the release and was considered full duty and offered the job. From then, to Petitioner's termination in February 2017 Petitioner had no work restrictions or trouble with the job. Respondent's Exhibit 6 at 2; Petitioner's Exhibit 3 (unpaginated).

A week later, On July 14, 2016, Petitioner saw McNally again complaining of constant pain in the neck and pain in his lower back. He had stopped taking Meloxicam and denied taking pain medication. McNally testified via evidence deposition. He testified he never reviewed Dr. Herman's records or those from immediate care. He did not know if Petitioner fell on his back. His examination of Petitioner's lumbar spine was normal. McNally said Petitioner aggravated a cervical and lumbar degenerative condition because of the accident. He said Petitioner had some preexisting conditions, the cervical and lumbar strains superimposed on those conditions caused them to become symptomatic and require treatment. He believed this causally related to the accident. McNally testified he offered Petitioner surgery in September 2016 but Petitioner did not want to accept the risks of surgery. Petitioner testified he did not want surgery. McNally saw Petitioner a total of five times, with a one year gap between Petitioner's third and fourth visits. Petitioner complains of constant pain, takes only over the counter medication and does not want surgery. Three times McNally noted Petitioner had no work restrictions. Despite Petitioner working full duty, without restrictions, McNally, after a one year gap in treatment, referred Petitioner for a Functional Capacity Evaluation and considered Petitioner's conditions and related symptoms permanent, expecting them to wax and wane over the years, and expecting

Petitioner to require lifelong pain management. Petitioner's Exhibit 3 (unpaginated); Petitioner's Exhibit 7 at 32-34, 29, 26, 17, 19, 44.

The Functional Capacity Assessment was done September 26, 2017 by ATI Physical Therapy. Petitioner's work status was noted as "Not Working," yet his occupation was noted as "Stocker" which he had not been by any stretch since May 2015. The occupational demand level was noted as "Heavy" even though ATI had no job description for Petitioner. Petitioner told ATI he worked in the garden department, which he had not done in over two years. ATI concluded Petitioner's demonstrated physical demand level at 'light." Petitioner's Exhibit 4 (unpaginated).

Referred by Dr. McNally, Petitioner saw Dr. Novoseletsky four times: July 25, 2016; then well over a year later on November 20, 2017; on December 4, 2017; and finally, on February 2, 2018, three and a half years after the accident. On July 25, 2016 Novoseletsky noted the date of the accident as August 20, 2014. He noted Petitioner was taking over the counter medication for a pain level Petitioner said was 9/10, always feeling pain. His impression, for neck pain was: facet syndrome; spinal stenosis; and IDD. His impression, for low back pain, was: facet syndrome, sacroiliitis; IDD; spinal stenosis; and radiculitis. He recommended physical therapy and an EMG. He placed no work restrictions on Petitioner at that time. Petitioner was working as a Pharmacy Sales Associate. By the last time Novoseletsky saw Petitioner, he prescribed topical Lidocaine for Petitioner's constant low back pain. A year after Petitioner was terminated from Respondent, Novoseletsky indicated Petitioner could return to work with restrictions as listed in the Functional Capacity Assessment. What those restrictions were, was left unsaid. Petitioner's Exhibit 3 (unpaginated).

As to physical therapy, there was passing testimony from Petitioner on the recommendation of therapy. Except for two brief notes on therapy in the records of Dr. McNally, there was no evidence submitted on any therapy sessions. The initial examination of August 1, 2016, over a year after Dr. Herman referred Petitioner for therapy, indicated Petitioner complained of back and neck pain. The therapists plan was therapeutic exercises, manual therapy, patient education, and electric stimulation two to three times a week for six weeks. A Progress Note of September 16, 2016, after 12 visits, found Petitioner reporting himself 80 percent improved in neck and back symptoms, and not taking any medication. A year later McNally found Petitioner facing permanent work restrictions and lifelong pain management. Petitioner's Exhibit 3 (unpaginated).

Petitioner submitted to a repeat independent medical examination with Dr. Steven Mather on January 23, 2017. Since the first IME, Petitioner started treating with Dr. McNally. Mather noted that Dr. Novoseletsky recommended epidural steroid injections even though Petitioner has a history of diabetes. Mather noted a month of chiropractic treatment. Petitioner told Mather he was working without restrictions. Mather noted as of July 19, 2016, Petitioner was told to return to work without restrictions by Dr. McNally. Mather noted that Petitioner had an EMG which could not be validated. An EMG of the lower extremities was also done with normal findings. Mather concluded his additional evaluation of Petitioner confirmed his previous opinion that Petitioner suffered a simple cervical and lumbar strain. He said Petitioner "...exhibits bizarre complaints that cannot be validated by examination, imaging, or comparing his current

examination during this IME to the exams of Dr. McNally and Dr. Novoseletsky, both of which showed normal cervical range of motion, normal grip, and no focal findings on exam." Mather said petitioner required no further treatment for the lumbar and cervical spine, and has no basis for work restrictions at this time. Mather testified he found evidence of symptom magnification by Petitioner. He said none of the treatment of Petitioner between January 4, 2016 and January 23, 2017 was medically necessary. Respondent's Exhibit 1 at 30; exhibit 3.

At the time of hearing Petitioner testified he had severe pain in his neck, lower back, and left leg; has imbalance with his leg; and numbness in his fingers and both arms.

Conclusions of Law

Disputed issue **F** is, is Petitioner's current condition of ill-being causally related to the injury.

To prevail in a claim for benefits under the Act, a petitioner must prove, by a preponderance of the evidence, that he suffered a disabling injury that arose out of and in the course of his employment. Sisbro, Inc. v. Industrial Commission, 207 Ill. 2nd 193, 203 (2003). The "arising out of" component concerns the causal connection between a work related injury and the employee's condition of ill-being. National Freight Industries v. Illinois Workers' Compensation Commission, 2013 Ill. App. (5th) 120043 WC paragraph 25. To establish causation, a petitioner must prove that some act or phase of employment was a causative factor in his ensuing injury. Land and Lakes Co. v. Industrial Commission, 359 Ill. App. 3d 582, 592 (2005). It is not necessary to prove that the employment was the sole causative factor or even the principal causative factor, but only that it was a causative factor. Republic Steel Corp. v. Industrial Commission, 26 Ill. 2d 32, 45 (1962).

At hearing, Petitioner claimed his condition of ill-being was severe pain in his neck, lower back, and left leg; imbalance with his leg; and numbness in his fingers and both arms. There is conflicting medical evidence by Dr. Steven Mather and Dr. Thomas McNally. I note that Dr. Dimitry Novoseletsky authored a "Rebuttal to Independent Medical Evaluation" on January 12, 2018, addressed "To whom it may concern." That is clearly written for the purpose of litigation and therefore violates Section 16 of the Act. His opinion is disregarded.

Weighing the medical records properly submitted into evidence by the parties, the testimony of Petitioner, Dr. Mather, and Dr. McNally, I find Dr. Mather more credible and reliable on this issue. Here, Petitioner suffered a cervical and lumbar strain as a result of the fall that had long since resolved, by August 4, 2015. That is the injury causally related to the stipulated work related accident, not Petitioner's alleged current condition of ill-being.

In doing so, I note Dr. Mather conducted a physical examination of Petitioner, reviewed records from both immediate care and Dr. Herman, and reviewed imaging. He twice saw Petitioner. In contrast, McNally never saw Petitioner's prior medical records, and changed his

testimony on the question of surgery, first saying he offered Petitioner surgery then saying he did not recommend it.

I note the huge gaps in the medical treatment of Petitioner over the last four years, as well as the lack of really any medication at all. For a lot of the time Petitioner essentially had no treatment at all. There was fundamental lack of specific evidence on physical therapy, and the peculiar way Petitioner came to see Dr. McNally and Dr. Novoseletsky. Petitioner was able to work for three years after the accident until his termination. Time after time McNally noted Petitioner had no work restrictions.

In this instance, Dr. Mather was in the superior position to Dr. McNally. I rely on Mather's observation that Petitioner had a perception of severe disability not consistent with the findings on physical examination. I rely on Mather's testimony: Petitioner was at MMI August 1, 2015; Petitioner needed no further treatment for his cervical or lumbar spine; Petitioner exhibited symptom magnification; and none of the treatment Petitioner received between January 4, 2016 and January 23, 2017, was medically necessary. Most telling is Mather's observation that Petitioner exhibited bizarre complaints that could not be validated by examination, imaging, or comparing his examination to those of McNally and Novoseletsky.

This Arbitrator finds, as a conclusion of law, Petitioner's current stated condition of ill-being is not causally related to the injury.

Disputed issue **L** is, what temporary total disability benefits are due Petitioner. Specifically, this is from the time of termination to hearing. This Arbitrator finds, as a conclusion of law, based on issue **F**, none are due. Moreover, the evidence presented at hearing, the testimony of Paul Ayala, the testimony of Dr. Mather, Petitioner's Job Descriptions, and the records of Dr. McNally shows Petitioner was not temporarily disabled as a result of his work place fall when he was terminated nearly three years later.

Disputed issue **O** is, whether Petitioner is entitled to prospective medical care. This Arbitrator finds, as a conclusion of law, based on issue **F**, he is not. I also note in Dr. McNally's testimony he was not actually recommending surgery.

Jerome L Cole

Arbitrator

July 10, 2018

STATE OF ILLINOIS)
) SS.
COUNTY OF MCHENRY)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

RICHARD OGLE,

Petitioner,

vs. NO: 14 WC 38555

CATALENT PHARMA SOLUTIONS,

20 IWCC0036

Respondent.

Timely Petition for Review having been filed by Respondent herein and notice given to all parties, the Commission, after considering the issues of medical expenses, temporary total disability benefits, permanent partial disability benefits, and an evidentiary ruling on the admissibility of Respondent's Exhibit 1, and being advised of the facts and law, reverses the Decision of the Arbitrator with respect to the admissibility of Respondent's Exhibit 1 as stated below, and otherwise affirms and adopts the Decision of the Arbitrator with respect to all remaining issues. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total disability 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 (1980).

Petitioner deposed Dr. Dana Tarandy, Petitioner's treating physician, on February 2, 2017. Before the evidence deposition commenced, Petitioner's counsel moved to exclude witnesses pursuant to Rule 615 of the Illinois Rules of Evidence. (PX9, p. 4) Petitioner's counsel stated, "...do you have any objection...to the motion to exclude witnesses as if this were a trial?" (PX9, p. 4) Respondent's counsel did not object, stating, "There's no witnesses here today. No problem." (PX9, p. 4)

The evidence deposition of Dr. Tarandy was concluded on that day and a copy of the transcript was provided to Dr. Bryan Neal, Respondent's §12 physician. Dr. Neal reviewed Dr. Tarandy's testimony and his own prior report and provided a supplemental report, dated September 18, 2017. (RX1) Petitioner's counsel advised Repondent's counsel he would waive his hearsay objection to the admission of Dr. Neal's reports. Dr. Neal was not deposed. At Arbitration,

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Respondent offered Dr. Neal's supplemental report into evidence as Respondent's Exhibit 1. Petitioner objected citing Respondent's violation of Petitioner's motion to exclude witnesses under Rule 615 when he forwarded Dr. Tarandy's testimony to Dr. Neal.

Respondent takes issue with the exclusion of Respondent's Exhibit 1 arguing as a matter of law it was erroneous to exclude the supplemental report. When Petitioner made the motion, it is argued, the hearing had not commenced. Alternatively, Petitioner argues the motion to exclude was made prior to taking any testimony in the matter, no objection was made to the motion, a witness reviewed the testimony from the evidence deposition and thus violated the motion. Therefore, Petitioner argues, the Arbitrator properly excluded the report. The Arbitrator excluded Respondent's Exhibit 1 noting the motion was made properly and timely prior to taking any testimony and Rule 615 uses the word "shall" which, the Arbitrator interpreted, is a mandatory order upon motion of either party. After reviewing the relevant facts and law, the Commission reverses the Arbitrator's evidentiary ruling and admits Respondent's Exhibit 1.

Section 9030.70(a) of the Rules Governing Practice Before the Illinois Workers' Compensation Commission states:

> The Illinois Rules of Evidence shall apply in all proceedings before the Commission, either upon Arbitration or Review, except to the extent they conflict with the Act, the Workers' Occupational Diseases Act (820 ILCS 310), or the Rules Governing Practice Before the Workers' Compensation Commission. (50 Ill. Admin. Code Ch. VI)

Rule 615 of the Illinois Rules of Evidence states:

> At the request of a party the court shall order witnesses excluded so that they cannot hear the testimony of other witnesses, and it may make the order of its own motion. This rule does not authorize exclusion of (1) a party who is a natural person, or (2) an officer or employee of a party which is not a natural person designated as its representative by its attorney, or (3) a person whose presence is shown by a party to be essential to the party's cause, or (4) a person authorized by law to be present. (Ill. R. Evid. 615)

Central to this issue is when does a hearing begin, for purposes of the motion to exclude witnesses. The issue was addressed in *City of Chicago v. IWCC*, 387 Ill. App. 3d 276, 899 N.E.2d 1247 (2008). In that case, the Commission rejected the employer's physician report under Section 12 because it was tendered after the treating physician's evidence deposition. Section 12 requires an examining physican's report to be provided to the injured employee no later than 48 hours before the start of the hearing and that, if the report is not disclosed, the examining physician will not be allowed to testify. 820 ILCS 305/12 (West 2004) The court held that the term "hearing" in section 12 referred to the Arbitration hearing, not the treating physician's deposition. *City of Chicago*, 387 Ill. App. 3d at 280, 899 N.E.2d at 1250. In his concurring opinion, Justice Gordon noted that the term "hearing" is generally defined as being synonymous with the term "trial." *City of Chicago*, 387 Ill. App. 3d at 281-82, 899 N.E.2d at 1251, (Gordon J., concurring) (citing *Donovan v. Industrial Comm'n*, 125 Ill. App. 3d 445, 449 465 N.E.2d 1071, 1074 (1984)).

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"Therefore, given its plain and ordinary meaning, a hearing begins when the parties start to present their arguments and evidence to the arbitrator, not with the taking of an evidence deposition." *City of Chicago*, 387 Ill. App. 3d at 281-82, 899 N.E.2d at 1251 (Gordon J., concurring).

The Commission also disagrees with the interpretation of Rule 615 as being mandatory on the court upon motion of a party. The decision points to the use of the word "shall" versus "may". It is well settled that the court has discretion to exclude witnesses from the courtroom during a trial. *People v. H.S.H. (In re H.S.H)*, 322 Ill. App. 3d 892, 751 N.E.2d 1236 (2001). Excluding a witness is an appropriate measure intended to preclude, intentionally or not, a witness's shaping of his or her testimony to that of witnesses who have already testified; to the same end, the court can instruct witnesses not to discuss their testimony with others who will testify. *Id.* at 896, 751 N.E.2d at 1241. Clearly, the court has discretion to grant a motion to exclude witnesses at Arbitration.

Also, the use of the word "shall" in this instance is not mandatory but directory. The Illinois Supreme Court addressed this "mandatory/directory dichotomy" in *People v. M.I. (In re M.I.)*, 2013 IL 113776, 99 N.E.2d 173. The language at issue was "the court shall commence a hearing within 30 days..." *Id.* at ¶14, 99 N.E.2d at 181. The Supreme Court stated:

> With respect to the mandatory/directory dichotomy, we presume that language issuing a procedural command to a government official indicates an intent that the statute is directory. This presumption is overcome, and the statute read as mandatory, under either of two conditions: (1) when there is negative language prohibiting further action in the case of noncompliance; or (2) when the right the provision is designed to protect would generally be injured under a directory reading. *Id.* at ¶17, 99 N.E. at 181, citing *People v. Delvillar*, 235 Ill.2d 507, 517, 922 N.E.2d 330, 336 (2009).

The Commission finds neither of those conditions to have been met, therefore, Rule 615 is directory, which is consistent with caselaw finding the trial court has discretion to grant a motion to exclude.

The cases cited in the Arbitrator's decision are distinguishable because in each case, the motion to exclude was brought at the commencement of trial. In *Skeleton v. Chicago Transit Authority*, 214 Ill. App. 3d 554, 573 N.E.2d 1315 (1st Dist. 1991), witnesses were excluded from observing testimony at trial. Likewise, in *Friedman* v. *Park District of Highland Park*, 151 Ill. App. 3d 374, 502 N.E.2d 826 (2nd Dist. 1986), the Appellate Court ruled the trial court acted within its discretion when it excluded the expert witness from the courtroom. Similarly, in *Gatto v. Curtis*, 6 Ill. App. 3d 714, 736, 286 N.E.2d 541, 555 (1st Dist. 1972), the court, noting enforcement of the rule was within the sound discretion of the trial court, ruled the witness should be excluded. There, a motion to exclude was made at the commencement of the trial and Respondent's counsel read portions of the trial testimony that had been transcribed to a witness. Again, the motion was made at trial.

Finally, in further support of the admission of Respondent's Exhibit 1, the Commission relies on *People v. Dresher*, 364 Ill.App.3d 847, 847 N.E.2d 662 (1st Dist. 2006). In *Dresher*, the court noted the distinction between excluding a lay witness and an expert witness whose testimony

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is offered to explain, repel, contradict or disprove evidence presented by the opposing party. *Id.* at 862, 847 N.E.2d at 674-675, citing *People v. Henny*, 334 Ill. App. 3d 175, 187, 777 N.E.2d 484, 495 (1st Dist. 2002). The *Dresher* court held the trial court did not err in allowing the State's experts to review transcripts of the defense witness testimony before the State's experts testified in rebuttal. *Dresher*, 364 Ill. App. 3d at 862, 847 N.E.2d at 675. Here, Dr. Neal was reviewing Dr. Tarandy's testimony for rebuttal evidence. Therefore, it was proper for him to review the transcript.

Based on the foregoing, the Commission reverses the Arbitrator's ruling and admits Respondent's Exhibit 1 into evidence.

The Commission, after reviewing the evidence, including Respondent's Exhibit 1, concludes that Dr. Tarandy's opinions concerning causal connection and Petitioner's need for further medical treatment are more credible than those of Dr. Neal's. Accordingly, the Commission affirms and adopts the Arbitrator's findings with respect to those issues as well as medical expenses and temporary total disability benefits.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent's Exhibit 1 is admitted into evidence and the Arbitrator's findings with respect to the admissibility of Respondent's Exhibit 1 are stricken from the Decision of the Arbitrator.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $330.43 per week for a period of 126-3/7 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 sum of $6,439.47 for medical expenses under §8(a) of the Act.

IT IS FURTHER ORDERD BY THE COMMISSION that Respondent provide and pay for the reasonable, necessary, and related medical treatment for Petitioner's left shoulder as recommended by Dr. Dana Tarandy, including the recommended arthroscopic rotator cuff repair, arthrotomy, and subacromial decompression surgery as well as other reasonable and necessary medical treatment related thereto.

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 $48,400.00. 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: JAN 17 2020
KAD/mav
O: 11/19/19
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Kathryn A. Doerries

Maria E. Portela

DISSENT

I respectfully partially dissent from the opinion of the majority and would fully affirm the Decision of the Arbitrator. It is indisputable that Petitioner properly made a motion to exclude witnesses pursuant to Illinois Rule of Evidence 615. Neither the majority nor Respondent has identified legal precedent that supports a reversal of the Arbitrator's well-reasoned evidentiary ruling.

As a preliminary matter at Dr. Tarandy's deposition, Counsel for Petitioner made a motion to exclude witnesses. The attorney further clarified that his motion was "to exclude witnesses as if this were a trial." Respondent made no objection and only noted that no additional witnesses were present at the deposition. After Dr. Tarandy's deposition concluded, Dr. Neal, Respondent's Section 12 examiner, produced an addendum to his Section 12 report. This addendum directly rebutted Dr. Tarandy's deposition testimony. It appears there is no Illinois appellate decision addressing this narrow issue. Absent direct guidance otherwise, I believe Arbitrator interpreted the applicability of Rule 615 consistently with existing legal precedent. After carefully considering this issue, I believe the rebuttal opinion of Dr. Neal was properly rejected by the Arbitrator.

For the forgoing reasons, I would affirm the Decision of the Arbitrator.

Thomas J. Tyrrell

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

OGLE, RICHARD
Employee/Petitioner

Case# **14WC038555**

CATALENT PHARMA SOLUTIONS
Employer/Respondent

20IWCC0036

On 1/9/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.57% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in 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
KEVIN S BOTHA
505 E HAWLEY ST SUITE 240
MUNDELEIN, IL 60060

2999 LITCHFIELD CAVO LLP
ANITA JOHNSON
303 W MADISON ST SUITE 300
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF McHenry)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Richard Ogle
Employee/Petitioner

v.

Catalent Pharma Solutions
Employer/Respondent

Case # **14** WC **38555**

Consolidated cases: _____

20IWCC0036

An *Application for Adjustment 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 **Rockford, Illinois**, on **November 9, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ 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 **Arbitrator's ruling on Petitioner's motion to exclude witness**

FINDINGS

On the date of accident, **May 16, 2014**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$25,773.80**; the average weekly wage was **$495.65**.

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

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

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

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

ORDER

- The Respondent shall pay Petitioner Temporary Total Disability benefits of $**330.43**/week, for **126-3/7** weeks, commencing **6/9/2015** through **11/9/2017**, pursuant to §8(a) of the Act.
- The Respondent shall pay the Petitioner medical expenses pursuant to §8(a) in the amount of $**6,439.47**, according to the Illinois Medical Fee Schedule, with Respondent receiving credit for bills already paid.
- The Respondent shall authorize and pay for the additional reasonable, necessary and related medical treatment as recommended by Dr. Dana Tarandy, for Petitioner's left shoulder including the recommended arthroscopic rotator cuff repair, arthrotomy and subacromial decompression surgery, as well as any associated temporary total, temporary partial disability benefits and other reasonable and necessary medical treatment related thereto.

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

1/8/18
Date

ICArbDec19(b)

JAN 9 - 2018

20IWCC0036

STATEMENT OF FACTS

Petitioner testified that on May 16, 2014, while working as a Production Assistant II for Respondent, he injured his left shoulder while bending over and pushing a skid across the floor. He testified that the empty skid was constructed of plastic and wood and estimated that it weighed approximately 15 pounds. He testified that while pushing it across a concrete floor, he felt a severe intense pain in his left shoulder. Petitioner stated the pain felt "like someone stuck a knife in my shoulder." He reported the injury to his supervisor, Terry Porter that same day and together they wrote up an accident/incident report. Accident and Notice is undisputed.

Petitioner testified that he asked his supervisor, Terry Porter for a copy of the incident report on several occasions during June and July 2014 because he wanted to go and see a doctor. During this period of time he did not receive any medical treatment. Ultimately he was given permission by Kareen Nunnally in Respondent's Safety Department in August 2014 to seek medical treatment.

On August 12, 2014, Petitioner presented at Centegra Occupational Health where he was evaluated by Nurse Practitioner Ashley Cochran. The date of initial injury was recorded as May 2014. Petitioner presented with a chief complaint of pain to the left shoulder. The records indicate that sometime in May, he was at work pushing a skid weighing approximately 15 pounds across the floor when he felt immediate pain to his left shoulder. He reported that the pain felt like being stabbed with a knife. The pain had been a constant dull ache since the time of the injury with intermittent sharp pain upon specific movements. The pain was provoked by internal rotation, overhead motions and repetitive movement and was essentially unchanged despite a home exercise program of stretching and nonsteroidal anti-inflammatory medications. (Px.1 p.4) On examination, he was tender to palpation over the bicipital groove of the left shoulder and had pain upon maximal internal rotation and flexion. He had a negative drop arm test and a positive supraspinatus test. The assessment was a left shoulder strain and he was prescribed a Medrol Dosepak, and instructed to ice the shoulder 3 times a day, follow a home exercise program and stop taking NSAIDs. He was also placed on light duty work restrictions no lifting more than 10 pounds with the left arm and minimal pushing, pulling, carrying, and no work above shoulder height with the left arm. (Px.1 p.4-5) The triage note indicated that the Date/Time of injury was May 2014. (Px.1 p.7)

Petitioner followed up at Occupational Health on August 19, 2014 where they noted no improvement and his pain level was 8/10. He continued to complain of intermittent left shoulder pain worse with certain activities. Petitioner reported that the pain woke him from sleep at night and that he could hear clicking with range of motion. On examination, there was full but painful range of motion to the left shoulder and palpable crepitation upon internal and external rotation. Drop arm test and supraspinatus test were positive. He was prescribed Ibuprofen, Norco, a home exercise program, physical therapy, an MRI and work restrictions. (Px.1 p.8) The records from Centegra Occupational Health indicated that the date of injury was May 30, 2014. (Id) Work restrictions consisted of no lifting more than 10 pounds and minimal pushing, pulling, carrying and no work above shoulder height with the left arm. (Px.1 p.18).

On September 2, 2014, Petitioner followed up at Occupational Health for left shoulder pain with no improvement. There was tenderness over the lateral surfaces with painful range of motion. The provider called Sedgwick for preauthorization and Petitioner was to continue current prescriptions and continue light duty. Authorization of the MRI and physical therapy was still pending. (Px.1 p.9, 19) Again, the records from Centegra Occupational Health indicate that the date of injury was May 30, 2014. (Px.1 p.9) On September 9, 2014, he followed up for left shoulder pain which was persistent with simple activities of daily living such as

washing hair. He had increased pain with lifting and the pain prevented him from sleeping. He had pain on internal and external rotation. The records indicate that he needed an MRI that was still pending authorization (voice mail messages were left for Carrie at Sedgwick and Kareen and Jerry at Catalent. (Px.1 p.10, 20) Petitioner's pain medication was refilled (Px.1 p.10) He was released to work with the same restrictions. (Px.1 p.20) On September 16, 2014, he reported increased pain with mandatory overtime since his last visit and the pain remained constant at 8/10. Pain was provoked with any overhead motion and he got only minimal relief from Norco and Motrin. Messages were again left for Sedgwick and J. Reget regarding a prolonged delay in necessary diagnostic services and maximum rehabilitation potential would be affected if not expedited. (Px.1 p.11) Work restrictions were again in effect. (Px.1 p.21)

On September 22, 2014, Petitioner underwent an MRI of the left shoulder which showed 1.) large full-thickness supraspinatus tendon tear with retraction of the torn tendon margin. There was also a punctate interstitial tear of the subscapularis tendon; 2.) disruption and distal retraction of the long head of the biceps tendon; 3.) probable degenerative type tearing of the labrum; 4.) small joint effusion with fluid extending into the subacromial/subdeltoid bursa; and 5.) degenerative changes of the shoulder. (Px.1 p.15)

Petitioner followed up at Occupational Health on September 30, 2014 and again on October 7, 2014 with worsening of left shoulder pain and decreased range of motion. Petitioner was then referred for an orthopedic consultation and was released from the care of Centegra Occupational Health. (Px.1 p.12-13) Work restrictions remained in effect and physical therapy was placed on hold until orthopedic evaluation. (Px.1 p.22-23) Petitioner was referred to see Dr. Patel. Petitioner testified that he elected to see Dr. Dana Tarandy with whom he had treated with in the past for a knee condition.

Petitioner testified that he was told that the date of injury was May 30, 2014 by the medical providers at Centegra Occupational Health. The records also confirmed that the date of injury was recorded as May 30, 2014 (See Px.1 p.8-13, 18-23). He testified that he could not recall the specific date of injury at the initial visit at Occupational Health but was later informed that the date of injury was May 30, 2014 by Occupational Health and he assumed that the date of injury was May 30, 2014. This is the date of injury that he gave to subsequent medical providers.

Petitioner was evaluated by Dr. Tarandy's Physician Assistant, Christopher Northern on October 14, 2014. The records reflect a date of injury of May 30, 2014 and that Petitioner was a 63-year-old Caucasian right-hand dominant male who presented for evaluation and treatment of a Worker's Compensation injury to the left shoulder. The injury occurred 5 months ago while at work when he was pushing an empty pallet across the floor and felt a pop in his left shoulder followed by pain which has hurt ever since. He was also there also to discuss his work comp knee injury which would be covered under a different office visit and note because it was a separate injury. (Px.2 p.43) On examination, there was moderate tenderness to palpation over the anterior and posterior aspect of the shoulder with evidence of a biceps tendon rupture. There was reduced strength against resistance with a positive empty can test. A review of the MRI from September 22, 2014 showed SS tear, biceps tendon tear, fraying of the labrum and degenerative joint disease. The assessment was left AC joint arthritis, supraspinatus tear, proximal biceps tendon tear as a result of a work-related injury. The plan was to manage his pain with injections, gradually resume regular activities as guided by his pain and he was given an injection in the shoulder on this day. He was to continue physical therapy as recommended by Occupational Health. It was agreed that his knee would be taken care of first. Dr. Tarandy discussed the case with Mr. Northern and agreed with the plan. (Px.2 pp. 45-46)

Petitioner had an initial evaluation for physical therapy for his left shoulder at Adult & Child Therapy Services on November 5, 2014 The records show that he had complaints of a left supraspinatus tear and left biceps tear. This condition started on May 30 when he was working at Catalent and lifting boxes to place on a

shelf when he heard a pop and had immediate intense left shoulder pain. He was placed on light duty and the pain was getting significantly worse during work/daily activities. He also noted difficulty manipulating the pill bottles and eye drop bottles at work, and was having a hard time twisting the tops of bottles and squeezing the eye drop bottles. Dr. Tarandy had recommended surgery in the future but recommended physical therapy in the meantime. (Px.5 p.60). The plan was to administer physical therapy twice a week for 4-6 weeks. (Px.5 p.63) Petitioner testified that he disagreed with the history contained in the physical therapy records. He testified that his left shoulder was injured when he was pushing a skid across the floor. He also explained that part of his job involves placing boxes on shelves which may have caused the confusion in the records.

Petitioner followed up with Dr. Tarandy on November 18, 2014 for his left shoulder. The doctor recorded that Petitioner had been involved in physical therapy with increasing pain and limited range of motion. Dr. Tarandy noted Petitioner had failed conservative treatment and as a result recommended surgical management which Petitioner would consider after undergoing his knee surgery first. (Px.2 p.107)

Petitioner underwent arthroscopic knee surgery on December 19, 2014 for a condition unrelated to this accident. Petitioner continued to follow up with Dr. Tarandy for both his left shoulder and right knee condition. On March 5, 2015, he followed up with Dr. Tarandy for his left shoulder and continued to complain of severe shoulder pain and limitation. An examination demonstrated he had range of motion to flexion to 150° with pain, abduction to 130° with pain, positive Neer and Hawkins impingement tests and a positive cross body adduction test. Strength was 3 out of 5. The assessment was a history of left shoulder injury while at work with resultant rotator cuff tear, impingement and acromioclavicular arthritis. Dr. Tarandy noted Petitioner had elected to proceed with surgery. (Px.3 p.161) Petitioner also attended physical therapy at Adult & Child Rehab on March 5, 2015. The physical therapy discharge summary related to Petitioner's left upper extremity provided that therapy was discontinued due to no change in Petitioner's pain levels. (Px.5 p.57-59)

Petitioner followed up again with Dr. Tarandy on April 7, 2015 for continued left shoulder pain. The records reflect Petitioner was considering operative treatment however waiting for the results of an independent medical exam. Dr. Tarandy opined that he was unable to return to work at this time. (Px.3 p.238-239)

On April 22, 2015, Petitioner was evaluated by Dr. Bryan Neal at Respondent's request pursuant to Section 12 of the Act. The conclusions and opinions were contained in Dr. Neal's May 19, 2015 report. (Rx.2) Dr. Neal noted that Petitioner reported he had no problems whatsoever with pain in his left shoulder prior to the May 2014 event. Nor had he never had any injury, physical therapy or medical treatment to his left shoulder in the past prior to the May 2014 event. (Rx.2 p.9-10) Upon examination, Dr. Neal noted that Petitioner was subjectively painful during some warmup exercises in the left shoulder. Dr. Neal immediately noted the Popeye deformity on the left. The left biceps muscle was more prominent and distally displaced relative to the right biceps muscle. Left shoulder flexion was 10° less than the right. He had a positive drop arm sign on the left, a positive and abnormal left shoulder external rotation lag sign and significant weakness on external rotation. He had definite subacromial crepitance with passive range of motion. (Rx.2 p.11) Dr. Neal reviewed the MRI images from September 22, 2014 and his diagnosis was left shoulder pain and weakness secondary to a full-thickness rotator cuff tear with an ipsilateral biceps tendon rupture proximally. (Rx.2 p.12)

Dr. Neal's opined that the incident in May 2014 of pushing an empty pallet across the ground did cause a shoulder condition but also opined that there were left shoulder conditions which were present and unrelated to any incident in May 2014. Dr. Neal further opined that Petitioner had a full-thickness rotator cuff tear which was obvious from his clinical examination and confirmed by MRI imaging. However, it was Dr. Neal's opinion that the large rotator cuff tear was not caused by the May 2014 incident. (Rx.1 p.13) Dr. Neal noted that there were degenerative findings in the shoulder from the September 22, 2014 MRI which were pre-existing. Dr. Neal opined that the MRI findings of diffuse fatty atrophy suggested chronicity and that there had been a period of

time greater than 6 months in order for the muscle to atrophy and fat to infiltrate the area. Dr. Neal noted the fact that the biceps tendon was not present on the MRI means that it ruptured at some point in time and further opined that the injury in question in May 2014 caused a proximal biceps tendon rupture but not a rotator cuff tear. (Rx.1 p.13) He reasoned that if Petitioner had a normal rotator cuff and suffered an acute rotator cuff tendon tear at the time of the May 2014 incident he would have presented with an instantaneous significantly painful shoulder with significant loss of motion which would have significantly impaired his ability to perform his regular job. Dr. Neal opined that it was much more likely he had a chronic rotator cuff tendinopathy secondary to his pre-existing degenerative changes. Dr. Neal explained that the immediate shoulder pain that Petitioner felt in May 2014 would not have been secondary to rotator cuff tearing, but in his opinion would plausibly be explained by a common condition where someone with a pre-existing rotator cuff tendinopathy and subacromial impingement which led to the chronic degeneration of the proximal biceps tendon. Dr. Neal opined that the left shoulder flexion maneuver while bending over and pushing the pallet forward resulted in the chronically weakened proximal biceps tendon to rupture and that it was his opinion that Petitioner suffered a proximal biceps tendon rupture as a result of the May 2014 incident only. (Rx.1 p.14) Dr. Neal opined that the rotator cuff tear was not caused by the work event because Petitioner would not have been able to continue to work and would have been seen by medical providers. (Id) Dr. Neal opined that Petitioner is a surgical candidate for rotator cuff repair because of significant pain and shoulder dysfunction but the need for surgery is not related to the incident in May 2014.

Petitioner followed up with Dr. Tarandy on May 7, 2015 for his left shoulder injury and reported pain 7/10 at rest and 9/10 with activity. He had most pain doing anything at shoulder level or above. Dr. Tarandy again recommended operative treatment including arthroscopic rotator cuff repair, subacromial decompression and distal clavicle resection. Petitioner could not return to work at this time with regards to his left shoulder and he was prescribed Norco. (Px.3 p.317) He followed up with Dr. Tarandy on June 9, 2015 for his left shoulder and reported pain 9/10 at rest and with activity. Dr. Tarandy again noted a delay in his care and physical examination was the same as before. Dr. Tarandy continued to recommend arthroscopic surgery. (Px.3 p.375-376)

During this period of time, Petitioner was also treating with Dr. Tarandy for his right knee. On June 9, 2015 Petitioner was released to go back to light duty work with regards to his right knee. Respondent was able to accommodate the light duty restrictions, however Petitioner was ordered off work for the left shoulder condition. (Px.3 p.365)

Petitioner followed up with Dr. Tarandy again on July 9, 2015 for both his right knee and left shoulder. Regarding the Petitioner's left shoulder, Dr. Tarandy noted that Petitioner was frustrated because authorization had not yet been given for the left shoulder surgery. The findings on physical examination were consistent as before. (Px.3 p.420) Regarding his right knee, work restrictions were advanced to no lifting more than 25 pounds. (Px.3 p.431) Dr. Tarandy placed him at maximum medical improvement and gave him a full duty release with respect to his right knee on August 27, 2015. (Px.4 p.68) Regarding the left shoulder, Petitioner continued to complain that his pain remained 9/10 with any motion and Dr. Tarandy was still awaiting surgical authorization. Dr. Tarandy continue to recommend surgical care and opined that Petitioner was unable to return to work. (Px.4 p.56) He followed up again on September 24, 2015 with no change in complaints of pain and physical examination. Dr. Tarandy again recommended surgical treatment and opined that Petitioner was unable to return to work. (Px.4 p.102) Dr. Tarandy also examined his right knee and released him to full duty work and placed him at maximum medical improvement. (Px.4 p115) Petitioner saw Dr. Tarandy again on October 22, 2015 and the complaints, physical examination and Petitioner's disability remained unchanged. (Px.4 p.145)

On November 24, 2015, Petitioner was again evaluated by Dr. Tarandy. The doctor noted that he an opportunity to review Dr. Bryan Neal's IME report. Dr. Tarandy opined that he had difficulty separating the

biceps tendon injury and rotator cuff tendon injury as Petitioner injured his shoulder, and both the biceps tendon and rotator cuff tendons are a part of the shoulder. Dr. Tarandy continued to recommend arthroscopic surgery and opined that Petitioner was unable to return to work. (Px.4 p.162)

Petitioner received a letter from Respondent dated February 24, 2016 advising him that they cannot leave his position open as an accommodation. Based upon his inability to perform the essential functions of his job at the Respondent his employment was terminated effectively February 24, 2016. (Px.8)

Petitioner followed up again on March 17, 2016 with Dr. Tarandy who continued to recommend arthroscopic treatment which had not been authorized. Dr. Tarandy noted that Petitioner had been very upset and was crying in the office on this date and his employment had been terminated. Petitioner expressed his wish that he would just like to have his shoulder repaired and get back to some type of gainful employment. (Px.4 p.232) Petitioner continued to follow up with Dr. Tarandy on a monthly basis with his last visit being October 18, 2017. Dr. Tarandy's treatment recommendation remained arthroscopic surgery of the left shoulder. Dr. Tarandy also opined that Petitioner remain off work. (See Px.10)

Dr. Tarandy testified via evidence deposition on February 2, 2017. Prior to any testimony by Dr. Tarandy, Petitioners counsel moved to exclude witnesses, to which Respondent's counsel had no objection. (Px.9 p.4) Dr. Tarandy testified that the initial evaluation on October 14, 2014 was performed by his Physician Assistant, Christopher Northern who had been his physician assistant for 5 years and essentially functioned as a sports medicine doctor. (Px.9 p.8-9) Dr. Tarandy then took into account the history and physical examination performed by his Physician Assistant and took his own history and physical exam and used diagnostic imaging to formulate a treatment plan. (Px.9 p.10) Dr. Tarandy noted the history of injury at work 5 months prior to the initial evaluation. On examination, Petitioner had a positive empty can test which is used to isolate the supraspinatus tendon out of the rotator cuff which is made up of four tendons. (Px.9 p.11) Petitioner also had moderate tenderness to palpation along the anterior–posterior aspect of his shoulder. He also noted a biceps tendon rupture on physical examination. Range of motion was slightly limited and strength of the supraspinatus tendon was 3 out of 5 and 4 out of 5 in external rotation and internal rotation. (Px.9 p.11-12) Dr. Tarandy reviewed the MRI images from September 22, 2014 and noted a supraspinatus tear, a biceps tendon tear, labral fraying and degenerative joint disease. He also noted mild diffuse fatty atrophy of the musculature which he testified was a nonspecific finding which was irrelevant. (Px.9 p.13) He testified that the large full-thickness supraspinatus tear with retraction meant that one of the four rotator cuff tendons had ripped off the bone and pulled away. He testified that some people have retraction of the tendon within a week or two of their injury and based upon an MRI one could not really ascertain whether or not something is accurately acute or chronic if the injury was 5 months prior to the MRI. (Px.9 p.14-15) Dr. Tarandy testified based upon a reasonable degree of medical and surgical certainty, his diagnosis of Petitioner's condition of ill-being was a supraspinatus tear, a biceps tendon tear, a labral tear and degenerative changes including acromioclavicular joint arthritis. (Px.9 p.22) He further testified based upon a reasonable degree of medical and surgical certainty that it was his opinion that there was a direct causal relationship between the work injury in May 2014 and the shoulder pathology. His opinion was based upon Petitioners history, the mechanism of injury, his physical examination, the MRI and Petitioner's symptoms. (Px.9 p.22-23) At the time of his deposition, Dr. Tarandy opined that Petitioner was capable of working with one hand only. He testified that Petitioner would benefit from a left shoulder arthroscopy, a possible arthrotomy, rotator cuff repair, debridement of the labrum, subacromial decompression and distal clavicle excision and that the need for the surgery was related to the injury in May 2014. (Px.9 p.24) Dr. Tarandy testified that he could not understand how one can separate a left shoulder injury to only a biceps tendon rupture and not a rotator cuff injury. He explained the basis for his opinion was that anatomically, the biceps tendon travels right underneath the rotator cuff. As the Petitioner was pushing the pallet and felt a severe burning pain and pop in the shoulder. He did not know how one could separate the injury as an isolated biceps tear or an isolated rotator cuff tear and say that one was caused by the accident and one was not, as it did not

make any anatomic sense. (Px.9 p.25) He testified that people work all the time with rotator cuff tears indicating one can tough it out and modify one's activity to try and work and do the best you can which he believes Petitioner did. (Px.9 p.26) Upon cross examination, Dr. Tarandy testified that the mechanism of injury to a biceps tendon is usually a lifting type, carrying type or sudden force pulling on the biceps tendon. (Px.9 p.45 He indicated that a rotator cuff injury is often a result of some type of torque across the shoulder creating the tear. He described the torque mechanism as pressure on the shoulder, or a sudden force that would jam the shoulder, twist the shoulder or force the shoulder back into the socket to tear the rotator cuff and/or the biceps tendon. (Px.9 p.46) He testified that by pushing a pallet, his shoulder is pressed up against something as he is pushing it, and the shoulder is not braced against anything other than the muscles holding it into the socket, like rotator cuff tendons and muscles holding it up against the ball and socket, and if there was any type of undue force or sudden force around the shoulder, this would explain the mechanism of injury creating a rotator cuff tear. (Px.9 p.48) The doctor added that Petitioner had no shoulder symptoms and then developed a shoulder injury. He indicated that trying to separate the two injuries didn't make any sense to him. (Px.9 p.45) Dr. Tarandy testified that Petitioner's left shoulder was asymptomatic and did not bother him prior to the injury then he had the injury resulting in problems to the left shoulder. (Px.9 p.47)

In support of the Arbitrator's Decision relating to (F), Is the Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds the following:

The threshold issue to be decided by the Arbitrator is whether or not Petitioner's condition of ill-being is causally related to the injury of May 16, 2014. Respondent's dispute is based upon the opinion of two Section 12 reports of Dr. Bryan Neal dated May 19, 2015 (RX. 2) and September 18, 2017 (Rx.1). Petitioner objected to the admissibility of Respondent's Exhibit #1 based upon a violation of Illinois Rule of Evidence 615. See the Arbitrator's ruling discussed below in Issue "O."

Dr. Neal examined Petitioner on April 22, 2015, who noted that prior to the May 2014 event, Petitioner had no problems whatsoever with pain in his left shoulder, he noted no injury, or any treatment to his left shoulder in the past. This was consistent with Petitioner's testimony as well as the records from Centegra Occupational Health and Dr. Tarandy. On exam, Dr. Neal immediately noticed the Popeye deformity in Petitioner's left bicep. Petitioner's left shoulder flexion was 10° less than the right shoulder, he had a positive drop arm sign on the left, a positive and abnormal left shoulder external rotation lag sign and significant weakness on external rotation with definite subacromial crepitance. Dr. Neal's diagnosis was left shoulder pain and weakness secondary to a full-thickness rotator cuff tear with a proximal biceps tendon rupture.

Dr. Neal opined that the May 2014 accident while pushing an empty pallet across the ground did cause a shoulder condition but also opined that it only caused the proximal biceps tendon rupture but did not cause the full-thickness rotator cuff tear.

Dr. Neal noted that Petitioner had a pre-existing degenerative left shoulder although he admitted that Petitioner was clinically asymptomatic prior to the May 2014 work event. He reasoned that if Petitioner had a normal rotator cuff and suffered an acute rotator cuff tendon tear at the time of the May 2014 incident he would have had instantaneous significantly painful shoulder with significant loss of motion which would have significantly impaired his ability to perform his regular job. Dr. Neal explained that the immediate shoulder pain that Petitioner felt in May 2014 would not have been secondary to rotator cuff tearing, but in his opinion a plausible explanation that someone with a pre-existing rotator cuff tendinopathy and subacromial impingement would lead to the chronic degeneration of the proximal biceps tendon and that the left shoulder flexion maneuver while bending over and pushing the pallet forward resulted in the chronically weakened proximal biceps tendon to rupture. It was his opinion that Petitioner suffered a proximal biceps tendon rupture as a result of the May 2014 incident only. His explanation that the rotator cuff tear was not caused by the work event was that

Petitioner would not have been able to continue to work and would have been seen by medical providers. Dr. Neal agreed however that Petitioner is a surgical candidate for rotator cuff repair because of the significant pain and shoulder dysfunction but the need for surgery is not related to the work injury in May 2014.

Dr. Tarandy testified that he reviewed the MRI images from September 22, 2014 and diagnosed Petitioner with a supraspinatus tear, a biceps tendon tear, labral fraying and degenerative joint disease. He also noted the mild diffuse fatty atrophy of the musculature which he testified was a nonspecific finding and was irrelevant. Dr. Tarandy testified some people have retraction of the tendon within a week or two of their injury and from an MRI one could not really ascertain whether or not something is accurately acute or chronic if the injury was 5 months prior to the MRI. Dr. Tarandy testified that there was a direct causal relationship between the work injury in May 2014 and the diagnosis of a left shoulder supraspinatus tear, a biceps tendon tear, a labral tear and degenerative changes including acromioclavicular joint arthritis. His opinion was based upon Petitioners history, the mechanism of injury, his physical examination, the MRI and Petitioner's symptoms. Dr. Tarandy disagreed with Dr. Neal in that he could not understand how one can separate a left shoulder injury into only a biceps tendon rupture and not a rotator cuff injury. He testified that anatomically, the biceps tendon travels right underneath the rotator cuff. As Petitioner was pushing the pallet and felt a severe burning pain and pop in the shoulder. He did not know how one could separate the injury as an isolated biceps tear or an isolated rotator cuff tear and say that one was caused by the accident and one was not, as it did not make any anatomic sense. Dr. Tarandy further testified that people work all the time with rotator cuff tears and some are able to tough it out and modify one's activity to try and work and do the best you can which he believes Petitioner did in this case. Dr. Tarandy testified that the mechanism of injury to a biceps tendon is usually a lifting type, carrying type or sudden force pulling on the biceps tendon but it was not absolute. The mechanism of injury to a rotator cuff is often a result of some type of torque across the shoulder creating the tear. He testified that by pushing a pallet, Petitioner's shoulder was not braced against anything other than the muscles holding it into the socket, such as rotator cuff tendons and muscles holding it up against the ball and socket, and if there was any type of undue force or sudden force around the shoulder, this would explain the mechanism of injury creating a rotator cuff tear. Petitioner had no shoulder symptoms prior to the injury, then developed a shoulder injury on May 16, 2014 resulting in problems to the left shoulder.

In the instant matter, the Arbitrator finds that the opinions of Dr. Tarandy are more persuasive and credible than those of Dr. Neal. The basis of Dr. Neal's opinion that the torn rotator cuff tendon was not related to the injury because Petitioner did not seek immediate medical care and was able to continue working is contradicted by the testimony of Dr. Tarandy that people work with torn rotator cuffs all the time. Furthermore, Petitioner testified that he attempted to get medical treatment during June and July 2014 but was not provided with a copy of the incident report. The Arbitrator notes that Dr. Neal merely provides a plausible explanation as to why the work injury did not cause the rotator cuff tear, however, Dr. Tarandy testified that there was a direct causal relationship between the work injury in May 2014 and the diagnosis of a left shoulder supraspinatus tear, a biceps tendon tear, a labral tear and degenerative changes including acromioclavicular joint arthritis. As noted above, Dr. Tarandy based his opinion upon the mechanism of injury that by pushing a pallet, Petitioner's shoulder was not braced against anything other than the muscles holding it into the socket, such as rotator cuff tendons and muscles holding it up against the ball and socket, and any type of undue force or sudden force around the shoulder would be sufficient to create a rotator cuff tear. Dr. Tarandy disagreed with Dr. Neal in that separating a shoulder injury into only a biceps tendon rupture and not a rotator cuff injury made no sense anatomically. Dr. Tarandy explained that the biceps tendon travels right underneath the rotator cuff and when Petitioner was pushing the pallet and felt a severe burning pain and pop in the shoulder, he sustained an injury to the left shoulder and lastly, Dr. Tarandy did not know how one could isolate a biceps tendon tear or an isolated rotator cuff tear and say that one was caused by the accident and one was not.

Based upon the medical records, Petitioner's credible and unrebutted testimony concerning his mechanism of injury, his symptoms of left shoulder pain which are consistent throughout the medical records and the more credible and persuasive opinions of Dr. Tarandy, the Arbitrator finds that Petitioner's condition of ill-being of a left shoulder supraspinatus tear, a biceps tendon tear, a labral tear and degenerative changes including acromioclavicular joint arthritis is causally related to the undisputed accident of May 16, 2014.

In support of the Arbitrator's Decision relating to (J), Were the medical services that were provided to the Petitioner reasonable and necessary, the Arbitrator finds the following:

The dispute as to Respondent's liability for payment of medical expenses is based upon the disputed issue of causal connection. Having found in favor of Petitioner regarding causal relationship, the Arbitrator finds that the medical bills related to the treatment of Petitioner's left shoulder contained in Petitioner's Exhibit 6 are reasonable, necessary and causally related to the accident of May 16, 2014, and that Respondent shall pay to Petitioner, the amount of $6,439.47 in medical expenses under Section 8(a) of the Act and pursuant to the Illinois Fee Schedule as follows:

1. Adult & Child Rehab Center $5,280.00
2. Mercy Health System $1,159.47

Respondent shall receive credit for any medical bills already paid by Respondent.

In support of the Arbitrator's Decision relating to (K) Is the Petitioner entitled to any prospective medical care, the Arbitrator finds the following:

The dispute as to prospective medical treatment under Section 8(a) is, likewise, based upon the disputed issue of causal connection. Having found that Petitioner's current condition of ill-being is causally related to the injury of May 16, 2014, the Arbitrator finds that Respondent shall authorize and pay for the reasonable and necessary cost of the a left shoulder arthroscopy, a possible arthrotomy, rotator cuff repair, debridement of the labrum, subacromial decompression and distal clavicle excision as recommended by Dr. Tarandy as well as any associated temporary total, temporary partial disability benefits or other reasonable and necessary medical treatment related thereto.

In support of the Arbitrator's Decision relating to (L) What temporary benefits is the Petitioner entitled to, the Arbitrator finds the following:

It is a well-settled principle that when a claimant seeks TTD benefits, the dispositive inquiry is whether the claimant's condition has stabilized, *i.e.,* whether the claimant has reached maximum medical improvement. *Westin Hotel v. Industrial Comm'n,* 372 Ill.App.3d 527, 542, 310 Ill.Dec. 18, 865 N.E.2d 342 (2007). Furthermore, when an employee who is entitled to receive temporary total disability benefits as a result of a work-related injury is later terminated for conduct unrelated to the injury, the employer's obligation to pay TTD benefits continues until the employee's medical condition has stabilized and he has reached maximum medical improvement. *Interstate Scaffolding v. Illinois Workers Compensation Comm'n*, 236 Ill.2d 132, 923 N.E.2d 266, 337 Ill.Dec. 707 (2010).

Following Petitioner's injury on May 16, 2014, he continued to work for Respondent. He underwent right knee arthroscopic surgery on December 19, 2014 for an unrelated injury. Relative to his right knee condition, he was released by Dr. Tarandy on June 9, 2015 to return to light duty work and the Respondent was able to accommodate these restrictions. However, on this same date, Dr. Tarandy advised that Petitioner was unable to return to work for his left shoulder condition. Petitioner was evaluated again by Dr. Tarandy on July

9, 2015 for both his right knee and left shoulder and was again released to light duty work regarding his right knee but was unable to return to work because of the left shoulder condition. Dr. Tarandy has kept Petitioner off work since June 9, 2015 through the time of trial. At the time of his evidence deposition on February 2, 2017, Dr. Tarandy opined that Petitioner was capable of working with one hand only. It is undisputed that Petitioner's employment with Respondent was terminated as of February 24, 2016.

The Arbitrator finds that Petitioner's medical condition has not yet stabilized and that he is in need of further treatment as recommended by Dr. Tarandy as well as Dr. Neal and is therefore entitled to TTD benefits.

Further, the dispute to Petitioner's entitlement to temporary total disability benefits is based upon the disputed issue of causal connection. Having found that Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator finds that Respondent shall pay to Petitioner, Temporary Total Disability benefits in the amount of $330.43 per week for 126-3/7 weeks, the period of June 9, 2015 through November 9, 2017.

In support of the Arbitrator's Decision relating to (O), the Admissibility of Respondent's Exhibit 1, the Arbitrator finds the following:

Petitioner objected to the admissibility of Respondent's Exhibit #1 based upon a violation of Illinois Rule of Evidence 615. The Arbitrator deferred his ruling on the objection to be addressed in this decision.

During the tendering of exhibits, Respondent offered a supplemental medical report dated September 18, 2017 from Dr. Bryan Neal as Respondent's Exhibit #1. Petitioner's counsel objected to the admissibility of this report based upon violation of Petitioner's motion to exclude witnesses pursuant to Rule 615 of the Illinois Rules of Evidence. The supplemental medical report by Dr. Neal included opinions and conclusions based upon his review of the testimony of Dr. Tarandy contained in his evidence deposition transcript marked and admitted as Petitioner's Exhibit #9. Dr. Tarandy's evidence deposition was conducted on February 2, 2017. Before any testimony was taken, Petitioner's counsel moved to exclude witnesses and Respondent's counsel had no objection. Subsequently, Dr. Neal reviewed the transcript and provided additional opinions based upon his review of Dr. Tarandy's testimony.

Section 7030.70(a) of the Rules Governing Practice Before the Illinois Workers' Compensation Commission states:

> "The Illinois common law rules of evidence and the Illinois Evidence Act (820 ILCS 305) shall apply in all proceedings had before the Industrial Commission, either upon arbitration or review, except to the extent they conflict with the Workers' Compensation Act, the Workers' Occupational Diseases Act (820 ILCS 310), or the Rules Governing Practice Before the Industrial Commission". 50 Illinois Admin. Code Section 7030.70 (a).
>
> Furthermore, Illinois Rule of Evidence 615 pertaining to exclusion of witnesses states:
> "At the request of a party the court shall order witnesses excluded so that they cannot hear the testimony of other witnesses, and it may make the order of its own motion. This rule does not authorize exclusion of (1) a party who is a natural person, or (2) an officer or employee of a party which is not a natural person designated as its representative by its attorney, or (3) a person whose presence is shown by a party to be essential to the presentation of the party's cause, or (4) a person authorized by law to be present."

As we know, in any Workers' Compensation proceeding, Petitioner bears the burden of proving all of the elements of his or her case by a preponderance of evidence. Parro v. Industrial Comm'n, 260 Ill.App.3d 551, 553, 630 N.E.2d 860 (1993).

The Illinois Supreme Court in Liptak v. Security Ben. Ass'n, 350 Ill. 614 (1932) held that the right to open and close evidence is a substantial right coexistent with the burden of proof and is corollary thereto. Whenever a plaintiff has anything to prove in order to secure a verdict, the right to open and close belongs to him. It is generally held that the right to open and close is not a matter resting merely in the discretion of the trial judge, but is a substantial right in the person who must introduce proof to prevent judgment against him.

Simply stated, Petitioner in a Worker's Compensation case has the burden of proof and therefore is the first to present evidence to prove all necessary elements of his or her claim. The evidence presented by Petitioner may include the testimony of Petitioner, lay witnesses as well as expert witnesses, medical records and other probative evidence. Respondent then has a right to present its defense by introducing similar evidence. Petitioner then has the right to rebuttal evidence if necessary (i.e. the substantive right to close evidence).

In Skelton v. Chicago Transit Authority, 214 Ill.App.3d (1st Dist. 1991) 554, 584, the First District of the Appellate Court noted that Illinois courts have long held that the exclusion of witnesses from the courtroom during trial is an appropriate device to preclude one witness from shaping his testimony to conform to that of those who have already testified. People v. Johnson, 47 Ill.App.3d 362, 369 (1977). It is within the discretion of the trial judge whether a witness who has violated an exclusion order should be permitted to testify. People v. Gibson, 42 Ill.2d 519, 525 (1969). This rule is predicated upon the theory that an innocent litigant should not be punished by deprivation of testimony material to his case because a witness, without the party's knowledge or fault, has violated the exclusion order of the court. People v. Viskniskki, 255 Ill. 384 (1912).

In Friedman v. Park District of Highland Park, 151 Ill.App.3d 374 (2nd. Dist.1986) the Appellate Court ruled that the trial court acted within its discretion when it excluded the expert witness from the courtroom. The trial court ruled that plaintiff's expert witness was to be excluded from the courtroom and not allowed to observe witnesses nor hear testimony. The purpose of the sequestration rule is to prevent the shaping of testimony by one witness to match that of another and discourage fabrication. Miller v. Universal City Studios, Inc. (5th Cir.1981), 650 F.2d 1365. However the rule does not furnish an automatic basis for exempting an expert from sequestration pursuant to Rule 615. Miller v. Universal Studios, Inc. (5th Cir.1981), 650 F.2d 1365.) The enforcement of a rule to exclude witnesses, made at the outset of a trial, is within the trial court's discretion. Gatto v. Curtis, 6 Ill.App.3d 714 (1st Dist. 1972). The Friedman Court ruled that the trial court acted within its discretion when it chose to enforce the order to exclude because plaintiff's expert proposed to join the proceedings to observe part of the testimony of numerous witnesses having already testified. The trial court permissibly determined that the presence of the expert for such an abbreviated portion of the trial would likely be more harmful and serve to distort the proceedings for the expert and therefore excluded the expert. The plaintiff failed to show it was prejudiced by the exclusion of said witness.

In Gatto v. Curtis 6 Ill.App.3d 714, 736 (1st Dist. 1972), a rule to exclude witnesses was entered at the commencement of the trial. A witness was called to testify who had not been physically present in the courtroom during the proceedings but counsel who called the witness to testify admitted to reading to the witness, certain portions of the testimony which had previously been transcribed. After a hearing on the matter, the trial court ruled that the witness should be excluded. The Appellate Court ruled that the trial court's ruling was a valid exercise of its discretion.

The Illinois Worker's Compensation Commission addressed this issue in Lenhardt v. Executive Construction, 92 ILWC 14503, 1999 WL 33321306. As a preliminary matter, Petitioner's attorney made a

motion to exclude witnesses. The testimony of Petitioner was then presented with Respondent's witnesses outside the hearing room. Respondent's witness Mr. Cipolla provided certain testimony on direct examination. Then following a lunch recess, Mr. Cipolla returned for cross-examination. Mr. Cipolla testified that during the lunch break, he had a conversation with Respondent's attorney regarding certain relevant facts. Petitioner's attorney made a motion to strike Mr. Cipolla's testimony based on his allegation that the Arbitrator's motion to exclude witnesses had been violated. The Arbitrator overruled this motion. The Commission modified the decision of the Arbitrator and found that the testimony of Mr. Cipolla should have been excluded by the Arbitrator and excluded same. The Commission found that the Arbitrator's order to exclude witnesses was violated by Respondent's attorney when certain facts of the case were discussed with Mr. Cipolla during the lunch break in the arbitration proceedings. In his decision, the Arbitrator acknowledged that the testimony was tainted. The Commission found that the Arbitrator should have excluded Mr. Cipolla's testimony and ruled that an Arbitrator's order that witnesses be sequestered is meaningless if the excluded witnesses then discuss the case with one of the party's attorney.

There is further direction and instruction from the Illinois Workers, Compensation Commission in *Kuhn v. Kansas Community Unit School District* 13 IWCC 1123, 2013 WL 7022639. In that case, the Arbitrator denied Respondent's Motion to strike the testimony of Dr. James Kohlmann, Petitioner's records review doctor, arguing that since Dr. Kohlmann reviewed the deposition testimony of Dr. Sandercock (Petitioner's treating physician) and Dr. Nogalski (Respondent's Section 12 physician), he violated the rule against exclusion of witnesses and, therefore, all of Dr. Kohlmann's opinions should be stricken and not considered. In affirming and adopting the Arbitrator's decision, the Commission noted that the rule is not self-executing and does not come into play unless a party makes a motion to exclude witnesses. The first deposition taken in that case was that of Dr. Donald Sandercock. No motion to exclude witnesses was made. The second deposition taken was that of Dr. Michael Nogalski. There was no motion to exclude witnesses made. There was also no evidence of the Respondent attempting to enforce the rule otherwise prior to being provided with the report of Dr. Kohlmann. The first time that Respondent sought to enforce the rule was at the deposition of Dr. Kohlmann.

In the instant case, Petitioners counsel moved to exclude witnesses at the outset of the first and only evidence deposition of Dr. Tarandy on February 2, 2017. The motion was made prior to the taking of any testimony in this case. Respondent's counsel did not object to Petitioner's motion during the evidence deposition. The transcript of Dr. Tarandy's evidence deposition was then provided to Dr. Bryan Neal who reviewed Dr. Tarandy's testimony as well as his own prior report, and Dr. Neal then provided additional conclusions and opinions based upon his review of Dr. Tarandy's testimony in a supplemental report addressed to Respondent's counsel dated September 18, 2017. (See RX 1) Respondent's counsel offered this report into evidence and Petitioners counsel objected to its admissibility based upon violation of the motion to exclude.

Initially, the Arbitrator notes that Illinois Rules of Evidence apply to all Worker's Compensation cases. Petitioners counsel moved to exclude witnesses before any testimony was taken in this case. Rule 615 states that at the request of a party, the Court shall order witnesses excluded so they cannot hear the testimony of other witnesses. The rule also only applies to non-party witnesses. The Arbitrator notes that the motion to exclude was made properly and timely prior to any testimony, with no objection from Respondent's counsel. The language of rule 615 indicates that a court "shall" order witnesses excluded not "may" order witnesses excluded. By the plain reading of the statute, this is a mandatory order upon motion of a party. The Arbitrator also notes that Dr. Neal is not a party to the case. Dr. Neal's review of Dr. Tarandy's testimony was a violation of the motion to exclude. Dr. Neal had an opportunity to conform and shape his opinions based upon his review of Dr. Tarandy's testimony without Petitioner's knowledge. Petitioner has the right to rebuttal testimony, not Respondent. This violates the substantial right of the party with the burden of proof that has the right to open and close evidence pursuant to *Liptak*. Evidence depositions in Worker's Compensation cases are commonly used in the context of medical testimony. The evidence deposition transcript is submitted as an exhibit and stands in lieu

of the witness's live testimony. If all witnesses in this case were to testify at hearing, Petitioner would have testified, followed by the testimony of Dr. Tarandy. Respondent would then present the testimony of Dr. Neal, and if necessary, Petitioner would present rebuttal testimony. Based upon a motion to exclude witness in a live trial, Dr. Neal would have been excluded from the hearing room. In the civil case of *Gatto v. Curtis*, testimony that had been transcribed and was later discussed with a witness precluded that witness's testimony. Similarly, the Commission found that witness's testimony should have been excluded after a discussion between the witness and his attorney in *Lenhardt v. Executive Construction*. Further, the Commission noted that a motion to exclude witnesses does not come into play unless a party makes a motion to exclude. Further, as stated by the *Friedman* Court, the exclusion of the witness resulted in no prejudice shown by the plaintiff. Similarly, in this case, Respondent suffers no prejudice by the exclusion of Dr. Neal's supplemental report. The supplemental report was primarily a re-statement of his prior opinions bolstered by his review and rebuttal of Dr. Tarandy's opinions. Respondent's Exhibit #2 was entered into evidence without objection and as discussed supra, the Arbitrator has found that the opinions of Dr. Tarandy are more credible and persuasive than those of Dr. Neal, therefore based upon the foregoing and the totality of the evidence, the Arbitrator sustains Petitioner's motion to exclude witnesses pursuant to Rule 615 and Respondent's Exhibit #1 is hereby excluded.

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ILLINOIS WORKERS' COMPENSATION COMMISSION

Illinois Workers' Compensation Commission, Insurance Compliance Division,	)	
Petitioner,	)	No. 10 INC 353
v.	)	
Gueorgui Gagov, Individually and As president of Gueorgui Gueorguiev Incorporated and Georgy G. Material Handling Equipment Corporation	)	
Respondent.	)	

ORDER

This matter, after oral request by the Petitioner, The Illinois Workers' Compensation Commission – Insurance Compliance Division, by and through its attorney, the Office of the Illinois Attorney General, is dismissed. The Office of the Attorney General has advised this Commission it is unable to locate the Respondent.

JAN 16 2020

Commissioner

Dated: 1-14-20

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Maria Berumen,
Petitioner,

vs. No. 17 WC 22926

20IWCC0037

Koch Foods, 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, nature and extent of temporary total disability, medical expenses, prospective medical expenses, wages and rate and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. 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 reserves until the final hearing of this matter the determination of whether Respondent is entitled to credit for a payment made to Petitioner after the first date of the hearing.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 8, 2018, 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.

SOIACC035

20IWCC0037

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

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, 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 removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $ 20,200.00. 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: JAN 17 2020

Marc Parker

Deborah L. Simpson

Barbara N. Flores

mp-dak
o-11/21/19
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S01NCC003A

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

BERUMEN, MARIA
Employee/Petitioner

Case# **17WC022926**

KOCH FOODS INC
Employer/Respondent

20IWCC0037

On 6/8/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.07% 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:

0059 BAUM RUFFOLO & MARZAL LTD
EDUARDO SALGADO
33 N LASALLE ST SUITE 1710
CHICAGO, IL 60602

2542 BRYCE DOWNEY & LENKOV LLC
RICH LENKOV
200 N LASALLE ST SUITE 2700
CHICAGO, IL 60601

20IWCC0037

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
CORRECTED ARBITRATION DECISION
19(b)

MARIA BERUMEN
Employee/Petitioner

v.

KOCH FOODS, INC.
Employer/Respondent

Case # 17 WC 22926

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 **MARIA S. BOCANEGRA**, Arbitrator of the Commission, in the city of **CHICAGO**, on **February 14, 2018 & March 13, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

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

20 IWCC0037

CORRECTED FINDINGS

On the date of accident, **March 24, 2017**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$26,959.89**; the average weekly wage was **$481.06**.

On the date of accident, Petitioner was **59** 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 **$0.00** 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.

CORRECTED ORDER

Petitioner's average weekly wage shall include overtime, resulting in an AWW of **$481.06**.

Respondent shall pay reasonable and necessary medical services of **$11,933.57**, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner temporary total disability benefits of **$320.70/week** for **24-1/7th weeks**, commencing **8/30/17** through **2/14/18**, as provided in Section 8(b) of the Act.

Respondent shall authorize recommended treatment by Drs. Nam and Sompalli for the left shoulder adhesive capsulitis and labral tear, including any and all incidental care thereto.

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

6-7-18
Date

JUN 8 - 2018

20IWCC0037

CORRECTED FINDINGS OF FACT

Petitioner is employed by Koch Foods, Inc. as a general laborer assigned to the Portioning Department since her date of hire on August 4, 2009. According to Petitioner's testimony she reported a March 24, 2017 injury to her left shoulder to Respondent on March 27, 2017. Petitioner testified that the direct cause of her left shoulder injury was a result of performing her required work duties. Specifically, Petitioner described she was injured while working on stages three or four of the production line in the Portioning Department at Koch Foods. Petitioner stated that production was so fast that often times she was unable to keep up with the pace of production. Per Petitioner's testimony this resulted in pieces of chicken breast that she failed to remove the access trim from. Petitioner indicated that she would have to extend her arm out to grab the pieces of chicken that she had failed to remove the trim. With her arm extended outward Petitioner stated that she would next pull towards her the missed pieces of chicken breast to remove the excess trim. Petitioner indicates that she performed this work in 8-hour shifts Monday through Friday and an additional overtime shift on Saturdays. When asked if overtime was a requirement of her position Petitioner stated that upon being hired on August 4, 2009 she was told by human resources that working overtime would be mandatory. For performing the described work Petitioner alleges she was paid an average weekly wage of $575.31. Petitioner alleged she injured her left shoulder as a result of working in this capacity.

Gabriela Martinez testified on behalf of Respondent. She is human resource manager for Respondent. According to Gabriela Martinez, Petitioner's work position consisted of a total of eight workers assigned to a production line in which chicken breast would be cut to size and the fat trimmed in accordance to specific client requests. Ms. Martinez indicated that each chicken breast on the production line could weigh approximately less than one pound, but this could be altered based on clients' demands. Specifically, Ms. Martinez indicated that each piece of chicken breast could be altered with respect to the size and thickness of individual pieces of chicken breast. Ms. Martinez testified that production consisted of a four-stage process. Stage one consists of the automated cutting of individual chicken breast in accordance with clients' requests for size and thickness of the chicken breast. The chicken breasts are cut and run through a conveyer system to be placed onto a sorting table. In stage two, line workers grab the chicken breast from the table and run the individual chicken breast through a sensor for scanning. The remaining production stages require line workers to manually pull the remaining excess fat off the chicken breast, known as "trim," where the automated process failed to remove. She admitted she was not an expert in production but stated that a worker would be required to manually remove the trim from 100 pieces of chicken per minute. Under cross-examination, Ms. Martinez clarified that each worker would be tasked with the goal of handling 150 pieces of chicken per minute in a given eight-hour shift.

On March 27, 2017, Petitioner completed a hand-written report using Koch Food's form. Rx4. She reported an injury to her left shoulder. The description was written in Spanish.

On March 27, 2017 Petitioner presented to PIC complaining of left shoulder pain since March 24, 2017 as the result of a work injury. Px6. Diagnosis was shoulder sprain. Petitioner was given medications, light duty and follow up. X-rays were taken, and history noted that Petitioner complained of left shoulder pain with an initial onset at work on March 24, 2017. She said she felt a sharp pain i the left shoulder while reaching for something on an assembly line and that her pain had worsened over the next few days. She was given light duty of limited repetitive movement of the left hand; no lifting over shoulder greater than two pounds using the left arm; no lifting below waist greater than two pounds using the left arm.

On March 31, 2017, Petitioner returned to PIC. Px1. Petitioner continued to complain of ongoing left shoulder pain as a result of a March 24, 2017 work accident. Petitioner denied prior medical history remarkable for left

shoulder pain or any non–work related illness or problems that could have contributed to her current reports of pain. Petitioner had complaints of pain measuring 5 out of 10. Petitioner had some loss in her range of motion in her left upper extremity as it specifies that Petitioner had increased her range of motion when compared with her initial appointment. Diagnosis was unchanged. Light duty was continued.

On April 3, 2017, Respondent completed the Illinois Form 45. Rx3. The typed document indicated that Petitioner's accident occurred on March 24, 2017 at 2:30pm. As to what Petitioner was doing when the accident occurred, the reported noted sprain to shoulder from pulling. It noted the accident occurred by strain or injury by pushing/pulling. The report was prepared by Paula Santiago.

On April 7, 2017, Petitioner returned to PIC. Px1. She rated her pain 4/10. Range of motion was reduced in flexion, extension, abduction and adduction. Petitioner was prescribed Mobic, light duty and physical therapy.

On April 21, 2017, Petitioner followed up with PIC. Px1. She was diagnosed with a sprain of the left shoulder girdle, recommended for physical therapy and provided with restriction of avoiding strong gripping and repetitive motion with her left hand.

On April 25, 2017, Petitioner presented to physical therapy for the shoulder. Px1. The mechanism of injury indicated that the condition was a result of repetitive reaching with the left arm for me parts of light weight. She reported significant pain in the anterior and lateral left shoulder with stiffness that came and went.

On April 28, 2017, Petitioner return for physical therapy unchanged. Px1. On May 3, 2017, Petitioner returned to physical therapy for the left shoulder. Px1. There was pain still in the lateral side with arm elevation.

On May 2, 2017, Petitioner followed up with PIC. Px1. Petitioner complained of loss of range of motion in her left upper extremity and further reported a pain 3 out of 10. Petitioner was diagnosed with a sprain of the left shoulder girdle and recommended to continue medications, light duty and follow up.

On May 9, 2017, Petitioner returned for physical therapy. Px1. She completed six therapy visits for the left shoulder. She continued to complain of pain in the anterior and superior left shoulder, worse with overhead elevation. On May 11, 2017, Petitioner return for physical therapy. PX one. The pain was worse from the front to the back of the shoulder.

On May 9, 2017, Petitioner followed up with PIC. Px1. She was still having pain and lack of range of motion. She reported that while working on the trim line Friday and she felt pain in the left shoulder while reaching for chicken. She reported the pain worsened. Light duty was given.

On May 12, 2017, Petitioner returned to physical therapy. Px1. Petitioner reported diffuse pain persisted through the left shoulder though indicated that particular point tenderness over one head of the biceps tendon. On May 17, 2017, Petitioner returned to physical therapy. PX1. There was a little change in the pattern of left shoulder pain. She was still having the most discomfort in the lateral shoulder with lateral arm elevation. On May 18, 2017, Petitioner returned to physical therapy. Px1. There was a pain in the left shoulder, rated 4 out of 10.

On May 22, 2017, Petitioner returned to PIC. Px1. Diagnosis was strain. Petitioner reported no improvement. She was discharged to full duty. According to Petitioner, she was discharged from care despite reporting a pain level of 7 out 10 and continuing to experience a loss of motion to her left upper extremity. The doctor concluded that Petitioner had not shown improvement to date in her condition. The treating physician released Petitioner from care because of the discrepancies between Petitioner's physical findings and the patient's reports.

Petitioner testified she returned to work full duty but that her left shoulder symptoms did not resolve. She elected to return for medical care.

On July 17, 2017, Petitioner presented to Taylor Rehab and Wellness Center for left shoulder physical therapy. Px2. She noted it was the result of a work injury. On July 19, 2017, Petitioner underwent formal evaluation. Px2. Petitioner stated that she had undergone physical therapy for the shoulder but that her pain is worse now than previous. She continued to work a normal duty which she said it had extreme difficulty in her left shoulder typically hurts more after work. She stated that she developed pain in the left shoulder and was sent to physician's immediate care for further evaluation. Petitioner was having trouble lifting her left arm overhead and had complaints of pain at a level of nine out of ten. Dr. Taylor indicated Petitioner suffered from a loss of range of motion to her left upper extremity. Petitioner had reduced flexion measuring 70 degrees and reduced abduction measuring 60 degrees. Dr. Taylor diagnosed left shoulder impingement; left shoulder adhesive capsulitis; left shoulder pain; left shoulder myofascitis. The plan was for MRI, therapy and orthopedic consult.

On July 24, 2017, Petitioner treated for the left shoulder and was released to return to work with no restrictions. Px2.

On July 27, 2017, Petitioner presented to Dr. Taylor for therapy for the left shoulder. Px2. He wrote a note excusing her from work that day. He noted that her condition worsened while working in now has restrictions of no overhead lifting. She waited approval for the MRI.

On August 17, 2017, Petitioner presented for reevaluation with Dr. Taylor. Px2. She continued to work normal duty which she said has extreme difficulty and that her left shoulder typically hurts more after work. She had applied for family medical leave act and she noted that her company occasionally has mandatory overtime. Diagnosis was left shoulder impingement syndrome, adhesive capsulitis, pain and myofascitis. Petitioner continue therapy throughout this time.

On August 26, 2017, MRI showed blunting in the anterior superior labrum suspicious for tear. Mild osteoarthritic changes were noted. Px3. Petitioner testified that she followed up with Dr. Taylor on August 28, 2017 to have her results evaluated. Px2. Dr. Taylor referred for an orthopedic consultation and was taken off work effective August 30, 2017. Px2.

On September 16, 2017, Petitioner was seen by Dr. Nam. Px4, 6. He noted persistent left shoulder pain and decreased range of motion following a work injury. He diagnosed left shoulder adhesive capsulitis. She was to continue therapy and follow up.

On September 20, 2017, Petitioner returned to Dr. Taylor for reevaluation. Px2. She had been taken off of work due to constantly aggravating her left shoulder condition. He noted MRI revealed labral tear. He recommended aggressive manual therapy to the left shoulder to reduce adhesions.

On September 22, 2017, Petitioner returned to Dr. Taylor. Px2. She had completed 4 weeks of therapy and was recently seen by Dr. Nam. Dr. Nam recommended additional therapy aggressive therapy.

On October 14, 2017, Petitioner followed up with Dr. Nam. Px4, 6. She still had pain and stiffness in the left shoulder. On exam, there was no AC joint pain, she had severe restricted range of motion of the left shoulder, she had forward flexion to about 115 degrees, external rotation to 10 degrees and internal rotation to the posterior hip. Impression remained adhesive capsulitis, status post work injury. The plan was to hold off on cortisone injections and for more therapy. They discussed manipulation under anesthesia. Follow up was ordered and she was continued off work.

Petitioner testified that after her second evaluation with Dr. Nam she continued with physical therapy. According to the treating records, Petitioner had an additional five therapy appointments with Dr. Taylor from October 16, 2017 through October 25, 2017 Px2.

On October 26, 2017, Petitioner was seen by Dr. Taylor. Px2. Petitioner continued to complain of left shoulder pain and loss of range of motion. On physical examination, Petitioner's left shoulder displayed signs of weakness when compared to her right shoulder and further stated that Petitioner was unable to perform an overhead reach. Dr. Taylor again diagnosed Petitioner with left shoulder impingement, left shoulder adhesive capsulitis, left shoulder pain and left shoulder myofascitis as a result of a March 24, 2017 work accident. He noted that Dr. Nam indicated that the adhesive capsulitis must be addressed before the labral tear. Range of motion was essentially unchanged. Mechanical changes were noted and strength was 3+/5. Additional therapy was recommended.

On October 27, 2017, Petitioner was evaluated by Dr. Kevin Chen at the request of Respondent. Rx1, Rx7. He noted Petitioner stated she worked trimming and moving meats in a factory. She said she had been in various positions that always involve moving objects and meats around the workplace. She said that she had been in this current position over the past six months. She stated her job was to move meat forward and trim it. The piece of meat weighs approximately 15 pounds. She described her injury as non-acute and that her pain started as she was using her shoulder that day, which became progressively painful. She said she was given medications and therapy, which did not help. She reported symptom aggravation with active repetitive motion. On exam, she was tender to palpation across the anterior and posterior shoulder capsule of the left shoulder. Range of motion was reduced and she reported some tingling into her fingertips. There were no signs of apprehension. The doctor reviewed the MRI and did not appreciate any tear or any sort of arthritis. Assessment was left shoulder adhesive capsulitis. The doctor concluded that the diagnosis was not related to any work injury. He did not find any trauma to the left shoulder or any significant increase in demand of the left shoulder. He concluded treatment to date had been reasonable, necessary and for the treatment of left shoulder adhesive capsulitis. Dr. Chen did not believe there was a significant injury sustained on March 24, 2017 as adhesive capsulitis can frequently occur without any clear etiology. He did not find Petitioner was at maximum medical improvement for the adhesive capsulitis and recommended a cortisone injection for transition from an inflammatory to a frozen state. He also recommended therapy. If things had not progressed, the doctor opined she would be a candidate for surgical release.

Per Petitioner's treating records she continued to perform physical therapy with Dr. Taylor from October 26, 2017 through November 15, 2017. Px2.

On November 18, 2017, Petitioner returned to Dr. Nam. Px4, 6. She was unchanged and unimproved. Exam was unchanged. Impression was unchanged. The plan was to hold off on injections and to proceed to surgery. She was kept off work.

Petitioner testified that after consulting with Dr. Nam she continued with her course of physical therapy. Per Dr. Taylor's treatment notes, Petitioner had an additional three physical therapy appointments from November 21, 2017 to November 24, 2017. Px2.

On November 27, 2017, Petitioner returned to Dr. Taylor for reevaluation. Px2. She remained off work. Aggressive additional manual physical therapy was recommended. Dr. Taylor opined to a reasonable degree of medical/chiropractic certainty that the injuries diagnosed were the result of the work accident. Petitioner continued to undergo physical therapy with Dr. Taylor during this time. She was referred to Dr. Sompalli. Petitioner's final visit with Dr. Taylor was February 5, 2018.

On December 23, 2017, Petitioner was seen by Dr. Sompalli. Px6. The doctor noted that Petitioner was taking the grease off the meat and she had to cut the meat in a special way and that she was working in a line doing this and she developed pain gradually over time in the left shoulder. She had no prior history and was unimproved with medications and therapy. Range of motion was reduced. The doctor assessed frozen shoulder and the shoulder was injected. The plan was for therapy. Dr. Sompalli opined that the cause of the frozen shoulder was that Petitioner developed some pain in the left shoulder and reluctance to move it, which further compounds the issue.

On December 29, 2017, Petitioner presented to ATI physical therapy for therapy to the left shoulder. Px5. She presented with signs and symptoms consistent with left adhesive capsulitis of the left shoulder. She was noted to be significantly limited during her evaluation with all range of motion and flexibility and strength of left shoulder. Therapists noted limited ability to perform all work-related activities like lifting, carrying, cutting pieces of chicken as well as all daily activities like self-grooming, dressing and household responsibilities with the left upper extremity without significant pain complaints. History further noted that Petitioner worked as a worker in a meat cutting plant as a meet trimmer that required a physical demand level of light to medium and would benefit from skilled therapy. Petitioner returned for physical therapy at ATI physical therapy on January 2, January 3 and January 4, 2018. At that time, she reported that overall her shoulder still felt painful and stiff in the front of her chest and in the neck and shoulder area.

On January 20, 2018, Petitioner returned to Dr. Sompalli. Px6. He noted that she had had this condition for approximately seven months along with extensive therapy. He recommended a cortisone injection that did not help her. The doctor opined to a reasonable degree of medical and surgical certainty that the adhesive capsulitis was related to her occupation. He noted it was well documented that her pain develops from her work activities on March 24, 2017, that she had been seen by company doctor who diagnosed her with left shoulder condition related to her work activities and that since that time, she had been treated conservatively with therapy, activity modification, medication, cortisone injection but continued to be symptomatic. He noted that both another orthopedic surgeon and the Section 12 orthopedic surgeon recommended surgery for that condition. The doctor believed that the need for the surgery was causally related to the work injury. The doctor recommended left shoulder manipulation under general anesthesia and then arthroscopic debridement of the shoulder. In the meantime, the doctor continued to recommend aggressive active and passive range of motion of the left shoulder for the next eight weeks and that Petitioner was to remain off work. Px6.

With regards to her employment, Petitioner testified that the Respondent terminated her employment during the month October 2017. Petitioner further indicated that she has never received temporary total disability payments throughout the entire duration of her treatment and is not currently receiving payments0

On February 16, 2018, Dr. Chen conducted a records review and issued an addendum opinion at the request of Respondent. Rx6. He reviewed additional records and continued to conclude that her condition was not work related. He noted no trauma, fall or explanation of why she would only have pain in the region where she had been working in the same job without pain before. He opined that diabetes and thyroid dysfunction are known to be associated and sometimes related to adhesive capsulitis. Because Petitioner had these conditions, she could be predisposed to adhesive capsulitis. He discounted that Drs. Troy and Sompalli had adequately explained how working normally would cause injury. He believed her pain was from the adhesive capsulitis she was developing. Dr. Chen did believe; however, Petitioner was now a surgical candidate for manipulation under anesthesia and lysis of adhesions.

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CONCLUSIONS OF LAW

Arbitrator's Credibility Assessment

The Arbitrator observed Petitioner's behavior and demeanor in and about the courtroom, including her behavior while testifying and having reviewed all of the evidence admitted the Arbitrator finds Petitioner to be credible and her testimony credibly corroborated by all the other evidence. The Arbitrator also finds the testimony of Martinez to be credible and forthright.

ISSUE (C) Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
ISSUE (D) What was the date of the accident?

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. At trial, Respondent disputed the issue of accident as to Petitioner's alleged March 2017 work accident. Ax1. Petitioner alleges that she suffered a work accident to the left shoulder under a theory of repetitive trauma. The Arbitrator concludes that Petitioner has proven by a preponderance of the evidence that she did sustain an accidental injury to her left shoulder that arose out of and in the course of her employment on March 27, 2017 under a theory of repetitive trauma.

In order to obtain compensation under the Act in a repetitive trauma claim, an employee must point to a date on which both the injury and its causal link to the employee's work became plainly apparent to a reasonable person. *Durand v. Indus' Comm'n*, 224 Ill.2d 53, 64, 862 N.E.2d 918 (2006). The date of injury in a repetitive trauma claim is the date in which the injury manifests itself. In determining the manifestation date, Courts have typically set the manifestation date on the day the employee requires medical treatment or the date in which the employee can no longer work. Because repetitive trauma claims by nature are progressive, the employee's medical treatment as well as 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.

In the instant case, the evidence demonstrates that Petitioner identified March 24, 2017 as the date of accident or the date in which her left shoulder condition became plainly apparent to her. In support of this finding, the Arbitrator notes that Petitioner consistently alleged March 24, 2017 as the date in which her condition was such that it prompted her to seek treatment as noted in her accident report(s) and in her initial treatment records with PIC. Further, Petitioner continued to allege repetitive use of the left arm in her line of work as a meat trimmer and continued to use that date of accident when seeking subsequent care.

The Arbitrator notes that Petitioner credibly explained that after she was released from PIC, she returned to her same job and there, her conditioned continued to worsen, prompting her to return to medical care. Upon her return to treatment, Petitioner again consistently identified that the mechanism of injury was repetitive use of her left arm and that on March 24, 2017 her pain was such that it prompted her to seek medical care.

As to whether Petitioner's work activities were repetitive in nature, the Arbitrator finds that the weight of the evidence demonstrates that Petitioner's work activities were sufficiently repetitive in nature so as to result in her work accident which arose out of and in the course of her employment. Specifically, Petitioner identified using her left arm in reaching for or grabbing chicken and pulling it toward her in order to trim fat. Martinez gave a similar description, indicating that line workers to manually pull the remaining excess fat off the chicken breast, known as "trim," where the automated process failed to remove. Petitioner's medical record also noted this process as either trimming fat or removing "grease." The Arbitrator notes that Petitioner solely identified the left arm as responsible for grabbing and pulling meat. This fact was unrebutted and otherwise unchallenged.

Having identified the left arm as the sole extremity in use for Petitioner's repetitive work activity, the Arbitrator concludes that Petitioner's work was quantitively repetitive. Petitioner identified the repetitive activity as using her left arm to pull and grab meat. She said she performed this work in a typical 8-hour shift, 40 hours per week. Petitioner's testimony in this regard is corroborated by her wage statements, which indicate hours worked. Rx2. At trial, Martinez estimated that a worker would be required to manually remove the trim from 100 pieces of chicken per minute. Martinez clarified that each worker would be tasked with the goal of handling 150 pieces of chicken per minute in a given 8-hour shift. Quantitively, the Arbitrator notes this potentially yields to 48,000 to 72,000 pieces per shift (100-150 pieces x 480 minutes per day). Even accounting for breaks and lunches, the Arbitrator finds that the range is significant for repetitive use of the left arm with each piece in one shift. Even dividing these numbers in half still yields a significant number of times Petitioner would be using her left arm. Petitioner said she failed to trim 1% of the pieces that moved by her the first time, this would result in Petitioner having to pull the pieces of chicken back towards her to trim approximately 630 times in a 7-hour shift. Finally, the Arbitrator notes that Petitioner's treating records identified the repetitive use of her arm as the mechanism of injury whereas Dr. Chen did not find any trauma to the left shoulder or any significant increase in demand of the left shoulder. The Arbitrator finds that Dr. Chen's opinion did not sufficiently account for or explore Petitioner's job activities or her allegations that she repeatedly used her arm and therefore assigns lesser weight to this portion of his opinion.

Based on a preponderance of the evidence, Petitioner's repetitive trauma theory is persuasive and entitled to greater weight than any contrary evidence proffered. The Arbitrator further finds Petitioner's accident arose out of and in the course of her employment as she was clearly working at the time of her injury for Respondent and was performing employment related duties.

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

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. Having found Petitioner has proven by a preponderance of the evidence that she sustained accidental injuries arising out of and in the course of her employment with Respondent, manifesting on March 24, 2017, the Arbitrator finds that Petitioner's current condition of ill-being with respect to the left shoulder is causally related to her March 24, 2017 work accident.

In the instant case, Petitioner identified her left shoulder as injured. Medical records corroborate Petitioner's consistent complaints to the left shoulder or arm. While she initially diagnosed with a sprain, subsequent medical records identified Petitioner as having adhesive capsulitis and a labral tear based on MRI. The Arbitrator notes that all doctors agree and do not otherwise seriously dispute that Petitioner suffers from adhesive capsulitis. Dr. Nam, Dr. Taylor and Dr. Sompalli related both the adhesive capsulitis and labral tear to her work accident, Dr. Sompalli further added that her hesitation to use the left arm could further compound the problem. Dr. Chen identified adhesive capsulitis but did not relate it to any work accident. Dr. Chen did not identify any labral tear. The Arbitrator assigns less weight Dr. Chen's causation opinion, having found in favor of Petitioner on the issue of accident, but further noting that Dr. Chen's suggestion that the adhesive capsulitis could be from Petitioner's known diabetic and/or thyroid condition is accorded little weight. This explanation or suggestion was not explored thoroughly, is not supported by any medical record, Petitioner said she does not have diabetes and the theory fails to account why Petitioner's co-morbidities would result in only left shoulder adhesive capsulitis and not right shoulder adhesive capsulitis. Arbitrator notes that Dr. Chen does not dispute the repetitive nature of Petitioner's work, but simply states on the date of injury there was not an increase in demand to the left shoulder. The only reasonable inference that can be drawn from the evidence is that Petitioner's work activities caused or contributed to her left shoulder adhesive capsulitis, even if or where Petitioner's diabetic and/or thyroid condition also played any role. As with any work-related injury, the claimant's employment need only be *a* cause of the claimant's condition of ill-being, it need not be the sole or primary cause. *Sisbro, Inc. v. Indus. Comm'n*, 207 Ill. 2d 193, 205, 797 N.E.2d 665 (2003).

Regarding Petitioner's short gap in treatment, this was reasonably reconciled by Petitioner, noting that she continued to work full duty which further caused left shoulder symptoms and prompted her to return to care. This is insufficient to break any causal connection between her work accident and current condition of ill-being.

Regarding Petitioner's state of health, Petitioner testified and it was established in her medical record that she had no prior history of problems to the left shoulder. The Arbitrator finds Petitioner was in a state of good health before her accident.

Based upon the preponderance of the evidence and the foregoing analysis, the Arbitrator concludes that Petitioner's condition of ill-being as it relates to her left shoulder adhesive capsulitis and left shoulder labral tear is causally related to her March 24, 2017 workplace accident.

ISSUE (G) What were Petitioner's earnings?

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. After carefully reviewing all of the testimony and all of the evidence the Arbitrator finds Petitioner's average weekly wage should include overtime pay and determines Petitioner's AWW to be $518.46 Ax1. The basis for computing a claimant's average weekly earnings is governed by Sec. 10 of Illinois Workers' Compensation Act. Section 10 defines the employee's average weekly wage as:

> *"the actual earnings of the employee in the employment in which he was working at the time of the injury during the period of 52 weeks 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." 820 ILCS 305/10 (West 2008).*

Although Sec. 10 specifically excludes the use of overtime for computing a Petitioner's average weekly wage, Illinois case law has carved out an exception to this rule of thumb and allows overtime to be included were it is mandatory and regular. *Airborne Express, Inc. v. Ill. Workers' Comp. Comm'n*, 372 Ill. App. 3d 549, 555, 865 N.E.2d 979 (1st Dist. 2007).

Here, the evidence submitted shows that Petitioner earned $21,125.60 in regular earnings and an additional $5,834.29 in overtime earnings. Rx2. Petitioner's average weekly wage is thus either $406.26 or $481.06 ($21,125.60 / 52 weeks or $25,015.13 / 52 weeks).

RX2	Gross Reg	Gross OT
1st Qtr.	$412.00	$2.63
2nd Qtr.	$5,273.60	$1,692.70
3d Qtr.	$5,696.00	$1,770.14
4th Qtr.	$4,872.00	$1,284.73
1st Qtr.	$4,872.00	$1,084.09
	$21,125.60	**$5,834.29**

Petitioner testified that upon hire, she was told overtime was mandatory. She said worked a regular work week and that overtime was done on Saturdays. Martinez testified that overtime is mandatory depending on whether you are a union worker, production demands require it or if one is scheduled to work. According to Martinez, union members were able to volunteer for overtime. Martinez did not indicate that this benefit extends to non-

union workers or that Petitioner was a union worker. Petitioner testified that she was not a member of a union while employed by Koch Foods. A review of the submitted wage statement shows Petitioner worked an overtime shift 51 out of a possible 52 weeks of the year preceding her March 24, 2017 accident. Rx2. Having considered all evidence, the Arbitrator finds that Petitioner has proven by a preponderance of the evidence that overtime was mandatory and that it should be included in her average weekly wage, calculated at the straight time rate.

Petitioner asserts that her resultant AWW with overtime should be $575.31 but provides no explanation how she arrives at this figure. The best evidence of her actual earnings with overtime is in Rx2 and therefore the Arbitrator concludes that Petitioner's average weekly wage shall include overtime, resulting in an AWW of **$481.06**.

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 incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. At trial, Petitioner claimed the following bills as unpaid as part of Respondent's liability:

Physicians Immediate Care:	$813.36
MRI Lincoln Imaging Center:	$1,500.00
Chicago Orthopaedics & Sports Medicine:	$296.00
Illinois Orthopedic Network:	$196.18
ATI Physical Therapy:	$1,958.03
Taylor Wellness & Rehabilitation Center:	$7,170.00

Based on the entirety of the evidence presented, the Arbitrator finds the Respondent liable for medical treatment rendered to Petitioner as a result of her workplace accident on March 24, 2017, and further finds the medical care and associated bills to be reasonable and necessary to treat Petitioner's injuries. Dr. Chen, Respondent's Section 12 doctor, did not dispute the reasonableness or necessity of this treatment, indicating that treatment had been appropriate. Thus, Respondent's dispute is as to liability. Having found in favor of Petitioner on the foregoing issues, the Arbitrator concludes that Respondent shall pay reasonable and necessary medical services of **$11,933.57**, as provided in Sections 8(a) and 8.2 of the Act.

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

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. Having found Petitioner's left shoulder adhesive capsulitis and labral tear condition of ill-being is causally related to the March 24, 2017 work accident, the Arbitrator finds prospective medical treatment is awarded based upon the preponderance of the evidence. Competing medical opinions to not dispute that Petitioner suffers from adhesive capsulitis and that she is a surgical candidate for same. The record demonstrates Petitioner has failed conservative care and reasonably refused further cortisone injection, electing to proceed with surgery by way of manipulation under anesthesia. As to the labral tear, Petitioner's treaters have recommended an arthroscopy but only after the adhesions have been addressed first. The Arbitrator concludes that Petitioner's condition of ill-being remains symptomatic, that she has not yet stabilized or reached maximum medical improvement as to either condition and that she is entitled to prospective care as recommended by Drs. Nam and Sompalli.

ISSUE (L) ***What temporary benefits are in dispute?***

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. The Arbitrator, having found that the Petitioner's medical condition is causally connected to her accident, the Arbitrator awards TTD for the periods August 30, 2017 through February 14, 2018 or 24-1/7th weeks. In so awarding, the Arbitrator notes that Petitioner was given kept off of work as a result of her work injury and in connection with her ongoing medical treatment during the time period specified. The Arbitrator finds these restrictions related to the work accident. Further, the evidence shows Petitioner's condition has not stabilized or reached maximum medical improvement and that therefore she is entitled to TTD.

In support thereof, the record shows that on August 30, 2017, Petitioner was seen by Dr. Taylor for a follow appointment. At this time Dr. Taylor placed Petitioner off work secondary to a left shoulder injury sustained on March 24, 2017. Thereafter, Petitioner's initial appointment with Dr. Nam occurred on September 16, 2017 and he took her off work until further notice. She remained off work in subsequent appointments. Petitioner obtained a second surgical opinion from Dr. Sompalli on December 23, 2017 and he took her off work as a result of her accident. Petitioner remains off work pending surgery.

Given the aforementioned, the Arbitrator finds Respondent shall pay Petitioner temporary total disability benefits of **$320.70/week** for **24-1/7th weeks**, commencing **8/30/17** through **2/14/18**, as provided in Section 8(b) of the Act.

Signature of Arbitrator

6-7-18
Date

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

LEONARD LUDTKE,

Petitioner,

vs.

NO: 16 WC 009295
19 IWCC 712

COUNTY OF DeKALB,

Respondent.

ORDER OF RECALL UNDER SECTION 19(f)

Pursuant to Section 19(f) of the Act, the Respondent finds that a clerical error exists in the Decision and Opinion on Review dated December 31, 2019, in the above captioned.

Respondent's Motion for Corrected Decision was timely filed on January 10, 2020.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision and Opinion on Review dated December 31, 2019 is hereby vacated and recalled pursuant to Section 19(f) for a clerical error contained therein.

IT IS FURTHER ORDERED BY THE COMMISSION that a Corrected Decision and Opinion on Review shall be issued simultaneously with this Order.

DATED: JAN 16 2020
o: 12/19/19
BNF/kcb
45

Barbara N. Flores

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 on Accident	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify Choose direction	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

LEONARD LUDTKE,

Petitioner,

vs.

NO: 16 WC 9295
19 IWCC 712

COUNTY OF DeKALB,

Respondent.

CORRECTED 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, medical expenses, partial permanent disability, and penalties, and being advised of the facts and law, reverses the Decision of the Arbitrator as stated below.

I. FINDINGS OF FACT

A. Background

On December 30, 2015, Petitioner was employed by Respondent as a Maintenance Worker II. Petitioner testified he had been employed by Respondent for approximately 17 years. Petitioner stated his job duties included general maintenance, snow removal, light electrical and plumbing work, and cleaning. Petitioner added that he was available to assist others or fill in for unavailable co-workers. Petitioner was 56 years old at the time of his injury.

On December 30, 2015, Petitioner was generally assigned to the DeKalb County Courthouse. He could not recall how long he had been assigned to the courthouse but estimated it had been a couple of years. Petitioner testified the campus of Respondent in Sycamore, Illinois

included the courthouse at the corner of State and Main, along with the Public Safety Building (commonly known as the jail), the Legislative Center and the Administration Building. According to Petitioner, the jail was across Main Street, directly east of the courthouse, while the Legislative Center and Administrative Building were north of the courthouse. Petitioner described the campus as an L-shape, with the Administration building at the top or furthest north, with the courthouse to the west. Petitioner acknowledged there is metered parking on the public streets surrounding the courthouse.

Petitioner testified that prior to December 30, 2015, there had been a substantial improvement of the courthouse, including an addition to the north side. He later clarified that the improvements were constructed years earlier and there was no ongoing construction. Petitioner stated that after the addition was completed, additional parking was created on the north side of the building, directly adjacent to the addition. He testified that part of the street was taken as in-line parking for the courthouse. He described the parking as angled spaces just off the street, generally reserved for courthouse employees from 8:00 or 8:30 a.m. through 4:30 p.m. Petitioner stated that his department (facilities management) maintained those parking stalls, including snow removal, ice removal, salting and the like.

Petitioner also testified that the public entered the courthouse only through the main entrance on the south side of the building but there were four other entrances available for employees. According to Petitioner, there was a main employee entrance on the north side of the courthouse, as well as entrances at the east side, northwest corner, and the west side. Petitioner stated the employee entrances required entering a code into a keypad.

B. Accident

Petitioner testified that on December 30, 2015, his shift was from 7:00 a.m. to 3:30 p.m. He stated he arrived on the campus that day at approximately 6:45 to 6:50 a.m. Petitioner acknowledged he was not called into work early and was not paid for the time before his shift.

Petitioner testified he parked in one of the spaces on the north side of the courthouse. According to Petitioner, these spaces were reserved for particular employees, including judges. Petitioner stated that other employees generally parked in the main parking lot east of the Legislative Center, but to his knowledge, they were not required to do so.

Petitioner explained that he parked in a space reserved for another county employee to drop off his lunch and coffee; he wanted to avoid carrying it across the campus because he generally ate lunch at the courthouse. He explained that his coffee would have become cold carrying it from the main lot to the Public Safety Building to sign in for work before going to the courthouse. Petitioner stated he typically would deposit his lunch, drive to and park in the main lot, and enter the Public Safety Building to sign in on his time sheet.

Petitioner acknowledged he could have parked elsewhere and was not required to eat lunch at the courthouse. He later added that he had occasionally been telephoned to respond to emergencies while off-site during lunch.

Petitioner testified that after parking, he entered the courthouse through the northwest entrance and dropped off his lunch in the shop area. He stated that while entering the building, he noticed there was a thin layer of ice covering the parking lot, but the sidewalk seemed clear. According to Petitioner, it did not appear that anyone had cleared ice or snow, or salted the parking lot, but he observed ice melt on the sidewalk. Petitioner acknowledged it was icy throughout the city and there was snow around. He also acknowledged that he walked through snow to reach the public sidewalk and his shoes may have become wet.

Petitioner testified that after dropping off his lunch, he exited the building. Petitioner stated that as he was returning to his car, he slipped and fell in the parking area, approximately five or six feet away from his car. He added that his feet came out from under him and he landed heavily on his left shoulder and arm. Petitioner agreed there was no crack or defect in the sidewalk, or anything other than ice that caused him to fall.

According to Petitioner, he experienced extreme pain in his left shoulder and further examination revealed very limited mobility of the arm with extreme pain. Petitioner also testified that prior to his fall, he had never injured or received medical treatment involving his left shoulder and arm. Petitioner testified he notified his supervisor of the incident and drove himself to the emergency room at Kishwaukee Hospital.

C. Medical Treatment

On December 30, 2015, Petitioner presented to the emergency department at Kishwaukee Hospital. The medical records indicate Petitioner informed the staff he was outside at work and slipped on the ice, landing on the left shoulder/humerus; he denied any head injury, neck pain, chest pain, abdominal pain, or syncope. According to the records, two X-rays of the left shoulder showed no fracture, dislocation, focal bony abnormality or degenerative changes. Two X-rays of the left humerus showed similar results. A report on a CT scan of the head indicated no evidence of acute intracranial abnormality. Another report on a CT scan of the cervical spine indicated: no fractures; straightening of the normal cervical lordosis, which may be secondary to patient positioning or can be seen with muscle spasm; and multilevel cervical spondylosis.

Petitioner was diagnosed with a left shoulder contusion, with the notation of no obvious fracture or dislocation. The patient summary report also indicates instructions were given for a shoulder sprain. Petitioner was discharged to home care with instructions for rest, heat, ice and a shoulder sling as needed.

On January 4, 2016, Petitioner was seen at the Midwest Orthopedic Institute by Marcus Roman, assistant to Dr. Tony Choi. After providing a history of the incident, Petitioner

complained of pain with sleeping, especially on the left shoulder. Petitioner also complained of pain with overhead movements. Roman noted Petitioner previously had a right rotator cuff repair performed by Dr. Choi.

Roman's physical examination indicated the range of motion on both shoulders actively was 160/60/T9. Roman noted that on the left, he could forward elevate Petitioner to 160 degrees with a little pain. Strength was 4/5 in forward elevation on the left, 5/5 with external rotation but with pain, and 5/5 with internal rotation. Roman's impression was left shoulder pain, with suspicion of a rotator cuff tear. Roman recommended obtaining an MRI to rule out a rotator cuff tear. Roman also issued a work note stating Petitioner could not return to work.

The MRI of Petitioner's left shoulder was performed on January 7, 2016. The interpreting radiologist's impressions were: (1) complete full-thickness tear supraspinatus tendon and full-thickness tear of the anterior-most infraspinatus tendon with more mild diffuse infraspinatus tendinosis; (2) full-thickness tear of the cephalad 2/3 subscapularis tendon; (3) moderately severe acromioclavicular degenerative change; and (4) moderately large hemarthrosis freely communicating with the subacromial-subdeltoid bursa.

On January 11, 2016, Roman reviewed the MRI results and recommended surgical fixation for Petitioner's acute rotator cuff tears, to which Petitioner agreed. Roman noted that Dr. Choi also reviewed the MRI. On February 5, 2016, Petitioner saw Dr. Choi, whose notes confirm he reviewed the MRI and recommended arthroscopic rotator cuff surgery (as opposed to open surgery).

On February 11, 2016, Dr. Choi performed a left shoulder arthroscopic double row subscapularis repair and supraspinatus repair, subacromial decompression and biceps tenodesis. Dr. Choi's pre- and post-operative diagnoses were the same: left shoulder massive rotator cuff tear supraspinatus, infraspinatus, subscapularis. Petitioner was also referred to Dr. Manav Salwan on this date for post-operative medical management and diabetic management.

On February 12, 2016, Dr. Choi noted Petitioner was doing well and the plan would be to discharge him home. The doctor also noted he was trying to arrange home health therapy, as Petitioner had troubles with transportation due to living alone.

On February 19, 2016, Petitioner followed up with Roman, rating his pain at 1/10 at rest and 6/10 with activity. Petitioner also reported his pain was moderately controlled with Norco. Roman scheduled another visit in a week to remove Petitioner's sutures. Roman noted Petitioner would continue physical therapy and transition from home health to outpatient therapy the next week. Roman also continued Petitioner's use of a sling and abductor wedge. On February 24, 2016, Petitioner began twice-weekly occupational therapy. On February 26, 2016, Roman continued therapy, as well as the sling and abductor wedge, scheduling a visit with Dr. Choi in two weeks.

On March 11, 2016, Petitioner saw Dr. Choi, reporting his physical therapy was going well. Petitioner reported he was not taking Norco most days but would occasionally for neck pain. Dr. Choi noted Petitioner externally rotated passively relatively easy to 45 degrees with forward elevation of approximately 90 degrees. The doctor noted Petitioner was progressing well and removed the abduction portion of the sling. He also scheduled a follow-up visit with Roman in four weeks.

Petitioner saw Roman again on April 8, 2016. The record indicates Petitioner complained of some left shoulder pain at night. Roman's physical examination showed an active range of motion for the left shoulder of 90/45/L5, while the passive range of motion was 140/50/L5. The range of motion for the right shoulder was 170/60/T10. Roman continued Petitioner's physical therapy and ordered a follow-up visit in four weeks.

On May 6, 2016, Petitioner's only complaint to Roman was of left shoulder pain in the mornings, which improved with exercises and extra-strength Tylenol. Roman's examination showed the range of motion of the left shoulder was 150/60/L1, while the right shoulder was 170/60/T10. Petitioner's strength in forward elevation was 4/5, while his strength in internal and external rotation was 5/5. Roman again continued Petitioner's physical therapy and scheduled a visit in four weeks.

On June 3, 2016, Petitioner reported to Roman that he had no change in his shoulder pain, but felt his left shoulder was getting a little stiff. The range of motion and strength measurements were the same as his prior visit. Roman noted that in that morning's therapy, Petitioner only reached 130 degrees in forward elevation, but was able to get to 150 degrees when tested at the clinic. Roman extended Petitioner's physical therapy and scheduled another monthly visit, noting Petitioner would remain off work because there was no light duty work available.

Petitioner saw Dr. Choi on July 1, 2016. The record indicates Petitioner's range of motion for his left shoulder remained the same, but the strength in forward elevation was 4+/5. Dr. Choi noted Petitioner was still weak in forward elevation, but gradually improving. The doctor ordered continued physical therapy, with a follow-up in four weeks.

On July 9, 2016, Petitioner complained to Dr. Choi that earlier in the week, he was exercising during physical therapy and felt a pop in his neck/trapezius region, resulting in soreness around the neck which made it difficult to progress in the protocol. Dr. Choi found Petitioner's range of motion in the left shoulder was 160/60/T11, while strength in forward elevation remained 4+/5. Dr. Choi noted that Petitioner may have strained something and recommended possible deep tissue massage in addition to physical therapy. The doctor also recommended continuing strengthening exercises for endurance.

On August 26, 2016, Petitioner reported some remaining weakness to Dr. Choi, but stated the physical therapy was going well. Dr. Choi's examination found Petitioner's range of motion

in the left shoulder was 160/60/T9, while strength in forward elevation was 5-/5. Dr. Choi noted that Petitioner's residual weakness should improve with further endurance strengthening in physical therapy. The doctor also discussed work with Petitioner, who stated his boss would not let him return until he reached 100 percent. Dr. Choi hoped to return Petitioner to work after another four-week evaluation.

On September 30, 2016, Dr. Choi found Petitioner's range of motion in the left shoulder was 160/60/T9, while strength in forward elevation was 5/5. Dr. Choi noted that Petitioner still had a little endurance-limited weakness but was able to hold against forward elevation for quite some time before he fatigued. As Petitioner was not experiencing pain and his strength was near normal, Dr. Choi believed he would advance Petitioner to full-duty work and consider placing him at MMI in four weeks.

Petitioner last visited Dr. Choi on October 28, 2016. Petitioner's range of motion in the left shoulder and strength in forward elevation remained the same. Dr. Choi noted he sent Petitioner back to work after the prior visit and Petitioner reported tolerating it well, with little to no discomfort. Dr. Choi placed Petitioner at MMI and indicated he would see Petitioner on an as-needed basis.

D. Narrative Report by Dr. Choi

On June 29, 2016, Dr. Choi wrote a two-page report on his treatment of Petitioner. In the report, Dr. Choi briefly recounts Petitioner's history, the MRI results, the surgery, and the post-operative follow-up visits. Dr. Choi then opined with a reasonable degree of medical certainty that the fall on December 30, 2015 in the workplace parking lot did cause the acute rotator cuff tear on Petitioner's left shoulder.

E. Section 12 Examination by Dr. Weiss

On February 8, 2017, Petitioner was examined by Dr. Stephen Weiss, an orthopedic surgeon, at Respondent's request. Dr. Weiss prepared a report on February 17, 2017 wherein, following a review of Petitioner's medical records and a physical examination, Dr. Weiss diagnosed Petitioner with a full-thickness rotator cuff tear of the left shoulder, and a right shoulder rotator cuff repair by history (approximately seven years prior). Dr. Weiss also provided ratings according to the AMA Guides of a 7% upper extremity impairment, equivalent to a 4% whole person impairment.

F. Additional Information

Petitioner testified that between December 30, 2015 and October 3, 2016, he did not return to work, excepting a half-day on January 2 or 3, 2016. Petitioner also testified that $92,699.94 was paid by his group health insurer for treatment of his left shoulder injury, and that after his $225.00 out-of-pocket payments, there was an outstanding balance of $12,172.74.

Petitioner further testified he has returned to his full job as a maintenance worker, earning slightly more than he did prior to his injury. Petitioner stated he is right arm dominant.

Regarding his current condition of ill-being, Petitioner testified that upon returning to work for Respondent, he has had to self-modify his work to compensate for lifting and moving heavy objects such as file boxes, copy paper, and bags of ice melt or water softener salt. Petitioner acknowledged he lifts items weighing over 50 pounds himself but is more careful about how he balances the load and stacks items. Petitioner added that climbing vertical ladders on the roof of the Public Safety Building (where he now works) to check the roof and exhaust fans is difficult; shoveling snow can be painful. Petitioner testified he has continued to exercise at home, though it was not prescribed.

II. CONCLUSIONS OF LAW

A. Petitioner's Work-Related Accident

The Arbitrator found Petitioner failed to prove by a preponderance of evidence that he sustained an accident that arose out of and in the course of his employment which resulted in a disabling injury. The Arbitrator concluded the danger of slipping on the ice was not peculiar to his work and his exposure to the risk was not greater than that of the general public.

The issue of whether an injury arose out of and in the course of employment is generally a question of fact. *Suter v. Illinois Workers' Compensation Comm'n*, 2013 IL App (4th) 130049WC, ¶ 15. "However, when the facts are undisputed and susceptible to but a single inference, the question is one of law subject to *de novo* review." *Id.* In this case, the material facts are not susceptible to a single inference, the chief examples being whether the parking lot at issue is a public lot or provided to Respondent's employees when its use is restricted to particular employees for much of the day. Accordingly, the issue remains a question of fact.

"To obtain compensation under the Act, a claimant bears the burden of showing, by a preponderance of the evidence, that he has suffered a disabling injury which arose out of and in the course of his employment." *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill. 2d 193, 203 (2003). An injury "arises out of" employment when "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." *Sisbro*, 207 Ill. 2d at 203.

The question of whether a claimant's injury arose out of his or her employment depends upon the type of risk to which he or she was exposed. *Baldwin v. Illinois Workers' Compensation Comm'n*, 409 Ill. App. 3d 472, 478 (2011). "There are three categories of risk to which an employee may be exposed: (1) risks that are distinctly associated with one's employment, (2) risks that are personal to the employee, such as idiopathic falls, and (3) neutral risks that have no particular employment or personal characteristics, such as those to which the

general public is commonly exposed." *Dukich v. Illinois Workers' Comp. Comm'n*, 2017 IL App (2d) 160351WC, ¶ 31.

"[B]oth our supreme court and our appellate court have repeatedly held that accidental injuries sustained on property that is either owned or controlled by an employer within a reasonable time before or after work are generally deemed to arise out of and in the course of employment when the claimant's injury was sustained as a result of the hazardous condition of the employer's premises." *Dukich*, 2017 IL App (2d) 160351WC, ¶ 40 (and cases cited therein); see also *Mores-Harvey v. Industrial Comm'n*, 345 Ill. App. 3d 1034, 1038 (2004) (and cases cited therein). "The presence of a 'hazardous condition' on the employer's premises renders the risk of injury a risk incidental to employment; accordingly, a claimant who is injured by such a hazardous condition may recover benefits without having to prove that she was exposed to the risk of that hazard to a greater extent than are members of the general public." *Dukich*, 2017 IL App (2d) 160351WC, ¶ 40. "In other words, such injuries are not analyzed under 'neutral risk' principles; rather they are deemed to be risks 'distinctly associated' with the employment." *Id.*

The Arbitrator, in focusing on whether Petitioner's exposure to the risk of the ice was greater than that of the general public, appears to have analyzed this case as a "neutral risk" situation and did not consider whether it was a "hazardous condition" situation. The "hazardous condition" cases generally involve injuries caused by the natural accumulation of snow or ice in a parking lot or other outdoor space owned or controlled by the employer. *Dukich*, 2017 IL App (2d) 160351WC, ¶ 41; see also *Mores-Harvey v. Industrial Comm'n*, 345 Ill. App. 3d 1034, 1038 (2004) (and cases cited therein).

In this case, the unrebutted evidence shows that Petitioner was injured after falling due to ice and show in a parking area controlled by Respondent. Indeed, Petitioner's department was responsible for ice and snow removal in this parking area. Therefore, it cannot be said that Petitioner would never be expected to be in this parking area in the course of his work duties. Moreover, Respondent controlled when the parking lot was to be used solely by employees and when it was open to other members of the public.

Respondent argues that Petitioner fell in a public parking lot and not one designated for employees. This is not strictly true. The parking area at issue is restricted to particular courthouse employees from 8:00 or 8:30 a.m. through 4:30 p.m. Respondent also permits members of the public to park in this area during "non-business" hours, including at the time of the injury in this case. However, in *Mores-Harvey*, our appellate court considered that dual usage of a parking lot was not the issue:

> "Whether a parking lot is used primarily by employees or by the general public, the proper inquiry is whether the employer maintains and provides the lot for its employees' use. If this is the case, then the lot constitutes part of the employer's premises. The presence of a hazardous condition on the employer's premises that causes a claimant's injury supports the finding of a compensable claim." *Mores-*

Harvey, 345 Ill. App. 3d at 1040 (citing *Archer Daniels Midland Co. v. Industrial Comm'n,* 91 Ill. 2d 210, 216 (1982)).

In *Wal-Mart Stores, Inc. v. Industrial Comm'n,* 326 Ill. App. 3d 438 (2001), however, the appellate court reversed an award based in part on the fact that the employer's parking lot was open to both employees and the public. See *id.* at 445 (distinguishing *Hiram Walker & Sons, Inc. v. Industrial Comm'n*, 41 Ill. 2d 429, 430-31 (1968), and *American Electric Cordsets v. Industrial Comm'n,* 198 Ill. App. 3d 87, 91(1990)). Respondent also notes that the *Mores-Harvey* court, relying in part on *Homerding v. Industrial Comm'n,* 327 Ill. App. 3d 1050 (2002), ruled in favor of the claimant in part because "the general public was free to park anywhere in the lot, [but] claimant's choices were restricted. Therefore, claimant's exposure to risk was necessarily greater than that of the general public." *Mores-Harvey*, 345 Ill. App. 3d at 1042.

Respondent overlooks that the *Mores-Harvey* court, *after* concluding that a hazardous condition in the parking lot supported finding a compensable claim, discussed *Wal-Mart Stores* and *Homerding* as cases which considered *only* the second exception to the "general premises" rule. See *Mores-Harvey*, 345 Ill. App. 3d at 1040. This second exception permits recovery for off-premises injuries where "'the employee's presence at the place where the accident occurred was required in the performance of his duties and the employee is exposed to a risk common to the general public to a greater degree than other persons.'" *Id.* at 1038 (quoting *Illinois Bell Telephone Co. v. Industrial Comm'n,* 131 Ill. 2d 478, 484 (1989)). The *Mores-Harvey* court concluded the claimant would also recover under the second exception. *Mores-Harvey*, 345 Ill. App. 3d at 1042. But it was not required to do so, having already concluded the first exception applied because the parking lot, even if dual-use, was maintained and provided for employees' use.[1]

Respondent contends Petitioner was also required to prove he had begun his work day, and that he was required to park in the lot where the injury occurred. The latter asserted requirement is based on the discussion of *Homerding* in *Mores-Harvey*. The former asserted requirement is not entirely accurate. Rather, the injury must be sustained "within a reasonable time before or after work." *Dukich*, 2017 IL App (2d) 160351WC, ¶ 40; see also *Hiram Walker & Sons, Inc. v. Industrial Comm'n*, 41 Ill. 2d 429 (1968) (affirming award where employee arrived 40-50 minutes early and slipped in parking lot before proceeding to breakfast at a nearby café). In this case, Petitioner's shift began at 7:00 a.m. He arrived on Respondent's campus at approximately 6:45 to 6:50 a.m. A gap of 10 to 15 minutes is within a reasonable time before or after Petitioner's shift.

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[1] This first exception was recently discussed by the Illinois Appellate Court in *Walker Brothers, Inc. v. Illinois Workers' Compensation Comm'n*, 2019 IL App (1st) 181519WC. The *Walker Brothers* court observed that "'[t]he decisive issue in parking lot cases usually is whether or not the lot is owned by the employer, or controlled by the employer, or is a route required by the employer.'" *Id.* ¶ 22 (quoting *Maxim's of Illinois, Inc. v. Industrial Comm'n*, 35 Ill. 2d 601, 604 (1966)). Here, the lot was controlled by Respondent.

Respondent notes Petitioner was not required to keep his lunch or coffee in the courthouse. This objection is consistent with Respondent's reliance on *Illinois Bell Telephone Co.*, but, as noted above, that case involved the second exception to the "general premises" rule, not the first. In a "hazardous condition" case, "[t]he rationale for awarding compensation is that the employer-provided parking lot is considered part of the employer's premises." *Mores-Harvey*, 345 Ill. App. 3d at 1038 (citing L. Larson, Larson's Workers' Compensation Law § 13.04[2][a], [b], at 13--40-13--41 (2002)).

The amount of control Respondent exercised over Petitioner's lunch arrangements, however, is relevant to establish that Petitioner's depositing of his lunch and coffee in the courthouse before parking in the main lot was a reasonably necessary act of personal comfort.

The personal comfort doctrine provides:

> "'Employees who, within the time and space limits of their employment, engage in acts which minister to personal comfort do not thereby leave the course of employment, unless the * * * method chosen is so unusual and unreasonable that the conduct cannot be considered an incident of the employment.'" *Karastamatis v. Industrial Comm'n*, 306 Ill. App. 3d 206, 211 (1999) (quoting 2 A. Larson & L. Larson, Workers' Compensation Law § 21.00, at 5-5 (1998)).

Moreover:

> "'If the employee voluntarily and in an unexpected manner exposes himself to a risk outside any reasonable exercise of his duties, the resultant injury will not be deemed to have occurred within the course of the employment. [Citation.] The employer may, nevertheless, still be held liable for injuries resulting from an unreasonable and unnecessary risk if the employer has knowledge of or has acquiesced in the practice or custom,'" *Karastamatis*, 306 Ill. App. 3d at 211 (quoting *Eagle Discount Supermarket v. Industrial Comm'n,* 82 Ill. 2d 331, 340 (1980)).

The personal comfort doctrine generally encompasses acts such as eating and drinking, obtaining fresh air, seeking relief from heat or cold, showering, resting, and smoking. *Karastamatis*, 306 Ill. App. 3d at 211 (citing 2 A. Larson & L. Larson, Workers' Compensation Law § 21.10, at 5-5 (1998)).

In this case, Petitioner sought relief from the cold for himself, his coffee and food during the short period before his shift. Using the nearest dual-use parking lot was foreseeable, not unreasonable or unexpected; parking south or west of the courthouse was metered while the east side was bounded by a major thoroughfare with no parking. The risk of ice in the area is not outside any reasonable exercise of Petitioner's duties; his department is responsible for clearing

snow and ice in the parking area. Petitioner's morning routine was not so unusual and unreasonable that the conduct cannot be considered an incident of the employment. Rather, it was a reasonably foreseeable act of personal comfort.

Lastly, Respondent argues Petitioner was not exposed to a risk greater than that to which the general public was exposed. This is again either dependent on *Illinois Bell Telephone Co.* (which involved the common area of a mall, not a parking lot controlled by an employer) or on characterizing this case as involving a "neutral risk." Accordingly, the Commission rejects the argument for the reasons stated above. Moreover, as Petitioner notes, he was accessing the courthouse using an employee entrance from an area where the public also was permitted to park, but would not be expected to park, given that the public entrance was on the other side of the courthouse.

For all of the aforementioned reasons, the Commission concludes that Petitioner proved by a preponderance of evidence that he sustained an accident which arose out of and in the course of his employment.

B. Causal Connection

The Commission next considers whether Petitioner's current condition of ill-being is causally related to the accident. In his narrative report, Dr. Choi opined with a reasonable degree of medical certainty that the fall on December 30, 2015 in the workplace parking lot did cause the acute rotator cuff tear on Petitioner's left shoulder. In his IME report, Dr. Weiss does not offer a contrary view. Petitioner testified regarding his continuing weakness and limitations at work. Given this record, the Commission concludes Petitioner's current condition is causally connected to the accident.

C. Temporary Total Disability

Petitioner claims he was entitled to temporary total disability benefits in the amount of $508.39 per week for the 39-week period from January 4, 2016 through October 3, 2016, pursuant to §8(b) of the Act. The parties stipulated in the Request for Hearing that Petitioner's average weekly wage, calculated pursuant to section 10 of the Act, was $762.59. Accordingly, Petitioner's claim represents the statutory two-thirds of his average weekly wage. See 820 ILCS 305/8(b)1 (West 2018). Respondent disputed this claim by denying the accident arose out of the course of Petitioner's employment. Having found Petitioner's accident compensable, the Commission awards Petitioner the claimed temporary total disability benefits.

D. Medical Expenses

Petitioner claims Respondent should pay outstanding reasonable and necessary medical expenses of $12,172.74 pursuant to the fee schedule and reimburse him $225.00 for out-of-pocket medical expenses pursuant to §§8(a) and 8.2 of the Act. Petitioner also acknowledges

Respondent should be given a credit of $92,699.94 for medical benefits paid by its group medical carrier and hold Respondent harmless for any claims for which it receives credit, pursuant to §8(j) of the Act. Respondent again disputed this claim by denying the accident arose out of the course of Petitioner's employment. Having found Petitioner's accident arose out of his employment, the Commission awards Petitioner the claimed medical expenses, and awards Respondent the credit under §8(j) of the Act as stipulated by the parties in the Request for Hearing.

E. Permanent Partial Disability

Petitioner further seeks permanent partial disability benefits representing a 15% loss of the person as a whole. Subsection (b) of section 8.1b of the Act lists five factors upon which the Commission must base its determination of the level of permanent partial disability benefits to which a claimant is entitled, including: (i) the level of impairment contained within a permanent partial disability impairment report; (ii) the claimant's occupation; (iii) the claimant's age at the time of injury; (iv) the claimant's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. 820 ILCS 305/8.1b(b) (West 2018). However, "[n]o single enumerated factor shall be the sole determinant of disability." *Id.* § 305/8.1b(b)(v).

Regarding the level of impairment contained within a permanent partial disability impairment report, the Section 12 examiner, Dr. Weiss, provided ratings according to the AMA guidelines of a 7% upper extremity impairment, equivalent to a 4% whole person impairment. Petitioner did not submit an impairment rating. The Commission gives some weight to this factor.

Regarding the claimant's occupation, Petitioner is employed by Respondent as a maintenance worker, a position which involves lifting and moving heavy objects such as file boxes, copy paper, and bags of ice melt or water softener salt. Some of these items weigh over 50 pounds. Petitioner's occupation also involves climbing vertical ladders to perform maintenance checks. Petitioner additionally performs light plumbing and electrical work, and shovels snow. The Commission places greater weight on this factor.

As for the claimant's age, Petitioner was 56 years old at the time of his injury. This is an age at which it may be expected that not only is Petitioner truly at MMI and unlikely to recover further, but also young enough that he may be expected to work for a number of years with lingering symptoms and the limitations he has imposed upon himself to complete his job duties. The Commission places some weight on this factor.

The claimant's future earning capacity appears to be undiminished. Petitioner has returned to his full job as a maintenance worker, earning slightly more than he did prior to his injury. Accordingly, the Commission places no weight on this factor.

Lastly, the Commission considers the evidence of Petitioner's disability corroborated by the treating medical records. Petitioner was diagnosed by Dr. Choi with left shoulder massive

rotator cuff tear supraspinatus, infraspinatus, subscapularis. Dr. Weiss also diagnosed Petitioner with a full-thickness rotator cuff tear of the left shoulder. To treat this condition, Petitioner underwent a left shoulder arthroscopic double row subscapularis repair and supraspinatus repair, subacromial decompression and biceps tenodesis. Petitioner then participated in approximately eight months of physical therapy and rehabilitation. Petitioner's medical records are entirely consistent with his lingering difficulty with job duties which include lifting and moving heavy objects, climbing vertical ladders, and shoveling snow. The Commission places greater weight on this factor.

Weighing the five factors pursuant to Section 8.1b of the Act, which does not simply require a calculation, but rather a measured evaluation of which no single factor is conclusive on the issue of permanency, the Commission agrees that Petitioner sustained a 15% loss of use of the whole person.

F. Penalties and Fees

Petitioner sought penalties from Respondent under section 19(k) of the Act, which provides:

> "In case[s] where there has been any unreasonable or vexatious delay of payment or intentional underpayment of compensation *** then the Commission may award compensation additional to that otherwise payable under the Act equal to 50% of the amount payable at the time of such award." 820 ILCS 305/19(k) (West 2018).

Petitioner also sought an award of attorney fees pursuant to Section 16 of the Act which provides for an award of attorney fees when an award of additional compensation under section 19(k) is appropriate. 820 ILCS 305/16 (West 2018). Section 19(k) penalties and section 16 fees are intended to address situations where the delay is deliberate or the result of bad faith or improper purpose. *Jacobo v. Illinois Workers' Compensation Comm'n*, 2011 IL App (3d) 100807WC, ¶ 24. The imposition of penalties under section 19(k) and fees under section 16 is discretionary. *Id.*

The Commission has in the past vacated an award of penalties and fees where the Respondent had a good faith argument regarding liability for a fall in a parking lot, in part due to the sometimes confusing state of the law regarding such injuries. See, *e.g.*, *Plucinski v. White Castle Systems, Inc.*, 5 IWCC 456. Given the record in this case, Respondent had a good faith argument regarding liability. Accordingly, the Commission declines to award penalties and fees in this case.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 14, 2017, is hereby reversed for the reasons stated above.

IT IS FOUND BY THE COMMISSION that Petitioner proved he sustained an accident arising out of and in the course of his employment with Respondent on December 30, 2015.

IT IS FURTHER FOUND BY THE COMMISSION that Petitioner proved his current condition of ill-being is causally connected to the accident.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner the temporary total disability benefits that have accrued from January 4, 2016 through October 3, 2016 at the rate of $508.39 per week, pursuant to §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is liable to pay Petitioner's outstanding reasonable and necessary medical expenses of $12,172.74 pursuant to the fee schedule and also to reimburse Petitioner $225.00 for out-of-pocket medical expenses pursuant to §§8(a) and 8.2 of the Act. Respondent is awarded a credit of $92,699.94 for medical benefits paid by its group medical carrier and is held harmless for any claims for which it receives credit, pursuant to §8(j) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $457.55 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 a 15% loss of use of Petitioner's person as a whole.

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

No county, city, town, township, incorporated village, school district, body politic or municipal corporation is required to file a bond to secure the payment of the award and the costs of the proceedings in the court to authorize the court to issue such summons. 820 ILCS 305/19(f)(2). Based upon the named Respondent herein, no bond is set by the Commission. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JAN 16 2020
d: 12/19/19
BNF/kcb
045

Barbara N. Flores

Deborah L. Simpson

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION

Illinois Workers' Compensation Commission Petitioner, v. Café Rumba, & West Hubbard Partners Respondent.	)	10 INC 534 18 WC 27927

ORDER

This matter, after oral request by the Petitioner, The Illinois Workers' Compensation Commission – Insurance Compliance Division, by and through its attorney, the Office of the Illinois Attorney General, is dismissed. The Office of the Attorney General has advised this Commission it no longer seeks to proceed in this matter against Respondents, as this matter has settled.

Commissioner Maria Portela

JAN 2 1 2020

Dated: 1/14/20

STATE OF ILLINOIS)
) SS.
COUNTY OF JEFFERSON)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Elizabeth McAlexander,
Petitioner,

vs.

NO. 12 WC 31793
14 WC 21613
19 IWCC 711

Mt. Vernon School District #80,

Respondent.

ORDER OF RECALL UNDER SECTION 19(f)

Pursuant to Section 19(f) of the Act, the Commission *sua sponte* finds that a clerical error exists in the Decision and Opinion on Review dated January 8, 2020. Specifically, the Commission recognizes the omission of language awarding possible cost-of-living adjustments to Petitioner, paid by the Rate Adjustment Fund, pursuant to section 8(g) of the Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision and Opinion on Review dated January 8, 2020 is hereby vacated and recalled pursuant to Section 19(f) for a clerical error contained therein.

IT IS FURTHER ORDERED BY, THE COMMISSION that a Corrected Decision and Opinion on Review shall be issued simultaneously with this Order.

DATED: JAN 2 1 2020
o:11/7/19
BNF/wde
45

Barbara N. Flores

STATE OF ILLINOIS)
) SS.
COUNTY OF)
JEFFERSON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Elizabeth McAlexander,

Petitioner,

vs.

NO: 12 WC 31793
14 WC 21613
19 IWCC 711

Mt. Vernon School District #80,

Respondent.

CORRECTED DECISION AND OPINION ON REVIEW

Timely Petitions for Review having been filed by both 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, Section 19(d) of the Act, permanent disability and Respondent's credit and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The underlying claim arises out of an accident[1] involving Petitioner's right ankle on March 13, 2012. Petitioner claimed that she was injured when, hurrying to a class, she tripped on stripping between carpet and tile. Petitioner tumbled forward landing on her hands and knees with her ankles and feet turned underneath her. Several witnesses testified regarding the school and condition of the flooring. The Arbitrator ultimately found that the stripping was higher than the carpet and tile and that Petitioner did sustain an injury arising out of and in the course of her employment with Respondent on March 13, 2012 as a result. He determined that Petitioner

1 The parties' request for hearing form at arbitration included both case numbers, but only referenced the March 13, 2012 accident claimed in Case No. 13 WC 31793. At the hearing, Petitioner testified that she suffered a second accident affecting the right ankle on November 12, 2012 (as claimed in Case No. 14 WC 21613). The Arbitrator did not reach any conclusions in his decision related to the second claimed accident. Neither party appealed the lack of findings or conclusions in the arbitration decision for the consolidated cases related to the latter November 12, 2012 accident claim.

suffered a right ankle sprain which aggravated her pre-existing arthritis and accelerated her need for a right ankle fusion performed on April 5, 2013. However, the Arbitrator concluded that Petitioner was noncompliant with treatment after her surgery severing causal connection effective April 16, 2013 pursuant to Section 19(d) of the Act. He awarded benefits commensurate with his conclusions of law. Thereafter, Petitioner and Respondent filed cross petitions for review of the arbitration decision filed on July 5, 2018.

I. FINDINGS OF FACT

A. Background

Petitioner was employed by Respondent as an Individual Aide at the time of her March 13, 2012 accident. In this position she taught special education students one-on-one ensuring their work was completed and that the students had the proper books and made it to their classes. If the child was disabled, Petitioner would have to feed him or her, change diapers, and lift the child from the floor to a chair and vice versa. Petitioner would also accompany students on field trips. Depending on what school she was assigned to, she may have to traverse three flights of stairs. Petitioner worked 23 years for Respondent.

Prior to her employment with Respondent, Petitioner had obtained a high school diploma, an associate in arts degree from Rend Lake College, and took several nursing classes. Her degree and nursing classes were completed in the 1970's. Petitioner also held several waitress jobs, nurse's aide jobs at two hospitals, and worked at a day care center.

Petitioner owns a computer but testified that she only used it for social media and searching the internet. She has no training in Microsoft or Excel and does not consider herself to be a good typist. While working for Respondent, Petitioner used a computer when working with 6th and 7th grade students.

B. Accident

On March 13, 2012, Petitioner was at Casey Middle School. She was walking to the science building where her student was located. Just inside the doors of the science building was a transition from carpet to tile flooring. A transition strip was used to separate the carpet and tile. While hurrying back to her child's class, Petitioner tripped on the strip, tumbled forward and landed on her hands and knees with her ankles and feet turned underneath her. Petitioner felt pain in her hands, wrists, knees and ankles. She was not carrying anything at the time.

Petitioner testified that she reported the injury to the Nurse, Lisa Tucker. Petitioner knew there would be a video recording of her fall because there was a camera at the end of the hall recording everything that came through the area. She requested to see a playback of the incident on video, which was granted by the substitute secretary. The video was requested by Petitioner's Counsel but was never provided.

Petitioner had pain and swelling in her feet and ankles prior to the accident. However, she testified that her right ankle became more swollen and painful following the accident.

C. Pre-injury Medical Treatment

Prior to the accident, Petitioner sought right ankle treatment with Dr. Gunzel in February of 2011 due to neuropathy and swelling in her feet and arthritic ankles. Petitioner also testified regarding prior treatment with a pain doctor, Dr. Juergens, for her feet on one occasion in February 2012.

On February 4, 2011, Petitioner presented to Dr. Gunzel for bilateral foot and right ankle pain, gradually worsening. She informed Dr. Gunzel that she had been diagnosed with osteoarthritis approximately 10 years ago. Petitioner's diagnosis included pain in the joint involving the ankle and foot, and osteoarthritis localized primarily involving the ankle and foot.

On May 20, 2011, Petitioner indicated to Dr. Gunzel that her foot pain had not improved. She received bilateral injections at the tarsal sinus and was placed on restrictions of no walking more than one block or standing over 20 minutes at a time. At this time her diagnoses included degenerative joint disease, unspecified inflammatory or toxic neuropathy, metatarsalgia bilateral, hallux limitus left, valgus bilateral and bunion deformity bilateral.

On December 9, 2011, Petitioner informed Dr. Gunzel that her condition was worsening. Another injection was performed, and shoe selection was discussed to minimize discomfort. Petitioner was told to follow up in four weeks. However, Petitioner cancelled her January 6, 2012 visit and her records were sent to Dr. Juergens.

On February 29, 2012, Petitioner's complaints to Dr. Juergens included pain in her neck, bilateral shoulders, bilateral hands, low back and bilateral feet. She was able to stand on her heels and toes bilaterally. Petitioner was diagnosed with unspecified hereditary or idiopathic peripheral neuropathy, prescribed medication and recommended to follow-up with a neurologist.

An October 2012 report by Section 12 examiner Dr. Schmidt later indicated that Petitioner denied any trauma or injury to her right ankle prior to March 2012.

D. Post-injury Treatment, Section 12 Examinations and Employment

On March 13, 2012, Petitioner presented at the Good Samaritan Hospital emergency room ("ER") with complaints of injury to her knees bilaterally and right ankle and foot. Abrasions were noted on the left knee and ankle and there was tenderness and swelling to her right foot and ankle. Bilateral knee x-rays revealed moderate osteoarthritic changes of the left knee. Right ankle x-rays revealed extensive soft tissue swelling and osteochondral defect and impacted fracture of the talus of indeterminate age and etiology, a healed displaced fracture of the anterior aspect of the tibia of indeterminate age, degenerative changes of the tarsal bones, and enthesophyte at the insertion of the plantar aponeurosis in the calcaneus. Right foot x-rays revealed a question of bony demineralization and osteonecrosis of the talus, and arthritic changes at the first metatarsophalangeal joint. Prescription medication was provided, and Petitioner was given an ace bandage and crutches. She was taken off work for three days.

Petitioner then presented to Dr. Freehill at the Orthopedic Center of Southern Illinois on March 27, 2012. She indicated that she had tripped over loose stripping on the floor and fell on both knees, both hands and her feet were bent underneath her. Petitioner had significant swelling over her lateral ankle ligaments. After a physical exam and review of x-rays, she was diagnosed with an acute right ankle sprain with evidence of old injury. Physical therapy was ordered and pain medication and a lace up brace were prescribed after Petitioner indicated she did not want a CAM walker boot. Petitioner was placed on light duty and was to avoid prolonged standing and walking.

On May 1, 2012, Dr. Freehill diagnosed Petitioner with a right ankle sprain with persistent pain and swelling. He was concerned about the swelling and possible osteonecrosis of the talus. Petitioner was also concerned that her cervical fusion with hardware would interfere with an MRI, thus she was sent for continued therapy while on light duty restrictions instead. The prescribed therapy at Physical Rehab Center in May and June of 2012 was unsuccessful and ultimately put on hold pending a follow up with Dr. Freehill due to Petitioner's persistent ankle pain. However, she was able to complete her work that school year.

On June 12, 2012, Dr. Freehill still noted a large amount of swelling over the lateral ankle ligaments, with tenderness over the ankle, ankle ligaments and tightness in the achilles tendon. Therapy was discontinued, and Petitioner was referred to an ankle specialist.

Petitioner also testified that she returned to work for the school year, but was working with a high functioning, older autistic child who did not require much physical aid. Petitioner still had pain and swelling and kept her ankle propped up on a chair during the school day.

Upon Dr. Freehill's recommendation, Petitioner underwent a right ankle MRI on September 17, 2012. On September 28, 2012 Dr. Freehill noted that the MRI revealed evidence of central collapse of the central and lateral talar articular cortex, degenerative changes of the anterior and posterior tibia and tibiotalar joint effusion with loose bodies. Petitioner was again referred to a foot and ankle specialist.

Petitioner underwent a Section 12 examination at Respondent's request with Dr. Schmidt, an orthopedic surgeon, on October 22, 2012. Petitioner complained of a painful and swollen right ankle and indicated difficulty with prolonged standing, walking and driving. A physical exam showed the circumference of her right ankle at the malleolar to be 31cm, while it was 29cm on the left side. Petitioner was unable to do a double-limb heel rise. Dr. Schmidt reviewed Petitioner's x-rays and diagnosed osteochondral lesion, osteonecrosis of the talus and osteoarthritis of the ankle. Dr. Schmidt agreed that Petitioner's current condition was related to the accident in question and recommended a CT scan. Dr. Schmidt further opined that Petitioner would likely require an ankle replacement.

Dr. Schmidt offered deposition testimony on December 20, 2017. He testified that Petitioner told him she spent 85% of her day lying down. He stated that his objective findings supported Petitioner's objective complaints, and that Petitioner had not reached maximum medical improvement ("MMI") at that time. Dr. Schmidt testified that his causal connection opinion was due to an absence of previous trauma to Petitioner's ankle. He stated Petitioner's osteochondral

lesion and osteoarthritis were long-standing but had been accentuated by the accident in question.

Petitioner suffered a second accident[2] affecting the right ankle on November 12, 2012. Petitioner testified that at the end of a class period some students were horse-playing. One student was then pushed into Petitioner's right ankle and kicked it. Petitioner felt pain and reported it to the Assistant Principal. Petitioner testified that she underwent x-rays at Good Samaritan and followed up with Dr. Freehill, who referred her to Dr. Klein at Washington University.

On November 21, 2012, Petitioner presented to another orthopedic surgeon, Dr. Aubuchon, for a second opinion. He noted significant right ankle swelling along with significant grinding with flexion and extension of the ankle. He diagnosed end stage arthritis of the ankle and recommended an ankle fusion and restricted Petitioner to sedentary work through December 1, 2012.

Petitioner testified that her student moved over Christmas Break of that school year. Upon returning in January, Petitioner was assigned to a child at the Early Childhood Center. This child was wheelchair-bound and could not speak. The child was the size of a 5 or 6-year-old, and Petitioner was tasked with lifting her regularly. Petitioner worked with the child for three days before deciding her ankle was too painful to assist this child. Petitioner spoke with the Superintendent about being assigned a new child, but none was available. Subsequently, Petitioner did not receive temporary total disability ("TTD") benefits, was denied disability benefits through the school district and ultimately went on FMLA. She did not receive payment, however, as she had no sick time available.

On January 18, 2013, Petitioner returned to Dr. Freehill who noted her persistent pain. He diagnosed right ankle arthritis and talar collapse and recommended an ankle fusion. Petitioner was placed on light duty and referred to Dr. Klein.

Petitioner underwent a second Section 12 examination at Respondent's request with Dr. Schmidt on February 4, 2013. Dr. Schmidt noted the November 12, 2012 injury, but maintained his prior causal connection opinions as unchanged.

Petitioner then began treatment with Dr. Klein on February 12, 2013. Severe pain and swelling were noted in her right ankle and a physical exam revealed a severely antalgic gait as well as Petitioner having difficulty bearing weight on her right foot. Dr. Klein reviewed x-rays and diagnosed severe right ankle arthritis, right ankle valgus deformity and idiopathic peripheral neuropathy. He also recommended a CT scan and explained to Petitioner that if she were to undergo surgery, she would be required to use a cast and boot. Dr. Klein cautioned against surgery if Petitioner did not think she would be able to adhere to post-operative restrictions.

The CT scan performed on February 28, 2013 revealed a large osteochondral lesion of the lateral right talar dome with articular collapse involving 2/3 of the talar articular surface, severe secondary right tibiotalar and tibiofibular joint osteoarthritis and mild right posterior subtalar joint

[2] The Arbitrator made no ruling relative to this accident in his Decision and the accident was not raised as an issue on appeal to the Commission.

osteoarthritis.

On February 28, 2013, Petitioner also presented to Dr. Klein who noted Petitioner's difficulty with wearing a walking boot in the past, as well as Petitioner's concern about surgical recovery. Dr. Klein indicated that post surgically Petitioner would be non-weight bearing in a cast for six weeks, followed by four weeks in a weight-bearing cast. After that, Petitioner would be allowed to bear weight in a walking boot.

On March 28, 2013, Petitioner returned to Dr. Klein for a pre-operative follow-up and was apprised of the risks and benefits of surgery. Dr. Klein recommended that Petitioner practice non-weight bearing at home prior to surgery.

Regarding her employment, Petitioner testified that she decided to retire effective April 10, 2013. She sent an e-mail to that effect on April 2, 2013, three days prior to her scheduled surgery date. Prior to e-mailing her resignation, Petitioner testified that she phoned the school district and informed them that she did not want to retire, but she had to due to financial reasons. She has not been employed since. Had she continued her employment, Petitioner explained that she would have been taken off work for at least six months to recover.

On April 5, 2013, Petitioner underwent surgery. Specifically, Dr. Klein performed a right ankle complex arthrodesis with interposition wedge allograft and a right iliac crest bone graft. The post-operative diagnosis was right ankle arthritis, right ankle valgus deformity, and obesity.

Post-operatively, Petitioner saw Dr. Klein on April 16, 2013. She reported that she was "doing her best" to non-weight bear. Dr. Klein noted it sounded like "she is putting her foot on the ground several times" and she reiterated the importance of non-weight bearing to give her the best chance for success. Petitioner was placed in a short leg non-weight bearing cast.

At the hearing, Petitioner denied putting full weight on her foot and testified that she was only putting her foot down to rest it due to the heaviness of her cast. Petitioner acknowledged that Dr. Klein was adamant about how she was to protect her ankle after undergoing surgery. She testified that there would be occasions where she put her foot down, but only to balance, which she explained Dr. Klein allowed. She testified that she did not walk on it and testified that the surgery decreased, but did not eliminate, her pain and swelling. She also testified that she followed post-operative orders not to walk on her ankle and she explained that she hopped around on her left foot using a walker.

The medical records reflect that on May 16, 2013, Petitioner again followed up with Dr. Klein who noted that it sounded like Petitioner had been walking on her foot somewhat. Dr. Klein noted the lengthy prior discussions with Petitioner about post-surgical restrictions, including the recommendation that Petitioner refuse surgery if she was not willing to avoid weight bearing. Dr. Klein again stressed the importance of Petitioner complying with post-surgical restrictions in order to have a successful recovery. Notwithstanding, no evidence of hardware loosening or failure was present in Petitioner's x-rays. Petitioner was placed in a short weight-bearing cast and told that she could place weight on the extremity. She explained to Petitioner that she could weight bear but should stop walking if painful. Dr. Klein remained concerned with Petitioner's ability to

comply and warned that Petitioner risked a non-union, which could lead to chronic pain.

On June 13, 2013, Petitioner still had clinical pain and had been weight bearing in the cast. An x-ray revealed stable hardware and a progressive fusion of the ankle joint line. Dr. Klein wanted to ease Petitioner into using a walking boot and noted that her radiographs looked good. Dr. Klein also allowed Petitioner to weight bear as tolerated in her boot and instructed not to walk without it. Dr. Klein further noted that Petitioner's "previous cast became somewhat loose because of calf atrophy. That may be why the ankle has been so sore." If she had discomfort, Petitioner was also advised to use her crutches and walker to keep weight off her foot.

On June 20, 2013, Petitioner presented to the Good Samaritan emergency room with right ankle pain status post fusion. A nurse practitioner noted the mechanism of injury that Petitioner "stepped wrong, possible twist." She also noted that Petitioner had a "(recent fracture repair, cast taken off about 1 week ago)." Petitioner's right ankle was swollen and tender, and she reported pain with ambulation in the boot. When she went in for x-rays, Petitioner was "wearing a boot [reporting p]ain shooting from ankle off leg." X-rays revealed an oblique fracture with mild displacement of the distal fibula. Petitioner was released from the emergency room with medication and follow up care instructions.

A telephone note from Dr. Klein's office on June 24, 2013 indicated Petitioner called requesting pain medication after being diagnosed with a fibular fracture the previous week. Dr. Klein believed the fracture was actually an osteotomy that was done during surgery. The following day during her scheduled appointment with Dr. Klein's nurse practitioner, Petitioner complained of increased pain at the right lateral ankle. Contrary to the fracture diagnosis at the emergency room, Petitioner's x-rays revealed no new fracture. She was placed in a short leg non-weight bearing cast.

On July 11, 2013, Petitioner reported to Dr. Klein that she was having good days and bad days with complaints of moderate swelling and tenderness to palpation around her ankle. Dr. Klein noted that Petitioner "came in a couple of weeks ago complaining of a lot of pain. I'm not sure what caused it." Dr. Klein was concerned that Petitioner was developing non-union due to her pain complaints. A CT scan was recommended.

On August 1, 2013, Dr. Klein reviewed Petitioner's CT scan taken August 1, 2013, which revealed a non-union of the right ankle arthrodesis, non-union of the distal fibular osteotomy, and mild subtular osteoarthritis. A bone stimulator was ordered. In a telephone note from that day, Dr. Klein restated Petitioner's post-surgical history and restrictions and told Petitioner that her arthrodesis had not healed. Dr. Klein did not restrict Petitioner from bearing weight and placed her in a boot allowing her to bear weight as tolerated. Dr. Klein allowed Petitioner to remove it to bathe and shower and indicated that she did not need to wear it to sleep.

On August 23, 2013, Petitioner returned to the emergency room at Good Samaritan after falling in her kitchen two weeks prior with worsened pain since then. Ankle x-rays revealed no changes.

On September 26, 2013, Petitioner underwent x-rays. Dr. Klein noted early signs of non-

union in Petitioner's ankle joint. Petitioner was to transition to a solid molded AFO at the ankle to help her get back into a shoe and out of a boot. Bone stimulator usage was to continue.

As of January 16, 2014, x-rays revealed evidence of a non-union including a broken screw and a loose screw and plate fixation of the talus. A CT scan several months later on April 2, 2014 confirmed the non-union. On April 4, 2014 Petitioner was told that a revision surgery was the next step. Petitioner requested time to consider her options.

Petitioner testified that Dr. Klein informed her that her ankle was not healing properly and discussed possible additional surgery. Petitioner testified that she was given the option to forego surgery and simply deal with the symptoms. She ultimately decided to forego another surgery.

Petitioner presented then presented for an independent medical examination ("IME") with Dr. Krause on June 30, 2014, which was scheduled at her attorney's request. Dr. Krause, an orthopedic surgeon, opined that without evidence to the contrary he did not dispute the causation opinions by Drs. Schmidt and Freehill, indicating Petitioner's need for a right ankle fusion was causally related to her March 2012 accident. Dr. Krause noted a non-union of Petitioner's ankle but did not recommend another surgery at that time and placed Petitioner at MMI. Dr. Krause opined that Petitioner could work at a sedentary capacity with intermittent standing.

At a deposition on June 2, 2017, Dr. Krause acknowledged that Petitioner did not tell him about any significant problems with her ankle prior to the accident. Had she done so, Dr. Krause's opinions could have changed regarding causal connection. However, he ultimately acknowledged the possibility that the accident in question accelerated Petitioner's need for the surgery performed by Dr. Klein. Dr. Krause testified that, despite his opinions regarding treatment, Petitioner probably could not stand 8-10 hours daily.

Dr. Krause also noted that Petitioner's eventual post-surgical non-union was most commonly caused by smoking. He mentioned other common causes including premature weight-bearing and a big piece of allograft bone inserted (which Petitioner had). Notwithstanding other common or possible causes, Dr. Krause testified that Petitioner could have been at risk for a non-union regardless of weight-bearing although he opined that premature weight-bearing contributed to Petitioner's non-union in some way. Dr. Krause also testified relative to Petitioner's complaint of a twisted ankle after being placed in a boot in June of 2013. He opined that this injury suggested Petitioner was not wearing her boot at the time, as instructed by Dr. Klein.

In an October 10, 2016 addendum report, Dr. Krause noted his review of additional records dating back to 2010 but indicated that they did not provide any significant additional information. His opinions from the June 2014 IME remained unchanged.

In a July 24, 2017 addendum report, Dr. Schmidt noted his review of additional medical records received from Respondent's counsel. Therein, he opined that, although Petitioner had right ankle difficulty prior to the accident in question, he believed her condition did deteriorate due to the accident in question. As evidence, he noted that prior to the accident on February 29, 2012 Dr. Juergens indicated that Petitioner was able to lift on her toes. Conversely, during Dr. Schmidt's first examination of Petitioner on October 22, 2012, she was unable to do the same.

In his addendum report, Dr. Schmidt noted that Petitioner had been weight-bearing post-operatively in direct contradiction to Dr. Klein's recommendations. He also opined that Petitioner's non-compliance "would directly relate to her developing a non-union, especially what appears as an atrophic non-union as described in the further notes." He stated it was imperative that the ankle be non-stressed so that proper healing can take place. In his deposition, Dr. Schmidt confirmed his opinion that early weight-bearing and non-compliance would be a contributing factor to a non-union.

Notwithstanding, Dr. Schmidt admitted in his deposition that it was possible for a person to have a non-union even if they did not bear weight on a fusion. He also acknowledged that staying off a foot is very difficult for an ankle surgery patient to do, especially when that patient also has neuropathy. Dr. Schmidt also testified that he was not informed by Petitioner of her pre-accident treatment with Dr. Gunzel but testified that he likely treated Petitioner's right ankle arthritis. Ultimately, Dr. Schmidt maintained his causal connection opinion that the accident accelerated Petitioner's need for surgery, which remained unchanged.

E. Accident Investigation and Work Accommodations – Ms. Clark, Ms. McGreer, Mr. Green and Ms. Herzing

Petitioner testified that on August 9, 2012, she returned to the school so her co-employee Terri Clark could take several photographs of the stripping, which was loose where it met the tile. PX 16, Tr. 36. Petitioner testified the carpet was still in the same condition as it was at the time of accident. She stuck a ruler underneath the stripping to show how loose it was and explained that one could only see the raised area of carpet by bending down, not standing over it. She testified that the photos are not of good quality and make it seem as though the ruler is propped up. Petitioner stated that it only seems that the ruler is propped up due to the incline of the floor. She further testified that by the time the new school year started the stripping had been repaired.

Petitioner called Terri Clark as a witness. Ms. Clark is now retired, but previously served as Respondent's Committee Liaison. In 2012 she was the president of the Mt. Vernon Association of Classified Employees, the support staff union for the district.

Contemporaneous to the accident in question Ms. Clark heard about Petitioner's incident. In August 2012 Petitioner called her, and Ms. Clark suggested she take photos. Ms. Clark accompanied Petitioner to the school and took photos of the accident location. Ms. Clark testified that she could tell the carpet was loose where it joined the tile. The tack strip was not adhered to the carpet, which is why they were able to slide a ruler underneath it.

Respondent called Mary McGreer as a witness. Ms. McGreer is the Principal at Casey Middle School and was so employed on the dates in question. Ms. McGreer was notified of Petitioner's March 2012 accident by the school nurse. She did not see Petitioner that day.

Ms. McGreer testified that the hallway where Petitioner's trip and fall took place is open to the general school population, staff and faculty. Groups of 75 students would traverse the hallway, as well as classes of 6th, 7th and 8th grade students, between 12 and 18 students per

class. Visiting parents also had hallway access.

Ms. McGreer also completed an accident report on March 21, 2012 including a handwritten attachment from Petitioner describing the accident. Petitioner testified that the handwritten portion was drafted on the date of accident, so she would not forget any details, and she acknowledged that the report did not mention any defects on the floor, but she attributed this to drafting the note prior to going back and inspecting the floor later on the date of accident. Ms. McGreer testified that she examined the hallway and noted that the stripping was not loose. She stated that the hallway does have an incline, and after the incline the carpet continues for quite a while before the stripping and change to tile. Had there been any work repair orders between the accident date and March 21, 2012, Ms. McGreer would have signed it.

During the summer after the March 2012 accident, the school underwent some construction. Everything was pulled out of every classroom and placed in the hallway so that rooms could be cleaned including desks, chairs, and filing cabinets. In the process, she acknowledged that it is possible that damage could have been done to the hallway. Ms. McGreer was shown a photo of the hallway from May of 2012 and did not see any defect in the carpet. She testified that custodians maintain the hallway and, when a repair is necessary, she completes a work order and maintenance is called. Ms. McGreer testified that she is very paranoid about safety, so she inspects her school closely. However, she acknowledged that if there were small, inexpensive repairs necessary over the summer she would not be notified, and no work order would be necessary.

Ms. McGreer further testified that, as a first-year principal in 2012 and a self-proclaimed techie, she believed the school video system was grainy and antiquated. The system has since been updated, but at the time the server had a small memory, so recordings would only stay for 2-3 days. The cameras were motion-sensored, so the more traffic went through, the quicker the memory would get used up. Ms. McGreer did not view the video and stated that if the substitute secretary alluded to by Petitioner showed Petitioner the video of the fall, that would be against Ms. McGreer's instructions. She only wanted herself and her usual secretary looking at video.

Ms. McGreer was also apprised of the November 12, 2012 incident by her assistant principal, as Ms. McGreer was away at meetings on the alleged date. She was unaware of any requests for professional accommodations made by Petitioner.

Respondent also called Michael Green as a witness. Mr. Green served as Respondent's Superintendent from July 1, 2011 through June 30, 2015. Prior to that he served as the Casey Middle School principal from 2006 to 2011. He testified that Petitioner was a very good employee.

One or two days after the incident, Mr. Green visited the school and had the head of maintenance show him the incident location. Mr. Green examined the location and noted that it appeared normal to him. Upon viewing Ms. Clark's photo of the hallway, Mr. Green stated that it did not look anything like that when he inspected the location. Mr. Green testified that the hallway in question was open to students, staff and faculty, as well as parents and other individuals who were authorized admission into the school.

When Mr. Green returned to work after spring break in 2013 he spoke with Petitioner who informed him that she was going to retire. He testified that Petitioner did not mention her reasons, however. After retiring Petitioner never contacted Mr. Green about employment that could accommodate her restrictions. Mr. Green testified that it would be difficult for Respondent to accommodate a person with Petitioner's restrictions due to the steps in the schools.

When Petitioner determined that she was physically unable to work with her newly assigned student in January 2013, Mr. Green testified that she did not ask him to assign her a new student. Mr. Green stated that such a request would definitely have been looked into.

In contrast, Petitioner testified that she had two meetings with Mr. Green regarding child assignment (one prior to Christmas break and one after), and she was told that there were no alternative children available. Petitioner acknowledged being told that there could be an opportunity to aid a new child, but no timeline could be placed on it. She reiterated that she did inform Mr. Green that she did not want to retire, but that it was her last resort due to financial needs.

Respondent called Nancy Herzing as a witness. Ms. Herzing was employed by Respondent through May 2017 as its Director of Business and is now retired. She performed all initial paperwork for workers' compensation claims and received Petitioner's papers for two claims, as well as retirement papers at some point. It was her understanding that Petitioner's retirement was voluntary.

F. Vocational Rehabilitation

On September 24, 2014, Petitioner presented to Stephen Dolan for a vocational evaluation. Petitioner had a cane and stated that she used it outside of the house. During the assessment Mr. Dolan noted that, after one hour and fifteen minutes, Petitioner had to elevate her right leg to waist level on another chair where she kept it elevated for the remainder of the evaluation.

Vocational testing revealed Petitioner had good word recognition and sentence comprehension and could spell above the high school level. Her math was at a ninth-grade level and her reading and spelling were in line with her education. A depression screening indicated a moderate depression level. Mr. Dolan opined that Petitioner had no specific vocational skills for a sedentary job, or a sedentary job that would allow intermittent standing. Mr. Dolan also noted Dr. Krause's restrictions placed on Petitioner of working in a sitting capacity with intermittent standing. These restrictions in conjunction with Petitioner's age, academic skills, work history and treating records from Dr. Klein led Mr. Dolan to conclude that there was no reasonably stable labor market for Petitioner.

At his deposition on June 20, 2017, Mr. Dolan indicated he had been a vocational rehabilitation counselor since 1972. He testified that Petitioner informed him that if she did not elevate her leg during the evaluation, her ankle would turn red. Mr. Dolan found this to be credible. He testified that Petitioner indicated she could only stand for five minutes before experiencing increased pain, could only walk five to ten minutes, stooping increased her pain, and she could not crouch or kneel. Mr. Dolan testified that Petitioner informed him that she avoided stairs and was

otherwise dependent on handrails, and she had fallen four times since her ankle surgery.

Mr. Dolan also testified that Petitioner had rudimentary computer skills and knew how to use e-mail, the internet and had some word processing experience. She also had superior organizational skills, good interpersonal skills, and possessed the ability to take, give and implement instructions. Mr. Dolan testified that these skills would assist someone with experience gain employment. Petitioner did not, however, have any spreadsheet software or bookkeeping software experience. Based on his testing, Petitioner would have good skills to take courses at a community college. Mr. Dolan testified that Petitioner's vocational profile was of a 60-year-old woman approaching retirement age with community college education.

Given Petitioner's limitations and complaints, Mr. Dolan testified that an employer would be more likely to hire another candidate with more vocational skills. He acknowledged that he did not check any resources for job availability in Petitioner's area, stating that he was already familiar with said availability there. Mr. Dolan testified that if he called several employers and asked if they would be willing to hire someone who needs to elevate a foot at waist-high level for much of the day, he would already know the answer. Considering all of this, in conjunction with Petitioner's medical restrictions, Mr. Dolan testified that Petitioner was not employable in the open labor market.

On cross examination, Mr. Dolan acknowledged that having an associate degree or any higher-level education makes a person more marketable in the open labor market. He also acknowledged that Petitioner's complaints regarding her symptoms and restrictions were not reflected in Dr. Krause's June 30, 2014 IME report; thus Mr. Dolan's recitation of Petitioner's complaints were based on her subjective reports. Mr. Dolan acknowledged that there were available jobs within Petitioner's restrictions, but he doubted an employer would hire an unskilled or semi-skilled worker with said restrictions.

G. Current Condition

Regarding her current condition of ill-being, Petitioner testified that she has right ankle range of motion issues. She does not feel comfortable driving anymore, and also has pain and neuropathy in her feet, so she has stopped driving. Petitioner experiences pain daily, which worsens if she stands for too long, walks too much or moves her ankle back and forth. She also props her foot up whenever she is seated to relieve swelling. Petitioner uses a cane or walker when walking and loses her balance when lifting things, although she testified that her use of the walker is not related to her right ankle. Petitioner no longer goes grocery shopping and has limited her housekeeping. After her surgery, Petitioner was given Vicodin and then Ibuprofen until she began having kidney problems, so now she just deals with the pain.

Petitioner testified that that she suffered a temporary setback when she twisted her ankle in June of 2013 getting out of bed too quickly. Another incident saw Petitioner fall while in her kitchen, but there were no significant consequences to this fall. Petitioner testified that at no point after her ankle fusion did she attempt to return to work for Respondent, nor did she apply for any other employment. Petitioner testified that she did not believe she could work any job after her surgery. She explained that she had to prop her leg on a chair to reduce swelling most of the time

and did not believe any employer would approve that. Petitioner currently receives social security disability.

II. CONCLUSIONS OF LAW

A. Accident

The Arbitrator found that Petitioner sustained an accident that arose out of and in the course of employment. "To obtain compensation under the Act, a claimant bears the burden of showing, by a preponderance of the evidence, that he has suffered a disabling injury which arose out of and in the course of his employment." *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill. 2d 193, 203 (2003). An injury "arises out of" employment when "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." *Sisbro*, 207 Ill. 2d at 203.

The question of whether a claimant's injury arose out of his or her employment depends upon the type of risk to which he or she was exposed. *Baldwin v. Illinois Workers' Compensation Comm'n*, 409 Ill. App. 3d 472, 478 (2011). "There are three categories of risk to which an employee may be exposed: (1) risks that are distinctly associated with one's employment, (2) risks that are personal to the employee, such as idiopathic falls, and (3) neutral risks that have no particular employment or personal characteristics, such as those to which the general public is commonly exposed." *Dukich v. Illinois Workers' Comp. Comm'n*, 2017 IL App (2d) 160351WC, ¶ 31.

"By itself, the act of walking across a floor at the employer's place of business does not establish a risk greater than that faced by the general public." *First Cash Financial Services v. Industrial Comm'n*, 367 Ill. App. 3d 102, 105 (2006). "Accordingly, for an injury caused by a fall to arise out of the employment, a claimant must present evidence which supports a reasonable inference that the fall stemmed from a risk associated with her employment." *Id.* at 106. Employment-related risks associated with injuries sustained as a consequence of a fall are those to which the general public is not exposed, including the risk of tripping on a defect at the employer's premises, or performing some work-related task which contributes to the risk of falling. *Id.*

In this case, as the Arbitrator found, the hallway where the accident occurred was not open to the general public but was open to students, staff, faculty, parents and other authorized individuals. Based on this record, the Commission agrees with the Arbitrator that Petitioner's presence in Respondent's hallway was both incidental to her employment and in the course of her employment.

The Arbitrator also concluded it was unnecessary to consider whether the stripping was defective. The Commission agrees, to the extent that the "defect" nomenclature does not entirely address the issue. "The presence of a 'hazardous condition' on the employer's premises renders the risk of injury a risk incidental to employment; accordingly, a claimant who is injured by such a hazardous condition may recover benefits without having to prove that she was exposed to the risk of that hazard to a greater extent than are members of the general public." *Dukich*, 2017 IL App (2d) 160351WC, ¶ 40. Thus, for example, in *University of Illinois v. Industrial Comm'n*, 365

Ill. App. 3d 906, 911 (2006), the Commission found that the claimant tripped over a metal strip connecting the employer's parking structure to a walkway into the employer's outpatient care facility and that the height of the strip constituted a hazardous condition. The Illinois Appellate Court ruled that the Commission's finding was not against the manifest weight of the evidence. *Id.* at 912.

In this case, Petitioner testified that she tripped on the stripping meant to hold the carpet down and tumbled forward while hurrying back to her child's class. She also explained that one could only see the raised area of carpet by bending down, not standing over it. Petitioner also submitted an exhibit of photographs depicting the loose, raised stripping. Ms. Clark also testified that she could tell the carpet was loose where it joined the tile. Ms. McGreer testified that she examined the hallway and noted that the stripping was not loose, while Mr. Green testified that the accident location appeared normal to him days later. The record does not indicate that Ms. McGreer or Mr. Green examined the area by bending down as Petitioner did. As the Arbitrator found, all witnesses agreed the stripping was higher than the carpet and tile.

Given the record as a whole, the Commission finds that Petitioner was engaged in a work-related task at the time of her fall and the hazardous condition of the stripping contributed to or caused Petitioner's fall. Accordingly, the Commission concludes that Petitioner's accident and injury arose out of and in the course of her employment.

B. Causal Connection/Section 19(d) of the Act

The Arbitrator found the opinions of Respondent's Section 12 examiner, Dr. Schmidt, to be more persuasive than those of Petitioner's independent medical examiner, Dr. Krause. In so concluding, the Arbitrator noted that Dr. Krause was unable to state whether Petitioner's accident aggravated or accelerated Petitioner's need for surgery. He further noted that Dr. Krause did not, like Dr. Schmidt, distinguish the localization of Petitioner's medical treatment prior to her accident and after her accident. The Arbitrator, thus, found the opinions of Dr. Schmidt to be more compelling and credible than those of Dr. Krause finding a causal connection. The Commission agrees with the Arbitrator that Petitioner established a causal connection and finds ample evidence in the record, including the opinions of Dr. Schmidt, supporting a causal connection between Petitioner's post-accident condition of ill-being and her accident on March 13, 2012.

However, the Arbitrator also found that causal connection was severed pursuant to section 19(d) of the Act. In so concluding, the Arbitrator noted that the Act does not require that an injurious practice be the sole cause of a claimant's condition of ill-being for the Commission to reduce or deny compensation. He noted that several physicians indicated that Petitioner's ongoing pain and permanent restrictions were related to the non-union that developed after her ankle fusion surgery. The Arbitrator found that Petitioner's post-surgical non-compliance with Dr. Klein's recommendations rose to the level of an injurious practice and contributed to the non-union. Pursuant to section 19(d) of the Act, all benefits were denied including treatment, TTD and maintenance subsequent to April 16, 2013.

Section 19(d) of the Act reads:

> If any employee shall persist in insanitary or injurious practices which tend to either imperil or retard his recovery or shall refuse to submit to such medical, surgical, or hospital treatment as is reasonably essential to promote his recovery, the Commission may, in its discretion, reduce or suspend the compensation of any such injured employee. 820 ILCS 305/19(d).

The Commission disagrees with the Arbitrator that Petitioner engaged in an injurious practice that should terminate her entitlement to benefits. There is no evidence in this record that Petitioner deliberately attempted to impede her recovery in any of her actions post-operatively. The cases in which section 19(d) of the Act has been invoked distinguish the intent of the conduct to determine if it is obstructing recovery. See e.g., *Global Prods. v. Illinois Workers' Comp. Comm'n*, 392 Ill. App. 3d 408, 412-13 (2009) (finding no evidence that the claimant smoked cigarettes for the purpose of retarding his recovery and, specifically, that he smoked "in spite of its potential impact on his recovery, not because of it."). The acts involved must rise above mere negligence. Larson's Workers' Compensation Treatise provides additional insight stating: "The degree of claimant misconduct required to break the chain of causation should therefore be not mere negligence, but intentional conduct that is clearly unreasonable. *Larson's Workers' Compensation-Desk Edition*, Section 10.10[1] at 10-34 (2018).

The record reflects that Dr. Klein was pre-operatively concerned with Petitioner's ability to comply with weight-bearing restrictions for optimal recovery. Petitioner was admittedly warned about the risks that might cause a non-union. Drs. Klein, Krause and Schmidt all stated that non-weight bearing was critical to recovery, and that the risk of non-union increases with premature weight-bearing. The physicians further agreed that weight-bearing and smoking were the two main factors causing a non-union of an ankle fusion. Petitioner was not a smoker, so the remaining issue rested with whether she bore weight on her foot too early in her recovery process. Petitioner maintained to both Dr. Klein and at the hearing that she would only put her foot down to balance when her cast got too heavy, which Dr. Klein characterized as weight bearing in her records.

It is reasonable that Petitioner, in particular, would have difficulty fully complying with her treating physician's instructions not to bear any weight for a time. She had been counseled by Dr. Klein pre-operatively to practice non-weight bearing to increase the likelihood of a successful surgical outcome. Dr. Schmidt also understood that it would be difficult for a neuropathic patient to fully comply with complete non-weight bearing restrictions throughout recovery. Indeed, he specified that it was harder for a neuropathic patient to do so because it doesn't hurt as much. Moreover, while the Arbitrator found that it was no coincidence that Petitioner's fusion did not take, with ample evidence in the medical records of non-compliance, no attention was paid to normal post-operative issues including an ill-fitting boot which may have contributed to Petitioner's discomfort, weight bearing, and need for emergency room care. The June 13, 2013 note from Dr. Klein, before Petitioner presented to the emergency room, reflects that Petitioner's "previous cast became somewhat loose because of calf atrophy[, which Dr. Klein believed] may be why the ankle has been so sore."

The evidence simply does not establish that Petitioner intentionally bore weight to impede her recovery, much less to do harm to herself, such that her conduct rises to the level of an injurious

practice requiring a termination of benefits. Accordingly, the Commission reverses the Arbitrator's ruling on this issue.

The Commission further finds that Petitioner's conduct does not rise to the level of an intervening cause severing Respondent's liability. The inquiry here is whether the evidence establishes that Petitioner's condition of ill-being was related, in whole or in part, to her accident. See *Dunteman v. Illinois Workers' Comp. Comm'n*, 2016 IL App (4th) 150543WC, ¶ 44 ("As long as there is a 'but-for' relationship between the work-related injury and subsequent condition of ill-being, the employer remains liable." [citation omitted]). Moreover, "an employer takes his employees as he finds them." *Global Prods.*, 392 Ill. App. 3d at 412 (quoting *Bocian v. Industrial Comm'n*, 282 Ill. App. 3d 519, 528 (1996)).

In this case, Petitioner suffered from neuropathy and degenerative conditions in the right ankle that pre-dated her accident but did not prevent her from working. The ankle fusion recommendation came only after her March 13, 2012 accident following unsuccessful treatment modalities. Petitioner eventually underwent an ankle fusion with Dr. Klein, which Respondent's examiner, Dr. Schmidt, repeatedly found necessary and related to her accident. Even if Petitioner developed a non-union, in part, as a result of premature post-operative weight bearing, her need for medical treatment including the ankle fusion would not have occurred "but for" her March 13, 2012 accident at work. See *Dunteman*, 2016 IL App (4th) 150543WC, ¶ 45. More specifically, "but for" the occupational injury there would have been no need for an ankle fusion and post-operative care of Petitioner's further debilitated right ankle. See *Id.* Thus, the Commission finds that Petitioner's employment remains a cause of her current condition of ill-being and that any premature post-operative weight bearing does not sever causal connection.

C. Medical Expenses

The Arbitrator awarded medical expenses, but only through April 16, 2013, based on his Section 19(d) analysis. In keeping with the ruling on causal connection, the Commission also modifies the Arbitrator's medical expenses award, which terminated Respondent's liability on April 16, 2013. Since the Commission has found causal connection and reversed the Arbitrator's section 19(d) ruling, it also awards all claimed reasonable and necessary medical expenses to Petitioner, pursuant to sections 8(a) and 8.2 of the Act.

D. Temporary Total Disability

The Arbitrator awarded TTD benefits from April 5, 2013 through April 16, 2013. Benefits were denied from January 11, 2013 through April 4, 2013, and from April 17, 2013 through April 4, 2014.

Regarding the period of January 11, 2013 through April 4, 2013, the Arbitrator reasoned that Petitioner voluntarily abandoned a job that was assigned to her within her restrictions. The Arbitrator noted that Petitioner was restricted to sit-down work only through December 1, 2012. Subsequently she was unrestricted until January 18, 2013, when Dr. Freehill recommended she do "absolutely no twisting, squatting, kneeling, standing, long periods of walking." However, beginning one week prior to that, the Arbitrator noted that Petitioner voluntarily removed herself

from the workforce, indicating that she was unable to physically care for the new student to whom she had been assigned after Christmas break. Respondent argues that Petitioner's voluntary removal from the workforce, coupled with Mr. Green's testimony that Respondent would have tried to accommodate any restrictions Petitioner brought to them (which he asserted Petitioner did not), thereby precludes Petitioner from receiving TTD benefits.

A claimant's stabilization is the determinative inquiry for deciding entitlement to TTD benefits. *Interstate Scaffolding, Inc. v. Illinois Workers' Comp. Comm'n*, 236 Ill. 2d 132, 149 (2010). However, the supreme court recognizes three exceptions allowing termination or suspension of TTD benefits. *Sharwarko v. Illinois Workers' Compensation Comm'n*, 2015 IL App (1st) 131733WC, ¶ 47 (citing *Interstate Scaffolding, Inc.*, 236 Ill. 2d at 146-47). The relevant exception to the case at bar is the third, which states TTD benefits may be suspended or terminated if the employee refuses work falling within the physical prescriptions prescribed by his doctor. See *Sharwarko*, 2015 IL App (1st) 131733WC, ¶ 47. Respondent argues that when Petitioner left her job in January of 2013 she triggered this third exception.

The Commission finds that the facts in *Sharwarko* are distinguishable from the case at bar. In *Sharwarko*, the employer was capable of accommodating the claimant's restrictions. *Id.* ¶ 48. In the case at bar, Petitioner wanted to work past January 10, 2013, but was physically unable to perform the job offered by Respondent. A review of Dr. Freehill's restrictions clearly suggests Petitioner was unable to work with a 5 or 6-year-old wheelchair bound child who required frequent lifting. The Commission notes the difficulty in attempting to lift a 5-year-old child alone without twisting and squatting. The Commission also notes that on February 8, 2013 Dr. Schmidt placed Petitioner on restrictions of no standing or walking greater than 2 hours without 15 minutes off her feet. While these restrictions may seem less cumbersome than Dr. Freehill's, it does not circumvent the fact that Respondent had no available work for Petitioner. Mr. Green testified that it would be difficult for Respondent to accommodate a person with Petitioner's restrictions due to the steps in the schools. A March 15, 2013 e-mail from Respondent's Assistant Superintendent indicated Petitioner's desire to return to work when capable. This taken in conjunction with Mr. Green's testimony regarding Petitioner's lack of employability corroborates Petitioner's testimony that her retirement arose out of financial necessity rather than a voluntary removal. Accordingly, the Commission finds that Petitioner does not fall into any of the exceptions to *Interstate Scaffolding*, and since her condition had not stabilized during this period she remained entitled to TTD benefits.

The Arbitrator denied TTD benefits from April 17, 2013 through April 4, 2014 based on his section 19(d) analysis. In keeping with its causal connection finding and reversal of the section 19(d) ruling, the Commission modifies the TTD award and awards benefits for this period as well. Petitioner did not reach maximum medical improvement post-operatively and was not offered work within her restrictions by Respondent. Respondent argues that, even if Petitioner was entitled to TTD benefits while off work, she failed to meet her burden to prove the period in which she could not work as she provided no off work slips from providers. However, determining the TTD period is a question of fact for the Commission and its decision should not be disturbed unless it is against the manifest weight of the evidence. *Ming Auto Body/Ming of Decatur, Inc. v. Industrial Comm'n*, 387 Ill. App. 3d 244, 256 (2008).

The Commission finds no evidence in Petitioner's treatment records that Petitioner's condition between April 17, 2013 and April 4, 2014 would have allowed her to work for Respondent. The Commission also notes the June 30, 2014 report or Dr. Krause supporting the proposition that Petitioner could not perform her duties for Respondent. Accordingly, the Commission finds that Petitioner is entitled to additional TTD benefits as claimed for the period of April 17, 2013 through April 4, 2014.

E. Permanent Disability

Despite Petitioner's argument for odd-lot permanent and total disability benefits, the Arbitrator found that Petitioner suffered a 25% loss of use of her right ankle. The Arbitrator agreed with Respondent finding that Petitioner did not meet her burden of proof for odd-lot permanent and total disablement. In so doing, the Arbitrator noted that Petitioner did not perform any job searches, nor did she look for employment after surgery. The Commission views the evidence differently and finds that Petitioner has established her entitlement to permanent and total disability benefits under an odd-lot theory.

An employee is totally and permanently disabled when she is unable to make some contribution to industry sufficient to justify the payment of wages. *A.M.T.C. of Illinois v. Industrial Comm'n*, 77 Ill. 2d 482, 487 (1979). If a claimant's disability is of such a nature that she is not obviously unemployable, or there is no medical evidence to support a claim of total disability, the burden is upon the claimant to prove that she fits into an "odd lot" category; that being an individual who, although not altogether incapacitated, is so handicapped that she is not regularly employable in any well-known branch of the labor market. *Valley Mold & Iron Co. v. Industrial Comm'n.*, 84 Ill. 2d 538, 546-47 (1981).

A claimant seeking "odd lot" status must establish it by a preponderance of the evidence. *City of Chicago v. Illinois Workers' Compensation Comm'n*, 373 Ill. App. 3d 1080, 1091 (2007). A claimant can satisfy the burden of proving she falls into the odd-lot category in one of two ways; (1) by showing diligent but unsuccessful attempts to find work, or (2) by showing that because of her age, skills, training, and work history, she will not be regularly employed in a well-known branch of the labor market. *Alano v. Industrial Comm'n*, 282 Ill. App. 3d 531, 534 (1996); *Westin Hotel v. Industrial Comm'n*, 372 Ill. App. 3d 527, 544 (2007). Once a claimant meets her burden of proving she falls into the "odd-lot" category, the burden then shifts to the employer to prove the claimant is employable in a stable labor market and that such market exists. *Waldorf Corp. v. Industrial Comm'n*, 303 Ill. App. 3d 477, 484 (1999); *Westin Hotel*, 372 Ill. App. 3d at 544.

Under this analysis, Petitioner is eligible for PTD benefits. Petitioner was 57 years old at the time of her accident and is currently over the age of 65. She had an associate degree obtained in the 1970's and a remote work history performing duties other than those performed for Respondent in recent decades. Respondent submitted into evidence a labor market survey prepared by an individual who had never met Petitioner nor reviewed her medical records outside of the June 30, 2014 report of Dr. Krause. The survey revealed nine (9) jobs within a 50-mile radius fitting within restrictions identified by Dr. Krause. Some required the ability to type 30-40 wpm, word processing experience, excel experience, collection experience, data entry and audit experience. Petitioner did not possess most of these skills.

Contrary to the conclusions in Respondent's labor market survey, Petitioner's vocational rehabilitation counselor, Mr. Dolan, opined that Petitioner was unemployable. He admitted that he did not perform his own labor market survey, but he testified that he did not need to do so because of his familiarity with the jobs in the area and his knowledge of Petitioner's medical condition/vocational profile. He further testified regarding the positions identified in Respondent's labor market survey and explained that Petitioner would require better skills to perform sedentary office work. Petitioner's computer skills were basic, she was not a good typist, and she had never prepared reports, used a spreadsheet, or used bookkeeping software.

Petitioner did have personal care skills that Mr. Dolan indicated were transferable, but he explained that the jobs looking for these skills (home attendant, certified nursing, etc.) were ones that she could not physically perform. Mr. Dolan also noted that Petitioner would be competing with younger applicants with more recent training, without physical restrictions, making her a less desirable candidate. Additionally, Petitioner experienced daily ankle pain and difficulty with range of motion. She had difficulty driving and climbing stairs, and she could not walk for extended periods. Petitioner also experienced swelling on a daily basis that frequently required her to sit with her foot elevated. Indeed, Mr. Dolan noted that Petitioner had to elevate her foot during his meeting with her, which he found to be credible.

Ultimately, Mr. Dolan opined that there was no reasonably stable labor market for Petitioner. He explained that she would be competing with younger applicants with more recent training and who do not have restrictions. Given Petitioner's age, skills, training, and work history, the Commission finds, as Mr. Dolan opined, that Petitioner will not be regularly employable in a well-known branch of the labor market and that no stable labor market exists for Petitioner.

Respondent also asserts that Petitioner never contacted Respondent for placement any time after surgery. Respondent relies on *Sharwarko* for the proposition that employers should not be liable for benefits if accommodations could have been made but for the employee voluntarily removing himself from employment. *Sharwarko v. Illinois Workers' Comp. Comm'n*, 2015 IL App (1st) 131733WC, ¶ 49 (2015). The Commission is not persuaded by Respondent's assertion, or its claim that it would be able to accommodate Petitioner's restrictions. Respondent's witness, Mr. Green, admitted that it would be difficult to accommodate Petitioner.

Based on the totality of evidence, the Commission finds the opinions of Mr. Dolan to be persuasive. The Commission thus finds that Petitioner is permanently and totally disabled under an odd-lot theory pursuant to section 8(f) of the Act.

All else is affirmed.

IT IS THEREFORE FOUND BY THE COMMISSION that Petitioner proved she sustained an accident arising out of and in the course of his employment with Respondent on March 13, 2012.

IT IS FURTHER FOUND BY THE COMMISSION that Petitioner has met her burden of proof in relation to causal connection to her work accident suffered on March 13, 2012. Moreover,

the Commission finds that Petitioner did not engage in any injurious practices pursuant to section 19(d) of the Act which would limit the duration of the causal connection period.

IT IS ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $345.33 per week from January 11, 2013 through April 4, 2013, and from April 17, 2013 through April 4, 2014, in addition to the period already awarded by the Arbitrator from April 5, 2013 through April 16, 2013. These being the periods of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner all reasonable and necessary medical expenses claimed by Petitioner in relation to her right ankle condition pursuant to sections 8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $483.36 (minimum rate) per week for life, beginning April 5, 2014 as provided in section 8(f) of the Act, for the reason that the injuries sustained caused Petitioner to be permanently and totally disabled.

IT IS FURTHER ORDERED BY THE COMMISSION commencing on the second July 15th after the entry of this award, the Petitioner may become eligible for cost-of-living adjustments, paid by the ***Rate Adjustment Fund,*** as provided in Section 8(g) of the Act.

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

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

No county, city, town, township, incorporated village, school district, body politic or municipal corporation is required to file a bond to secure the payment of the award and the costs of the proceedings in the court to authorize the court to issue such summons. 820 ILCS 305/19(f)(2). Based upon the named Respondent herein, no bond is set by the Commission. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JAN 2 1 2020
o:11/7/19
BNF/wde
45

Barbara N. Flores

Marc Parker

DISSENT

I respectfully dissent from the decision of the majority. The majority modified the Decision of the Arbitrator to award all medical bills incurred, to increase TTD from 1&5/7 weeks to 64&2/7 weeks, and to increase the PPD award from 25% loss of use of the right "ankle" [foot] to declare Petitioner permanently and totally disabled as of April 5, 2014. I would have affirmed the Decision of the Arbitrator in which he found that Petitioner's proved compensable accident caused the condition of ill-being of her right ankle, that such causation ceased after April 16, 2016, awarded TTD and medical expenses to that date, and awarded 41.75 weeks of PPD representing loss of the use of 25% of the right foot. The Arbitrator held that causation ceased on April 16, 2016 pursuant to Section 19(d) of the Act because he found Petitioner engaged in injurious practices.

Petitioner sustained a fall at work on March 13, 2012. The Arbitrator found that the accident was compensable, that it aggravated Petitioner's underlying pre-existing arthritis, and caused the need for ankle fusion surgery. The surgery was performed on April 5, 2013. Prior to surgery, her surgeon, Dr. Klein, counseled Petitioner on the need to be completely non-weight bearing after the surgery. She even indicated that she would not proceed with the surgery if Petitioner would not comply with that directive. In the initial post-surgical visit, Dr. Klein noted that it appeared to her that Petitioner was not completely complying with her non-weight bearing direction. Dr. Klein considered that to be of sufficient importance to again admonish Petitioner about the necessity of avoiding all weight bearing. She advised Petitioner that bearing weight could lead to non-fusion and chronic pain. Dr. Klein continued such admonishments in later visits. While Petitioner denied that she bore weight to Dr. Klein at the time of her visit, she acknowledged in her testimony that she was repeatedly admonished to avoid all weight bearing and that she occasionally put weight on her right foot when it became tired from the weight of the cast or to balance herself. Respondent's Section 12 medical examiners, Dr. Krause and Dr. Schmidt, concurred with Dr. Klein that avoiding weight bearing is absolutely essential to recovery from ankle-fusion surgery.

On June 13, 2013, Petitioner was put in a walking boot. She was advised that she could bear some weight on the right foot while wearing the boot. Seven days later, Petitioner presented to the emergency department at Good Samaritan Hospital reporting that she had twisted her right ankle. Dr. Krause specifically testified that it would be impossible for Petitioner to have twisted her ankle if she were wearing the boot. Thereafter, Petitioner's fusion failed resulting to a non-fusion. The non-fusion resulted in a significantly increased period of time she was off work and significantly increased permanent partial disability. As correctly noted by the Arbitrator, Section 19(d) does not mandate that the injurious practice be the sole cause of a claimant's condition of ill-being to deny benefits.

For the reasons stated above, I would have affirmed the Decision of the Arbitrator in which he found Petitioner's failure to comply with treatment directives from her treating surgeon aggravated her work-related condition of ill-being and resulted in cessation of causation. Therefore, I respectfully dissent from the decision of the majority.

Deborah L. Simpson

DLS/dw
O-11/7/19

Deborah L. Simpson

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Belen Trujillo,

Petitioner,

vs.

NO: 13 WC 8312

20IWCC0038

Labor Network, Inc., Loaning Employer and Cloverhill Bakery, Inc., Borrowing Employer,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 2, 2018, 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

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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: JAN 2 1 2020
TJT:yl
o 11/19/19
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Thomas J. Tyrrell

Maria E. Portela

DISSENT

I disagree with the majority's award of penalties and attorney's fees.

The Arbitrator awarded Section 19(l) penalties for the 212 days between Petitioner's counsel's demand for payment of medical bills, on July 18, 2017, and the hearing date of February 14, 2018. The Arbitrator awarded Section 19(k) penalties for 50% of the awarded TTD benefits, awarded from March 7, 2013, through June 26, 2013, and Section 16 attorney's fees for said period, additional Section 19(k) penalties for 50% of the awarded MRI-related fee schedule expense, and additional Section 16 attorney's fees for non-payment of said medical expense.

The relevant provisions of the Workmen's Compensation Act, pursuant to which the penalties were imposed, are:

Attorneys' Fees under Section 16

> Whenever 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 the provisions of paragraph (c) of Section 4 of this Act; or has been guilty of unreasonable or vexatious delay, intentional underpayment of

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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 insurance carrier. *820 ILCS 305/16(2013).*

Penalties under Section 19(k)

In case where there has been any unreasonable or vexatious delay of payment 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. Failure to pay compensation in accordance with the provisions of Section 8, paragraph (b) of this Act, shall be considered unreasonable delay." *820 ILCS 305/19(k)(2013).*

Penalties under Section 19(*l*)

If the employee has made written demand for payment of benefits under Section 8(a) or Section 8(b), the employer shall have 14 days after receipt of the demand to set forth in writing the reason for the delay. In the case of demand for payment of medical benefits under Section 8(a), the time for the employer to respond shall not commence until the expiration of the allotted 30 days specified under Section 8.2(d). In case the employer or his or her insurance carrier shall without good and just cause fail, neglect, refuse, or unreasonably delay the payment of benefits under Section 8(a) or Section 8(b), the Arbitrator or the Commission shall allow to the employee additional compensation in the sum of $30 per day for each day that the benefits under Section 8(a) or Section 8(b) have been so withheld or refused, not to exceed $10,000. A delay in payment of 14 days or more shall create a rebuttable presumption of unreasonable delay. *820 ILCS 305/19(l)(2013).*

As the Illinois Supreme Court stated:

Although the statutory language is not uniform, it is apparent that the legislative intent is to implement the Act's purpose, *i.e.* to expedite the compensation of industrially injured workers and penalize an employer who unreasonably, or in bad faith, delays or withholds compensation due an employee. Similar provisions exist in other jurisdictions. (See 3 A. Larson, Workmen's Compensation sec. 83.40 (1980).) Penalties for delayed payment are not intended to inhibit contests of liability or appeals by employers who honestly believe an employee not entitled to compensation; they are intended to promote the prompt payment of compensation

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where due and to deter those occasional employers or insurance carriers who might withhold payment from other than legitimate motives.

The prevailing rule is stated in 3 A. Larson, Workmen's Compensation sec. 83.40, at 15 -- 632 (1980):

"[G]enerally a failure to pay because of a good faith belief that no payment is due will not warrant a penalty."

As long as the insurer "had a legitimate doubt, from a legal standpoint, of its liability, its conduct [refusing payment] was not unreasonable." *Bourgeois v. Brown & Root, Inc.* (La. App. 1974), 303 So. 2d 217; see also *Mayes v. Genesco, Inc.* (Tenn. 1974), 510 S.W.2d 882; *Showalter v. Campbell Soup Co.* (Minn. 1977), 253 N.W.2d 154.

Avon Prods. v. Indus. Comm'n, 82 Ill. 2d 297, 412 N.E.2d 468 (1980).

In *Jacobo v. Ill. Workers" Comp. Comm'n*, the Court reviewed Illinois precedent for assessing penalties and attorneys' fees, finding penalties under Section 19(k) and attorneys' fees under Section 16 to be reserved for situations where the delay is premised on bad faith. Penalties under Section 19(l) are given heightened scrutiny and considered mandatory if the employer does not meet its burden of proving a justifiable delay. The *Jacobo* Court explained:

Penalties under Section 19(*l*) are in the nature of a late fee. *Mechanical Devices v. Industrial Comm'n*, 344 Ill. App. 3d 752, 763, 800 N.E.2d 819, 828 (2003). In addition, the assessment of a penalty under Section 19(*l*) is mandatory "[i]f the payment is late, for whatever reason, and the employer or its carrier cannot show an adequate justification for the delay." *McMahan v. Industrial Comm'n*, 183 Ill. 2d 499, 515, 702 N.E.2d 545, 552 (1998). The standard for determining whether an employer has good and just cause for a delay in payment is defined in terms of reasonableness. *Mechanical Devices*, 344 Ill. App. 3d at 763, 800 N.E.2d at 829. The employer has the burden of justifying the delay, and the employer's justification for the delay is sufficient only if a reasonable person in the employer's position would have believed that the delay was justified. *Board of Education of the City of Chicago v. Industrial Comm'n*, 93 Ill. 2d 1, 9-10, 442 N.E.2d 861, 865, 66 Ill. Dec. 300 (1982).

An award of penalties and attorney fees pursuant to Sections 19(k) and 16 are "intended to promote the prompt payment of compensation where due and to deter those occasional employers or insurance carriers who might withhold payment from other than legitimate motives." *McMahan v. Industrial Comm'n*, 289 Ill. App.

3d 1090, 1093, 683 N.E.2d 460, 463 (1997), *aff'd*, 183 Ill. 2d 499, 702 N.E.2d 545 (1998).

The standard for awarding penalties and attorney fees under Sections 19(k) and 16 of the Act is higher than the standard for awarding penalties under Section 19(*l*) because Sections 19(k) and 16 require more than an "unreasonable delay" in payment of an award. *McMahan v. Industrial Comm'n*, 183 Ill. 2d 499, 514-15, 702 N.E.2d 545, 552 (1998). It is not enough for the claimant to show that the employer simply failed, neglected, or refused to make payment or unreasonably delayed payment without good and just cause. *McMahan*, 183 Ill. 2d at 515, 702 N.E.2d at 552. Instead, Section 19(k) penalties and Section 16 fees are "intended to address situations where there is not only a delay, but the delay is deliberate or the result of bad faith or improper purpose." *McMahan*, 183 Ill. 2d at 515, 702 N.E.2d at 553. In addition, while Section 19(*l*) penalties are mandatory, the imposition of penalties and attorney fees under Sections 19(k) and Section 16 fees is discretionary. *Id.*

Jacobo v. Ill. Workers' Comp. Comm'n, 2011 IL App (3d) 100807WC, 959 N.E.2d 772, 777-778.

In the instant case, Petitioner complained solely of left-hand pain at her initial treatment at Clearing Clinic after the first accident. In subsequent visits, several different providers noted that Petitioner's symptoms were out of proportion to their objective findings. By the time of Petitioner's last visit with Dr. O'Keefe and after a myriad of diagnostics, it is apparent that the initial medical observations were credible. Based upon the unreliability of Petitioner's testimony, pain complaints, and inconsistencies in the record, I find that Respondent's non-payment of temporary total disability and medical bills was based on a good faith defense including Dr. Bare's June 23, 2013, and May 18, 2016, Section 12 opinion reports, Utilization Reviews, and responses to the Petitioner's Petitions for Immediate Hearing and Penalties and Fees. I do not find penalties under Section 19(l) or Section 19(k) or attorney's fees under Section 16 were warranted for the reasons explained below.

Section 19(k) penalties were awarded for 50% of the awarded TTD benefits for the period March 7, 2013, the Petitioner's second accident date, through June 26, 2013, the date of Dr. Bare's first Section 12 evaluation and contemporaneous report. In addition, Section 16 attorney's fees were awarded for said period. By this finding, the Arbitrator, and the majority, contend that the Respondent's delay of payment of these benefits was "deliberate or the result of bad faith or improper purpose." *McMahan*, 183 Ill. 2d at 515. To the contrary, I find that the Respondent's non-payment of TTD benefits is based on a good faith defense that was due, in part, to misrepresentations Petitioner made to her treating doctor that conflated the first and second accidents.

Petitioner testified she sustained a work injury at 8:00 p.m. on December 29, 2012, when she grabbed a box to put on the assembly line and she felt pain in her left hand. (T. pp. 26, 27)

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Petitioner testified she reported the accident as soon as it happened because she was not able to continue working. Under cross-examination, she conceded that she completed her shift after the accident and worked the next day before she sought any medical treatment on December 31, 2012, with Dr. Sorokin at MacNeal Occupation Health. (T. pp. 27-30, 58)

On December 31, 2012, Petitioner reported to Dr. Sorokin at Clearing Clinic that "while packing, I felt pain in my left hand, the line was too fast." Dr. Sorokin noted the absence of bruising and clicking on wrist motion. He diagnosed a wrist sprain. (PX1) She never reported left arm, left shoulder or neck pain on that date. On January 3, 2013, Dr. Sorokin noted that Petitioner's symptoms appeared out of proportion to and inconsistent with the findings. Nonetheless, he released Petitioner to work with a 5 pound lifting restriction. (PX1) Respondent maintains they accommodated and could continue to accommodate her restrictions.

On January 9, 2013, Petitioner saw Dr. Carani at Clearing Clinic. Petitioner complained of pain all over her arm but she had no pain in her hand. On exam, she had no pain over her elbow on wrist flexion/extension against resistance and, notably, had no pain in her wrist at all. Her effort was noted to be poor and again her symptoms out of proportion to the findings and were noted to be inconsistent. Petitioner asked to be taken off work. She was given a 10 pound lifting restriction, analgesic balm and advised to continue Meloxicam.

On January 25, 2013, Petitioner still reported symptomatic diffuse left arm pain from the elbow down and she also reported left cervical pain. She was referred to Midwest Hand Surgery. Petitioner underwent a cervical spine x-ray at MacNeal Hospital on January 25, 2013, which was negative and showed no evidence of degenerative joint disease. (PX1)

At physical therapy on February 7, 2013, Petitioner complained of pain, numbness and tingling in her entire left arm. Petitioner saw Dr. Shah of Midwest Hand Surgery on February 8, 2013, and told him the accident occurred "while she was moving approximately a ten pound box from the conveyor belt, she felt that her wrist had bent and then she immediately noticed the symptoms." (PX2) Dr. Shah opined that her pain was likely related to flexor carp radialis (FCR) tendinitis. On exam, Petitioner exhibited no wrist instability and she reported that her elbow and neck pain improved with therapy. His office note reflects that she had a self-limiting condition that improves with splinting and anti-inflammatory medication. (PX2)

Petitioner continued to treat at MacNeal Occupational Health until February 28, 2013, and never complained of left shoulder pain. (PX1)

The Petitioner next opted to treat with Dr. John O'Keefe of Central Medical Specialist on March 7, 2013. Petitioner told Dr. O'Keefe that her injury on December 29, 2012 occurred seven hours into her shift, approximately 12:00 a.m., when she was lifting a large container weighing 20-30 pounds, filled with bread loaves, at a very fast pace (120 boxes/hour) when she felt a pop and had intense pain in her nondominant wrist.

Petitioner testified at trial she sought treatment from Dr. O'Keefe because her health had gotten worse. (T, p. 34) At the March 7, 2013, office visit Dr. O'Keefe noted that Petitioner had restrictions from the December 29, 2012, accident and her employer had her cleaning a production machine. He noted that this light duty task caused her to have intense pain in the neck, shoulder and arm. (PX3A)

Dr. O'Keefe's notes also indicate she was referred by a relative for "severe overuse symptoms" yet, according to the same office note, she was working light-duty. Petitioner testified that she decided to treat with Dr. O'Keefe because she received a pamphlet at her home; she denied that she had any relatives that treated with Dr. O'Keefe. Petitioner testified Dr. O'Keefe's records would be wrong if he stated that she was referred by a relative. (T. pp. 34, 67-68)

Petitioner testified that she was lifting repetitively after the first accident, again, contrary to what she told Dr. O'Keefe. Petitioner testified she was lifting 300 boxes per hour at her job at the time of the second accident. (T. p. 70) Petitioner further testified she was not working light duty after December 29, 2012, she was lifting the same amounts. (T. p. 72) Petitioner testified that even if Dr. O'Keefe's record reflected that she told him she was lifting lighter material, that was wrong. If Dr. O'Keefe's record indicated that her job consisted of cleaning a machine, she would not agree that was correct. She was on a packing line. (T. p. 74)

Dr. O'Keefe testified on November 17, 2016, by way of evidence deposition. (PX22) He testified that Petitioner reported she often worked 60-hour weeks, 12-hour shifts. (PX22, p. 7) The Arbitrator noted that the Petitioner's wage records did not support her testimony or this history. Petitioner reported she was working for Respondent for one year, also unsupported. Thus, the foundation of Dr. O'Keefe's understanding of the Petitioner's job is unsubstantiated.

In each of his next office visits on March 13, 2013, April 16, 2013 and on May 16, 2013, Dr. O'Keefe refers all of Petitioner's conditions to the accident on December 29, 2012, an accident that was reported to Respondent as an injury solely to her left wrist.

Dr. O'Keefe kept Petitioner off work but related her off-work status to the first accident, which was the injury reported to the left wrist. He then ordered a cervical spine MRI that was done at Advantage MRI on March 16, 2013, only days after Petitioner reported a second accident. The radiologist's impression was "cervical neural foramina and spinal canal are patent." (PX4) On April 16, 2013, Dr. O'Keefe's notes confirm the MRI of the cervical spine was ordered on March 16, 2013, and was negative for any abnormalities.

At the April visit, Dr. O'Keefe ordered an MRI of the left shoulder which revealed tendinopathy/mild partial tearing of the distal supraspinatus tendon, no full-thickness rotator cuff tear and mild subacromial bursal fluid collection suggestive of bursitis. (PX4) Three views of the left navicular performed on May 16, 2013, showed an intact wrist without fracture or subluxation. (PX3)

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When Petitioner saw Dr. Bare for the first Section 12 evaluation on June 26, 2013, he documented that Petitioner reported two separate injuries. The first was reportedly sustained on December 29, 2012, when she was packing bread when she felt a "sharp pain" to her wrist. Dr. Bare's report states that she subsequently developed neck pain and shoulder pain. Then, on March 7, 2013, she reported an injury again where repetitive reaching and lifting caused pain in the arm. Dr. Bare opined it was apparent on clinical examination that her shoulder was not the source of pain. He opined that it could be her neck or wrist noting that the original diagnosis was a wrist sprain. He recommended the EMG/NCV to rule out nerve impingement or neuropathology. He opined that she did not need any other diagnostic tests except an EMG/NCS. Further, Petitioner did not require any temporary or permanent restrictions. (RX2, p. 3) He imposed a 10 pound lifting restriction due to her wrist splint.

When Dr. Bare testified, he described Petitioner's diagnosis as "vague" when he examined her on June 26, 2013. He testified that Petitioner complained of a lot of pain, but he did not note any objective findings other than a complaint of tenderness to palpation. (RX. pp. 15-16) This was consistent with Dr. Shah's findings.

In fact, on June 20, 2013, Petitioner underwent an EMG/NCS of the left upper extremity which revealed, "No evidence of left peripheral entrapment neuropathy or cervical radiculopathy present at this time." A second EMG/NCV was performed on October 9, 2013 that was again normal, with full recruitment pattern present and confirmed that there was no evidence of left cervical radiculopathy or peripheral entrapment neuropathy present.

The evidence shows that Petitioner initially complained of left wrist and forearm pain as a result of the accident of December 29, 2012. Approximately one month after the accident, Dr. Davidson at Clearing Clinic noted that Petitioner had diffuse left arm pain from the elbow down. She also reported cervical/thoracic pain, but this was not a result of the wrist injury. There is no medical evidence that she voiced shoulder complaints until March 7, 2013. Dr. Shah's February 8, 2013, office note history reflects that Petitioner told him that her neck pain as well as her elbow pain "is nearly resolved with therapy." Dr. Shah's assessment and plan also stated "I cannot for sure state that her current symptoms are completely related to her injury that she sustained at work. (PX2) The complaints when Petitioner saw Dr. O'Keefe on March 7, 2013, "for neck, left shoulder and left arm severe overuse symptoms" did not comport with the Petitioner's original left wrist and forearm complaints. The medical records from March 7, 2013, are inconsistent in that Petitioner describes her accident of December 29, 2012, but also the records relate she was reaching behind a machine. This inconsistency as to the mechanism of the second accident creates an adequate justification to deny TTD payments from March 7, 2013, through June 26, 2013. Thus, I disagree with the majority that Section 19(k) penalties and Section 16 attorney's fees are appropriate for non-payment of TTD benefits from March 7, 2013, through June 26, 2013.

Additional section 19(k) penalties were imposed for 50% of the awarded March 16, 2013 cervical spine MRI-related fee schedule expense, 50% of the June 21, 2013 left wrist MRI fee

schedule expense and 50% of the April 23, 2013, left shoulder MRI fee schedule expense, plus Section 16 attorney's fees were awarded for non-payment of said medical expenses.

I find that Respondent's non-payment of these bills was not vexatious or the result of bad faith for all the reasons referenced above. Imposition of section 19(k) penalties and section 16 attorney's fees is discretionary. *McMahan v. Industrial Comm'n*, 183 Ill. 2d 499, 515. Given the afore-referenced facts, penalties and fees are not warranted in this case. The very foundation of Dr. O'Keefe's opinions was flawed, and, therefore, not credible and entitled to little weight. *See, e.g.*, *Sunny Hill of Will County v. Ill. Workers' Comp. Comm'n*, 2014 IL App (3d) 130028WC, 14 N.E.3d 16 (Expert opinions must be supported by facts and are only as valid as the facts underlying them.) Dr. O'Keefe's surgical treatment recommendations have been rejected by the majority for this very reason. In retrospect, the diagnostics he ordered were deemed to be reasonable only to the extent that they supported the original diagnosis of a left wrist sprain and that Petitioner's subjective complaints were not supported by the objective findings.

Finally, by awarding Section 19(l) penalties for the 212 days between Petitioner's counsel's demand for payment of medical bills, on July 18, 2017, and the hearing date of February 14, 2018, the majority finds that the employer's justification for the delay in this case does not meet the standard where "a reasonable person in the employer's position would have believed that the delay was justified." I disagree.

Section 19(l) requires an employer to reply to Petitioner's demand for payment of benefits under Section 8(a) or 8(b) within 14 days in writing. The Respondent filed multiple responses comporting with the strictures of Section 19(l). The Petitioner entered into evidence Petitioner's Exhibit 23, a copy of an email that was sent to Respondent's attorney on July 18, 2017 that purports to have attached a copy of outstanding medical bills and corresponding fee schedule analysis. The email then lists the bills and the amounts allegedly owed per the fee schedule. I note, however, that the medical bills that were purportedly attached to the email were not included in the exhibit and thus not entered into evidence.

I also note that the Respondent's Response to Petitioner's Penalties and Fees Petition, filed on January 19, 2018, ten days after the Petitioner's Petition was filed, alleges that Respondent "does not possess all bills for medical treatment replete with the required data elements (*i.e.*, CPT codes) and therefore demands the same from Petitioner."

The Respondent had also filed multiple responses to Petitioner's Petitions for Immediate Hearing under Section 19(b) of the Act. (RX6) In each of those responses, Respondent's attorney noted that with respect to issue number 8, "Medical bills in dispute," there were no attachments with the Petition and that CPT codes were required. Similarly, the responses noted that no attachments from medical providers were included with the Petitions for Hearing, and no dates of treatment listed.

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Section 19(l) clearly states that in the case of demand for payment of medical benefits under Section 8(a), the time for the employer to respond shall not commence until the expiration of the allotted 30 days specified under Section 8.2(d). I find that Section 19(l) must be read and considered in conjunction with Section 8.2(d). Section 8.2(d)2 requires "If the claim does not contain substantially all the required data elements necessary to adjudicate the bills, or the claim is denied for any other reason, in whole or in part, the employer or the insurer shall provide written notification, explaining the basis for the denial and describing any additional necessary data elements, to the provider within 30 days of receipt of the bill." *820 ILCS 305/8.2(2013).*

In this case, the Respondent maintained that they never had all the required data necessary to adjudicate the bills. Further, many of the bills were denied based on Dr. Bare's June 26, 2013, opinion that no additional diagnostics were warranted. By not tendering the attachments to the email, there is no evidence in the record confirming which bills, if any, were tendered at the time of the email that contained the elements necessary to adjudicate the bills. Respondent's responses to Petitioner's Petitions for Immediate Hearing, and to the Petitioner's Petitions for Penalties and Fees maintain the data was not included.

Further, on October 16, 2016, Dr. Sammy Dean performed a Utilization Review regarding the Petitioner's treatment and non-certified treatment recommended by the pain management doctor. Dr. Dean's deposition was taken on December 19, 2017, and he testified consistent with his report that a cervical spine nerve block performed on May 8, 2015, and the Keterolac injection performed on May 21, 2015, were not medically necessary. (RX 4) Other treatment including specific charges for range of motion measurements, the March 21, 2015, cervical spine MRI, and the September 22, 2015, left shoulder MRI arthrogram, were non-certified as medically necessary by Dr. Brecher. (RX3) Under Section 8.7 of the Act, when payment for medical services had been denied pursuant to Utilization Review, the employee has the burden of proof to show by a preponderance of the evidence that a variance from the standards of care used by the person or entity performing the Utilization Review is reasonably required to cure or relieve the effects of the injury. *820 ILCS 305/8.7(2013).*

With respect to the Arbitrator's award of Section 19(l) penalties for the 212 days between Petitioner's counsel's demand for payment of medical bills, on July 18, 2017, and the hearing date of February 14, 2018, I disagree penalties are warranted.

Based on the foregoing, including disputes regarding accident, causal connection, reasonableness and necessity of medical treatment, and work restrictions, the Respondent's denial of benefits as referenced was premised on a good faith dispute and was reasonable.

Therefore, I respectfully disagree with the majority in awarding penalties under Section 19(l), Section 19(k) or attorney's fees under Section 16 as a result of any of the Petitioner's three cases.

Kathryn A. Doerries

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

TRUJILLO, BELEN
Employee/Petitioner

Case# **13WC008312**

13WC008313
13WC032552

LABOR NETWORK INC LOANING EMPLOYER AND CLOVERHILL BAKERY INC BORROWING EMPLOYER
Employer/Respondent

20IWCC0038

On 4/2/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.89% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

1922 SALK, STEVEN B & ASSOC LTD
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5001 GAIDO & FINTZEN
ALEX OTTENHEIMER
30 N LASALLE ST SUITE 3010
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

20IWCC0038

☐ 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

Case # 13 WC 08312

Belen Trujillo
Employee/Petitioner

v.

Consolidated cases: 13 WC 08313
13 WC 32552

Labor Network, Inc., loaning employer and Clover Hill Bakery, borrowing employer

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 **Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **2/14/2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☒ 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**

FINDINGS

On **12/29/12**, 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.

For the reasons set forth in the attached decision, the Arbitrator finds a causal connection between the accident of December 29, 2012 and Petitioner's left wrist, left shoulder and neck conditions, with those conditions requiring conservative care through Dr. Bare's re-examination of May 18, 2016. Bare Dep Exh C. The Arbitrator further finds that Petitioner failed to establish causation as to the need for the left wrist and left shoulder surgeries recommended by Dr. O'Keefe.

Petitioner's average weekly wage was **$444.64**.

On the date of accident, Petitioner was **36** years of age, ***married*** with **5** dependent children.

Petitioner has in part received reasonable and necessary medical services.

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

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$0**. [See the parties' post-arbitration stipulation.]

Respondent is entitled to a credit of **$0** under Section 8(j) of the Act. [See the parties' post-arbitration stipulation.]

ORDER

The Arbitrator awards Petitioner the following fee schedule/prescription expenses: 1) Central Medical Specialists and Central Medical Specialists - facility, exclusive of any transportation-related expenses; 2) Advantage MRI, $2,301.22; 3) EQMD, $6,517.82; 4) MRI Lincoln Imaging Center, $1,134.39; 5) Marian Orthopedics, through Dr. Bare's re-examination of May 18, 2016; 6) Pro-Clinics, $79.85; and 7) Preferred Open MRI, $2,401.57. The Arbitrator declines to award certain other claimed expenses, for the reasons set forth in the attached decision.

Respondent shall pay Petitioner temporary total disability benefits of $330.00/week [the applicable minimum rate] from **3/7/13** through **9/22/13** and from **9/26/13** through **5/18/16,** a total of 166 3/7 weeks, as provided in Section 8(b) of the Act.

For the reasons set forth in the attached decision, the Arbitrator finds Respondent liable for Section 19(k) penalties in the amount of $4,357.80, Section 16 attorney fees in the amount of $1,743.12 and Section 19(l) penalties in the amount of $6,360.00.

For the reasons set forth in the attached decision, the Arbitrator declines to award prospective care in the form of the left wrist and left shoulder surgeries recommended by Dr. O'Keefe.

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

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

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

Molly C Mason

Signature of Arbitrator

3/28/18
Date

APR 2 - 2018

20IWCC0038

Belen Trujillo v. Labor Network and Cloverhill Bakery
13 WC 8312-3 and 13 WC 32552 (consolidated)

20IWCC0038

Summary of Disputed Issues

Petitioner, a packer, claims a specific trauma of December 29, 2012 (13 WC 8312), repetitive trauma injuries manifesting March 7, 2013 (13 WC 8313) and a specific trauma of September 23, 2013 (13 WC 32552). She seeks temporary total disability benefits, medical expenses, prospective care in the form of left wrist and left shoulder surgeries recommended by Dr. O'Keefe and penalties/fees. Respondent disputes accident, notice and causation in all three claims. Respondent paid no benefits under the Act other than the expenses associated with Petitioner's initial care at the Clearing Clinic. Arb Exh 1-3.

Post-Arbitration Stipulation

In 13 WC 8312, the parties initially agreed that Respondent was entitled to Section 8(j) credit in the amount of $2,979.61. Arb Exh 1. They later realized this figure represented the amount Respondent paid to the Clearing Clinic. After the hearing, they submitted a stipulation agreeing that Respondent is not entitled to Section 8(j) credit in 13 WC 8312.

Arbitrator's Findings of Fact

Petitioner testified through a Spanish-speaking interpreter.

Petitioner testified that Labor Network hired her and sent her to Cloverhill Bakery to work. She testified she worked at the bakery for over a year before the initial accident of December 29, 2012. T. 25. Petitioner testified she was required to work twelve hours per day, from 5 PM to 5 AM, with a half hour for lunch. Petitioner also testified she worked seven days per week. T. 24. She would ask Juan Reyes if she could work fewer hours and he would say, "no, this is the schedule." T. 23.

Petitioner testified she worked as a packer on a line. Small boxes containing bread came down the line toward her, moving from left to right. She lifted the small boxes off the line and put them inside big boxes. Each big box could hold about 20 small boxes. She then had to "make a pallet with the boxes." She stacked the filled big boxes on top of one another. Her job duties also included securing the stacked boxes with tape, sweeping, mopping, breaking down boxes and putting "bad" bread in containers. T. 19.

Petitioner testified her health was fine before the accident of December 29, 2012. T. 21. She had no difficulty performing her assigned duties before the accident. She denied injuring her left arm, left shoulder, left hand or neck before the accident. T. 21-22.

Petitioner testified she was injured at 8 PM on December 29, 2012, while in the process of putting a box on a pallet. T. 27-28. She felt "very strong pain." She also felt as if something cracked inside her hand. The box fell out of her hands. T. 27. She immediately reported the accident to two supervisors: Jose Perez and Juan Reyes. They were employed by Labor Network but worked at the bakery. T. 28. Petitioner testified she reported the accident as soon as it happened because she was not able to continue working. T. 28-29. Under cross-examination, however, she conceded she completed her shift after the accident. She also worked her regular shift on December 30-31, 2012.

Petitioner first sought treatment on December 31, 2012. She testified she went to Clearing Clinic that day, at Respondents' direction. T. 29-30. A form in the clinic records reflects that Jose Perez authorized the visit. She underwent "post-accident" drug/alcohol testing at the clinic. The results were negative. PX 1.

A form entitled "informacion ocupacional" in the clinic records contains handwritten descriptions of the accident in both Spanish and English. The description in English is: "while packing I felt pain in my left hand – the line was too fast." The description in Spanish contains the same description along with a second sentence indicating Petitioner grabbed a box ["al agarrar la caja"] and felt pain. Petitioner's signature and the date December 31, 2012 appear at the bottom of the form. PX 1.

Petitioner saw Dr. Sorokin at the clinic on December 31, 2012. Under cross-examination, Petitioner testified she had no difficulty communicating with the doctor. The doctor's note sets forth a date of accident of December 29, 2012 and the following description: "while packing, I felt pain in my left hand, the line was too fast." Dr. Sorokin described Petitioner as right-handed. He noted that Petitioner complained of 10/10 pain in her left hand. On left hand examination, he noted a decreased range of motion and "global" tenderness to palpation. He diagnosed a wrist sprain. He indicated this condition was "probably related to work activities." He prescribed Meloxicam, ice applications and brace usage as needed. He released Petitioner to light duty with no lifting over 5 pounds and no repetitive grasping. He directed Petitioner to return in three days. PX 1.

Petitioner testified that Respondents did not respect the doctor's restrictions. She resumed her regular packer duties after seeing Dr. Sorokin. T. 30.

Petitioner returned to Clearing Clinic on January 3, 2013 and again saw Dr. Sorokin. The doctor noted that, according to translation provided by "Rosa," Petitioner was "doing worse." Specifically, he noted a complaint of pain over the dorsal aspect of the left wrist "radiating to [middle/ring] fingers/left posterior elbow." He also noted a complaint of left hand weakness. He described the complaints as "out of proportion to clinical findings." On left wrist examination, he noted movement with pain, a decreased range of motion in all directions, decreased muscle strength "with poor effort" and "global" tenderness to palpation. On left elbow examination, he noted wrist pain with flexion/extension against resistance and elbow pain with movement. He continued the Meloxicam, dispensed an analgesic balm and prescribed occupational therapy. He continued the previous restrictions. PX 1.

Petitioner underwent an initial occupational therapy evaluation at Clearing Clinic on January 7, 2013. She testified she was experiencing neck pain as of this date. T. 31. The evaluating therapist noted complaints of 8-9/10 pain, numbness and tingling in the "entire left arm" and medial elbow swelling. On examination, the therapist noted pain and parasthesias reproduced down the left arm with cervical rotation to the left and right, a positive Tinel's over the radial tunnel and a positive Finkelstein's maneuver. She indicated that Petitioner's symptoms seemed to be "stemming from forearm tightness/trigger points." She also indicated Petitioner "may even have a double crush injury to her nerve in the thoracic outlet or neck." She directed Petitioner to continue using the wrist brace and noted she might need a thumb spica splint. PX 1.

Petitioner continued attending occupational therapy thereafter, through February 7, 2013. On January 25, 2013, the therapist noted that Petitioner complained of 9/10 pain when working. On

February 7, 2013, the therapist recommended that therapy be discontinued, noting no left wrist improvement and some left elbow improvement. PX 1.

Petitioner returned to Clearing Clinic on January 9, 2013 and saw a different provider, Anita Carani, M.D., DPM. Dr. Carani described Rosa as translating for Petitioner. She noted a primary complaint of left hand pain and other complaints of pain "all over" the left arm and a "ball" in the left forearm. Dr. Carani's left wrist and elbow examination findings were similar to Dr. Sorokin's. Dr. Carani also examined Petitioner's left shoulder, noting a full and painless range of motion, and neck, noting a full and painless range of motion. She described Petitioner's symptoms as disproportionate and inconsistent. She noted that Petitioner expressed a desire to be taken off work. Like Dr. Sorokin, she found the problems to be "probably related to work activities." She dispensed Biofreeze and directed Petitioner to continue therapy. She continued the previous work restrictions. PX 1.

On January 25, 2013, Petitioner returned to Clearing Clinic and saw yet another provider, Daniel Davison, DO. Dr. Davison noted complaints of left hand pain, diffuse left arm pain from the elbow down, anterior elbow pain and left-sided cervical and trapezius pain. On cervical spine examination, Dr. Davison noted mild left palpable spasm and a negative Spurling's maneuver. On left wrist and elbow examination, he noted a negative Finkelstein's test, a questionable ganglion in the antecubital area of the elbow, an improved range of motion and global tenderness to palpation. He obtained cervical spine X-rays which were negative on preliminary reading. He indicated the problems were "probably related to work activities." He recommended that Petitioner see Dr. Speziale, a hand specialist, and continue therapy. He imposed a 10-pound lifting restriction.

Dr. Shah, Dr. Speziale's partner, saw Petitioner on February 8, 2013. T. 32. He recorded a history of the accident, noting that Petitioner was moving a 10-pound box from a conveyor belt when "she felt that her wrist had bent." He noted a complaint of constant, burning pain in the left hand and wrist, mainly on the volar radial side of the wrist. He also noted a complaint of occasional numbness and tingling. He indicated that Petitioner described her neck and elbow pain as "nearly resolved with therapy." On left upper extremity examination, he noted some difficulty with wrist extension secondary to pain, tenderness to palpation over the flexor carpi radialis tendon, negative Finkelstein's testing, no tenderness over the TFCC and minimal tenderness over the flexor pronator wad and medial epicondyle. He indicated he viewed the neck and elbow issues as "likely self-limiting." He recommended that Petitioner continue therapy and "continue to use her fingers to avoid digital stiffness." He indicated he "[could] not for sure state that her current symptoms are completely related to her injury." He issued a handwritten "consult note" (PX 1), indicating he obtained X-rays and diagnosed "left wrist flexor carpi radialis tendonitis." He recommended that Petitioner take anti-inflammatories and continue occupational therapy. He indicated he would administer a cortisone injection in three weeks if Petitioner did not improve. He imposed a 5-pound lifting restriction with respect to the left hand and directed Petitioner to wear a splint at all times. PX 2.

On February 14, 2013, Dr. Sorokin noted that Petitioner had seen Dr. Speziale [sic]. He reiterated that physician's treatment recommendations. PX 1.

On February 28, 2013, Dr. Sorokin re-examined Petitioner and referred her to Dr. Shah "for definitive diagnosis and treatment." He dispensed an analgesic balm and continued the 5-pound lifting restriction. PX 1.

Petitioner testified she continued working while undergoing treatment at Clearing Clinic. Her hand pain and weakness worsened during this time. Objects would fall from her hands. T. 33. She "constantly" informed Jose Lopez and Juan Reyes of her symptoms. T. 33-34.

Records in PX 2 reflect Petitioner was scheduled to return to Dr. Shah on March 8, 2013 but was a "no show/no call" on that date.

Petitioner testified she saw a different physician, Dr. O'Keefe, on March 7, 2013. T. 34. She testified she changed doctors because her health had worsened. T. 34. She chose to see Dr. O'Keefe after she received a pamphlet from him in the mail. T. 34-35.

Dr. O'Keefe's initial note of March 7, 2013 describes Petitioner as a "new patient referred by relative for neck, left shoulder and left arm severe overuse symptoms." The doctor indicated that Petitioner routinely worked 60 hours per week. He also noted that, on December 29, 2013, Petitioner was "7 hours into her shift" when she lifted a large "cardinal" [sic] and felt a pop and intense pain in her left, non-dominant wrist. He also indicated that, after a clinic physician imposed a 5-pound lifting restriction, Petitioner was assigned to "cleaning production machine." He indicated that this task involved awkward positioning which caused "intense pain in the neck, shoulder and arm." He stated that Petitioner's regular job involved lifting 30-pound boxes 120 times per hour, primarily at waist level but sometimes at calf level. He also stated that the injury occurred when Petitioner lifted her twentieth 30-pound load.

Dr. O'Keefe obtained left wrist X-rays, which showed no obvious fracture or dislocation.

Dr. O'Keefe prescribed Relafen and Norco, along with therapy, a long arm splint and a strap arm splint. He took Petitioner off work and indicated she was unable to drive and would need medical transportation.

Petitioner underwent an initial physical therapy evaluation at Central Medical Specialists on March 11, 2013. She began attending therapy sessions on a regular basis thereafter. PX 3A.

On March 13, 2013, Petitioner filed Applications for Adjustment of Claim alleging neck, left arm, left shoulder and left hand injuries of December 29, 2012 [13 WC 8312] and repetitive trauma injuries of March 7, 2013 involving the same body parts [13 WC 8313].

On April 16, 2013, Petitioner's therapist noted complaints relative to the left wrist and shoulder but described Petitioner's neck as "much improved." PX 3A.

On June 19, 2013, Dr. O'Keefe described Petitioner as "working 60-hour weeks" and regularly encountering "faulty machines" as of her December 29, 2012 accident. He also described Petitioner as "miserable" and "using high doses of medications and analgesics to try to suppress symptoms." He viewed the previously recommended EMG as now urgent. After re-reviewing left wrist X-rays taken on May 16, 2013, he prescribed a left wrist MRI. He renewed Petitioner's Relafen, Prilosec, Ultram, Norco and Neurontin. PX 3A.

On June 19, 2013, Petitioner's therapist noted complaints of left wrist popping, neck stiffness and left shoulder weakness and popping. She also noted that Petitioner complained of numbness and tingling into her third and fifth fingers. PX 3A.

At Dr. O'Keefe's recommendation, Petitioner underwent an upper extremity EMG on June 20, 2013. Dr. Paly performed this study. He found no evidence of neuropathy or radiculopathy. PX 3B.

At Dr. O'Keefe's recommendation, Petitioner underwent a left wrist MRI on June 21, 2013. The doctor's MRI prescription reflects he specifically asked Dr. Goldstein to interpret this MRI. It also reflects he directed the doctor to look for a TFCC tear. Dr. Goldstein interpreted the study as showing a small distal radioulnar joint effusion and a small amount of fluid surrounding the scaphoid. He described the triangular fibrocartilage complex [TFCC] as intact. PX 5, 6.

At Respondent's request, Petitioner saw Dr. Bare for purposes of a Section 12 examination on June 26, 2013. In his report of the same date, Dr. Bare indicated he reviewed a cover letter from Respondent's counsel, a packer job description, the Clearing Clinic records and a March 2013 work status note in connection with the examination. He also indicated he relied on an interpreter to obtain Petitioner's history. He described the first accident as occurring when Petitioner lifted a box from waist level to floor and felt sharp pain in her left wrist. He indicated Petitioner later developed neck and shoulder pain. He stated Petitioner reported a left arm injury, secondary to repetitive reaching and lifting, on March 7, 2013. He noted that Petitioner was wearing a wrist splint and complained of pain in her left wrist, the left side of her neck and down the left arm "with shoulder pain."

Dr. Bare noted no abnormalities on cervical spine and left shoulder examination. He interpreted the left wrist MRI as showing "no substantial abnormalities."

Dr. Bare diagnosed a left arm injury and neck pain. He agreed with the treatment rendered to date. He also agreed with the wrist splint and activity modifications. He viewed Petitioner's symptoms as stemming from either the neck or the wrist but not the shoulder. Based on the chronicity of the symptoms, he recommended "further medical work-up" and EMG/NCV testing "to determine whether or not nerve impingement or neuropathology is present." [He apparently did not know that Petitioner had already undergone an EMG.] He indicated Petitioner might require an MRI if the EMG/NCV test was positive. He also recommended a "short course of physical therapy, probably 4-6 weeks, working on the neck and the shoulder." He indicated Petitioner's subjective complaints did not match the objective findings. He addressed causation as follows:

> "I believe that her condition is potentially related to the work injury due to the fact that [she] reported to the doctor after the injury and noted wrist pain. Subsequently, [she] developed shoulder and neck pain. It is reasonable and possible secondary to wrist injury lifting boxes."

Dr. Bare recommended restrictions of no lifting above chest level and lifting of 10 pounds at chest level due to Petitioner's wrist splint usage. He did not believe Petitioner would need permanent restrictions. RX 2, Exhibit B.

Petitioner returned to Dr. O'Keefe on July 18, 2013. The doctor noted that "the electrical testing done by Dr. Paly did not show neck or peripheral radicular pathology." He described the cervical spine and left shoulder MRI results as abnormal. He noted the left wrist MRI disc was not yet available.

On left hand/wrist examination, Dr. O'Keefe noted a very weak grip in the left hand, tenderness over the radiocarpal joint, tenderness with palpation of the TFCC and positive carpal tunnel findings. On left elbow examination, he noted positive ulnar tunnel symptoms. On left shoulder examination, he noted tenderness on the anterolateral aspect of the acromion and positive supraspinatus and impingement testing. On cervical spine examination, he noted tenderness at C5-6-7 with pressure there producing radicular symptoms, left worse than right.

Dr. O'Keefe noted the recent Section 12 examination. He described the examiner as assessing only the wrist. He renewed the Relafen, Neurontin and Ultram. He reduced the therapy to two to three times weekly due to Petitioner's lack of funds and resultant inability to travel. PX 3A.

On August 20, 2013, Dr. O'Keefe reviewed the June 21, 2013 left wrist MRI images. He interpreted the study as showing "edema of triquetral bone and TFCC ligament with probable tear of that latter structure." PX 3A.

At Dr. O'Keefe's recommendation, Petitioner saw Dr. Chunduri of Central Medical Specialists on August 21, 2013. The doctor noted that, on December 29, 2012, Petitioner "was moving rapidly and then she suddenly felt a pain in her left wrist as well as her shoulder." He also noted that Petitioner complained of bilateral arm tingling. On initial examination, he noted left shoulder and left wrist tenderness to palpation.

Dr. Chunduri indicated he reviewed an upper extremity EMG, a cervical spine MRI and a left shoulder MRI. He described the EMG and cervical spine MRI as "within normal limits." He described the left shoulder MRI as showing a partial supraspinatus tendon tear.

After noting the absence of cervical pathology, Dr. Chunduri referred Petitioner back to Dr. O'Keefe. PX 3A.

On August 26, 2013, Dr. O'Keefe performed an ultrasound-guided left wrist arthrogram and a cortisone injection of the distal radioulnar joint. He described the arthrogram as positive, indicating it showed extravasation of dye consistent with a TFCC tear. PX 3A. Petitioner testified the injection provided only temporary relief. Her pain came back. T. 37.

In a work status medical report issued on August 26, 2013, Dr. O'Keefe kept Petitioner off work and recommended occupational therapy. PX 3B.

On August 30, 2013, Petitioner saw Dr. O'Keefe's assistant, Lauren Kirsch, PA-C, and reported about one hour of relief following the wrist injection. Petitioner indicated her left wrist pain "returned promptly after the block wore off." She complained of intense tenderness over the left wrist, stabbing pain into the first, fourth and fifth fingers and pain in her left shoulder. On left wrist examination, Kirsch noted marked tenderness about the dorsum, ¼ edema, intense tenderness to palpation of the TFCC, diminished grip power on the left and intact pinch function. She recommended that Petitioner continue wearing her brace, attending therapy and taking medication. She described Petitioner as "currently in too much pain" to attempt returning to work "before 9/2/13." PX 3A.

Kirsch continued to keep Petitioner off work at the next visit, on September 6, 2013. She directed Petitioner to see Dr. O'Keefe in two weeks. PX 3A.

On September 19, 2013, Dr. O'Keefe renewed Petitioner's medications and directed her to continue therapy once a week. He released Petitioner to light duty as of September 23rd, with up to 10 pounds of lifting (T. 37-38), consistent with Dr. Bare's recommendation, while indicating he had no hope of Petitioner tolerating this since she was "still only at 2 pounds" in therapy. PX 3A.

Petitioner testified she resumed working at Cloverhill Bakery on September 23, 2013, per Dr. O'Keefe's release. T. 38-39. At 6 PM on that date, she sustained another accident. She grabbed a box, put it on the line, turned to her right, away from the moving conveyor belt, and "felt a very strong blow in [her] back." She testified that an electric band on the conveyor broke, flew off the line, struck her and "threw [her] to the floor." T. 39. The band struck her left upper back and the base of her neck. T. 40.

Petitioner testified she immediately reported this accident to Jose Lopez and Juan Reyes. T. 41.

Petitioner testified she returned to Dr. O'Keefe on September 26, 2013. T. 42. The doctor recorded a history of the recent accident. He took Petitioner off work and recommended EMG/NCV testing. PX 3B.

Petitioner underwent repeat EMG testing on October 9, 2013. Dr. Paly performed this testing. He noted no evidence of neuropathy or radiculopathy. PX 3B.

On October 22, 2013, a physical therapist at Central Medical Specialists dispensed another thumb spica splint to Petitioner. PX 3A.

Petitioner continued seeing Dr. O'Keefe thereafter. The doctor recommended left wrist and left shoulder arthroscopies. Petitioner testified that Dr. O'Keefe put her recommended surgeries on hold as of September 23, 2014 because she was pregnant. She subsequently delivered a healthy baby girl. T. 44. She returned to Dr. O'Keefe on March 19, 2015. T. 44. He continued to keep her off work and again recommended left wrist and left shoulder surgery.

On March 21, 2015, Petitioner underwent another cervical spine MRI at Dr. O'Keefe's recommendation. Dr. Pai interpreted this study as showing minimal bulging with no significant foraminal narrowing at C5-C6. PX 6.

Petitioner saw Dr. Abdellatif at Pro Clinics on April 21, 2015. In his note of that date, the doctor recorded a history of the September 23, 2013 accident and noted that Petitioner "had previous injury to left hand/wrist with same company that was aggravated on current accident." He also noted that Petitioner was experiencing neck pain and had been seeing Dr. O'Keefe for her left hand and wrist. On examination, he noted multiple trigger points in the neck, shoulders, left hand/wrist and upper, middle and low back. He diagnosed cervical radiculopathy and cervical facet syndrome, as well as left hand/wrist pain. He recommended trigger point injections and continued therapy and medication. PX 6.

Petitioner testified she underwent a neck injection on May 8, 2015. Dr. Hassan [sic] administered this injection. Petitioner testified the injection provided only temporary relief. T. 45. Dr. Abdellatif's records reflect he injected the trapezius and romboid muscles, as well as C3-C4, C4-C5, C5-C6 and C6-C7 bilaterally, on May 8, 2015. PX 6.

Petitioner returned to Dr. Abdellatif on May 21, 2015. The doctor described Petitioner as reporting 50% improvement secondary to the injections. He recommended additional injections and directed Petitioner to continue therapy and medication. PX 6.

On September 15, 2015, Dr. O'Keefe recommended MR arthrograms of the left wrist and left shoulder. PX 3B. The left shoulder MR arthrogram, performed at Preferred Open MRI on September 22, 2015, showed no abnormalities other than a small amount of subacromial/subdeltoid bursal fluid. PX 7. Dr. O'Keefe continued to seek surgical authorization thereafter.

At Respondent's request, Dr. Bare re-examined Petitioner on May 18, 2016. In his report of the same date, he described Petitioner as "cooperative throughout the examination." He indicated he reviewed his prior report along with the left wrist and left shoulder MRI reports, the left shoulder MR arthrogram report, the October 9, 2013 EMG report and "Dr. O'Keefe's office notes and medical records" in connection with the re-examination.

Dr. Bare noted that Petitioner reported a new shoulder injury occurring on the day she returned to work. He indicated she reported the conveyor belt broke that day, causing an object, perhaps a box, to strike her arm.

Dr. Bare indicated he examined Petitioner's neck, left shoulder, left elbow and left wrist. He described Petitioner as exhibiting pain to "pretty much all testing." He noted diffuse tenderness to palpation throughout the shoulder and wrist. He interpreted the left shoulder MR arthrogram as showing no abnormalities other than possibly "some signal changes around the labrum." He indicated he reviewed the left wrist MRI report but conceded he did not see the images and is "primarily a shoulder specialist." He did not view Petitioner as a surgical candidate. He did not view the newly reported accident as having changed Petitioner's complaints.

Dr. Bare recommended against any further treatment. He found Petitioner capable of full duty. He indicated the objective findings did not match Petitioner's subjective complaints. He indicated that, if the accidents occurred as Petitioner described them, they "could have caused temporary complaints from a bruise or contusion, especially when the conveyor belt broke, but did not lead to structural problems that would lead to surgery or long-term problems." He described the three years of treatment to date as "appropriate, reasonable and necessary." He indicated Petitioner would probably have been capable of resuming full duty within about three months of each of her injuries. He did not render any AMA impairment rating. Bare Dep Exh C.

Dr. O'Keefe testified by way of evidence deposition on November 17, 2016. PX 22.

Dr. O'Keefe testified he is a board certified orthopedic surgeon who regularly treats patients with hand, shoulder and neck disorders. PX 22, p. 5. O'Keefe Dep Exh 1.

Dr. O'Keefe testified that, when he first saw Petitioner, on March 7, 2013, she told him she had worked at Clover Bakery for about a year and often worked 60 hours per week. PX 22, p. 7. She complained of pain in her left wrist, left shoulder and neck. PX 22, p. 7. She reported experiencing a "pop" and intense pain in her left wrist on December 29, 2012, when she lifted a large box of bread about seven hours into her shift. PX 22, pp. 7-8. She is right-handed. PX 22, p. 8. After the accident, a company doctor put her on light duty but she was assigned to work that "wasn't really light duty." The work consisted of cleaning equipment. She deteriorated while performing this work. PX 22, p. 9. On

left shoulder and neck examination, he noted a limited range of motion. He also noted positive supraspinatus and impingement testing. On left wrist examination, he noted intense tenderness "at the ligament called the triangular fibrocartilage complex." PX 22, pp. 11-12. Petitioner denied having health problems before she began working at the bakery. PX 22, p. 12. He ordered a cervical spine MRI and EMG/NCV testing. He took Petitioner off work. PX 22, p. 13. The MRI, performed on March 16, 2013, showed "a thickening along the anterior surface of C6-C7." PX 22, p. 15.

Dr. O'Keefe testified he diagnosed a shoulder sprain as of April 16, 2013. At that point, he believed Petitioner would require an arthroscopy if this sprain did not improve. He suspected the sprain was not minor since Petitioner had been symptomatic for five months. PX 22, pp. 15-17. He prescribed a left shoulder MRI, which he later interpreted as showing a rotator cuff tear and traumatic bursitis. PX 22, p. 18. He also recommended a left wrist MRI, based on AP X-rays which showed ulnar deviation. PX 22, p. 19. On July 18, 2013, he diagnosed an "overuse type" of injury based on the lifting Petitioner reported doing. He recommended a left shoulder arthroscopy. PX 22, p. 23. He interpreted the June 21, 2013 left wrist MRI as showing edema in one of the carpal bones adjacent to the TFCC ligament. Based on this, he felt there was "probably a tear" in the TFCC. PX 22, p. 25. He then prescribed a ultrasound-guided, diagnostic injection. He performed this injection on August 26, 2013. Petitioner reported experiencing about an hour of relief following this injection. PX 22, p. 31. She then returned to baseline. PX 22, p. 31.

Dr. O'Keefe testified he noted Dr. Bare's opinion that Petitioner could work subject to a 10-pound lifting restriction. As of August 20, 2013, he did not believe Petitioner would be successful at this since she had tears in her rotator cuff and TFCC. Nevertheless, he released Petitioner to work, subject to a 10-pound lifting restriction, on September 19, 2013. Up to this point, he had kept Petitioner off work. PX 22, p. 35. Petitioner returned to him on September 26, 2013 and reported another injury occurring three days earlier. She told him a conveyor belt broke, causing her to fall forward, hitting her extremities and landing on concrete. PX 22, p. 36. He took her off work, effective September 23, 2013. PX 22, p. 37. Petitioner's neck was stiff and painful. Her shoulder "was showing signs of cuff tear." Her "elbow had some serious issues going into the left wrist." PX 22, p. 38. On November 7, 2013, he prescribed an "H wave" machine for Petitioner. This machine is "used to impact neuritic pain.." An H-wave machine "probably scrambles pain signals to the brain so that the brain doesn't interpret it as painful." PX 22, pp. 39-40. On December 10, 2013, he again recommended a left shoulder surgery and a left wrist arthroscopy with open repair of the TFCC tear. PX 22, p. 40. On September 23, 2014, he noted that Petitioner was unable to undergo these surgeries "due to personal health issues." He does not operate on a pregnant woman unless her situation is life-threatening. PX 22, pp. 42-43. At that point, Petitioner was "barely able to sleep" and "stressed out with intense pain in her neck and radicular symptoms and shoulder tear symptoms and wrist tear symptoms." He did not view Petitioner as capable of working, even with restrictions. PX 22, p. 43. In March of 2015, he recommended a TFCC injection because Petitioner "was deteriorating." In July 2015, he recommended a left shoulder MR arthrogram. Petitioner underwent this study on September 22, 2015. PX 7. In his opinion, the MR arthrogram results were consistent with the previous MRI. He is continuing to recommend the left wrist and left shoulder surgeries. When he last saw Petitioner, on August 30, 2016, he continued to keep Petitioner off work. PX 22, pp. 51-52.

Under cross-examination, Dr. O'Keefe testified he tried to obtain the initial records from the occupational clinic. PX 22, pp. 52-53. He did not witness Petitioner's September 23, 2013 accident but he wants to be able to stand by Petitioner's account. PX 22, pp. 56-57. The accident of September 23, 2013 did not cause Petitioner's injuries but it "hugely aggravated" them. PX 22, p. 58. If, in fact, the

conveyor belt did not break, then it was probably Petitioner being assigned to work exceeding her restrictions that caused the aggravation. PX 22, p. 59. Petitioner told him Respondent was not honoring the restrictions. PX 22, pp. 59-60. His actual note of September 26, 2013, however, mentions Petitioner working for only a few hours before the accident occurred. PX 22, p. 62. Petitioner's cervical spine MRI did not show any discal injury but it did show "findings compatible with spinal symptoms." PX 22, p. 63. Petitioner's left shoulder diagnosis is a sprain. PX 22, p. 63. Her left wrist diagnosis is a sprain and ligament tear. PX 22, p. 63. He believes the involved ligament is the TFCC. A MRI should show a TFCC tear. Dr. Goldstein, who saw no tear on Petitioner's left wrist MRI, did not know Petitioner's history and did not examine Petitioner. If Petitioner did not have a TFCC tear, she would not continue to experience pain and popping in the area of the TFCC. PX 22, p. 65. An MRI is, at best, 80% accurate. He believes the increased signal on Petitioner's MRI is consistent with a TFCC tear. It is Dr. Goldstein's interpretation, not the MRI, that is wrong. PX 22, pp. 65-66. This is why Petitioner needs a wrist arthroscopy. PX 22, p. 66. In stating that Petitioner has a brutal, 60-hour work week, he is relying on Petitioner's report. He did not review any job description or wage statement. PX 22, p. 67. He has never been to the bakery but he knows, based on patient reporting, that it is a "nest of overuse pathology." Initially, Petitioner had a left shoulder sprain but, by the time the MRI was done, she had a tear. PX 22, p. 69. Doctors at occupational clinics are paid by the employers and carriers. If a doctor at such a clinic says "treat the wrist," it is rare for anyone at the same clinic to mention non-wrist complaints. PX 22, p. 71. It is also possible that Petitioner's inability to speak English affected the documentation of her complaints. PX 22, p. 72. Petitioner's shoulder problem was "acutely related" to the December 29, 2012 accident because Petitioner had "to continue to perform and function with heavy work." PX 22, pp. 75-76. The shoulder deteriorated during the two or three weeks after the accident. PX 22, p. 76. An intake sheet dated March 7, 2013 reflects Petitioner was working at a fast pace and heard a snap in her left wrist, causing pain and weakness, seven hours into the shift. PX 22, p. 77. When he used the term "personal medical challenge" in his note, he was referring to Petitioner's pregnancy. PX 22, pp. 82-83. He is "not jumping up and down" to recommend neck surgery. He wants to deal with the shoulder and wrist. The neck "probably comes in third." PX 22, p. 89.

On redirect, Dr. O'Keefe testified the left shoulder problem was due to overuse. The September 23, 2013 accident aggravated Petitioner's conditions. PX 22, pp. 90-91.

Under re-cross, Dr. O'Keefe testified that, if Petitioner did not injure her left shoulder on December 29, 2012, she injured it secondary to the work, i.e., cleaning equipment, she performed after that date while she was supposed to be performing only restricted duty. PX 22, p. 93. If a person has wrist pain and working 12-hour days, she could get worse, even if she is handling very light objects, so long as the work is highly repetitive. The history he obtained on September 26, 2013, i.e., that Petitioner was working within parameters for several hours before the conveyor belt broke, was not accurate. The history of November 7, 2013 is accurate. PX 22, pp. 96-97.

Petitioner testified she last saw Dr. O'Keefe on November 29, 2016. T. 45. In his note of that date, the doctor indicated he had been awaiting authorization of a left shoulder arthroscopy since July 2013 and was also seeking authorization of a wrist arthroscopy. On left wrist examination, he noted intense tenderness at the distal radioulnar joint, a mechanical pop with supination/pronation and grip strength of less than 4/5. On left shoulder examination, he noted intense tenderness anterolaterally, positive supraspinatus and impingement testing and increased laxity of 3-5 millimeters with AP testing. He asked workers' compensation to authorize the arthroscopies he requested years earlier.

Petitioner testified she has not returned to Dr. O'Keefe since November 29, 2016 because she has no money to pay for more treatment. T. 46. She has sustained herself financially since that time by borrowing money from relatives. T. 46.

Petitioner testified she has remained off work at Dr. O'Keefe's direction since September 26, 2013. T. 46. She wants to undergo the surgeries the doctor recommended. She wants to get better and be the same person she was before. She lacks sufficient strength to carry her baby. She wants to resume working so she can support her family. T. 47. Therapy helped her only temporarily.

Under cross-examination, Petitioner testified she started her shift at 5 PM each day and left work at around 5 AM. T. 49. She worked as a packer. If the packer job description states she never lifted or carried more than 25 pounds, it is not correct. T. 51-52. Before the first accident, she lifted up to 60 pounds. A box full of bread could weigh that much. T. 52. She had to lift big boxes that were full of small boxes of bread. When full, a big box could hold about 20 small boxes. T. 53. She lifted from 200 to 300 big boxes per shift. T. 54. Petitioner recognized her signature on the Application she filed for the December 29, 2012 accident. T. 55. That accident did not occur at 2 PM. T. 56. She worked about 3 hours before the accident occurred. T. 56-57. She did not clock in or punch a timecard when she started or finished a shift. T. 57. After the 8 PM accident on December 29, 2012, she finished her shift. T. 57-58. She did not go to the Clearing Clinic until December 31st because Jose Perez and Juan Reyes "didn't want to send [her] right away." T. 58. She worked her regular shift on December 30, 2012. T. 58. She had no difficulty communicating with Dr. Sorokin at the clinic on December 31, 2012. T. 59. She did not tell Dr. Sorokin she felt left hand pain while packing because the line was moving too fast. She does not know why he wrote this down. She told him she was in a lot of pain and "felt a crack." T. 59. If the doctor's records do not mention complaints of neck and shoulder pain, they are not correct. T. 60. On her body, the top of the conveyor belt was at the lower abdominal level. T. 60-61. The boxes came down the belt from left to right. She worked alone at the time of the December 29, 2012 accident but there were 8 to 10 other workers positioned at various points along the same line. She could see these workers. They were ahead of her, removing damaged parts. T. 62. They would have been able to see her accident. T. 62-63. Jorge Garcia, a co-worker, saw her December 29, 2012 accident. He helped her and was nearby when she went to the office to report the accident. Jorge Garcia is not present to testify. T. 63. She saw different doctors at the Clearing Clinic. Every time she went to the clinic, someone examined her. They examined her left hand, shoulder and neck. If the records state that her left hand was not bruised, they are not correct. T. 65. On January 7, 2013, she told a therapist she had pain in her entire left arm. T. 66-67. None of her relatives have treated with Dr. O'Keefe. T. 67. If Dr. O'Keefe said this, he was wrong. T. 68. She had no problems communicating with Dr. O'Keefe. She told him the truth. T. 68. She did not tell Dr. O'Keefe the December 29, 2012 occurred seven hours into her shift. T. 69. She lifted over 3,000 boxes during a 12-hour workday. T. 70. She screamed and cried after the December 29, 2012 accident but resumed working after a little while. T. 71. If Dr. O'Keefe described her as cleaning machinery during the period after this accident, he was wrong. T. 74. She continued to perform packing work on a line after this accident. T. 74. The September 23, 2013 accident took place at about 6 PM. A piece of plastic broke off the conveyor belt and struck her. T. 76. After this accident, she continued working only until 9 PM. T. 77. She left early due to the injury. T. 77. She stayed home on September 24 and 25, 2013. T. 77. She did not see a company doctor right away because "they didn't want to" send her. T. 77. The impact caused her to be propelled forward. She struck her chest on a waist-high table.

On redirect, Petitioner reiterated that her packer job involved removing small boxes of bread from a moving conveyor belt, putting the small boxes into big boxes and putting the big boxes on a

pallet. T. 83. She had to walk between the conveyor belt and the pallet. She removed many boxes from the line on December 29, 2012, before the accident. T. 84. The form she completed (in Spanish) at the Clearing Clinic states she was injured while packing. T. 85-86. When she later saw Dr. Shah, at the clinic's referral, she told him she was moving a box off of the conveyor belt when she felt wrist pain. T. 86.

Dr. Bare, Respondent's Section 12 examiner, testified by way of evidence deposition on February 22, 2017. RX 2. Dr. Bare testified he attended medical school at Northwestern University and performed his residency there. RX 2, p. 6. He obtained board certification in orthopedic surgery in 2008. RX 2, p. 7. He specializes in shoulder and knee injuries. He has published articles concerning such injuries. RX 2, p. 7. He has privileges at Central DuPage Hospital and Delnor Hospital. RX 2, p. 8. Bare Dep Exh A.

Dr. Bare testified he examined Petitioner on June 26, 2013. He did not independently recall this examination and required his report to testify. RX 2, p. 9. He was asked to examine Petitioner's left upper arm. He conceives of the arm as "basically the base of the neck through the fingers." RX 2, pp. 9-10.

Dr. Bare testified he reviewed a cover letter, a packer job analysis, the Clearing Clinic records and a work status note from March 2013 in connection with his examination. RX 2, p. 11. His practice is to review any records he receives with the examinee. RX 2, p. 11. He communicated with Petitioner via an interpreter. He speaks very little Spanish. RX 2, p. 12. Petitioner provided a history of two separate work accidents. The first occurred in December 2012. She reported feeling wrist pain while lifting a box "she believed weighed 30 pounds." The wrist pain eventually developed into shoulder and neck pain. On March 7, 2013, she had a second episode "where she was lifting and [it] caused more pain in the arm." RX 2, pp. 12-13. She complained of left wrist pain and was wearing a wrist splint. She also complained of pain in the left side of her neck running down her arm. Dr. Bare described Petitioner's pain as "rather diffuse involving essentially the entirety of the arm." RX 2, p. 13. Her past medical history was relevant to the extent she denied any prior problems or injuries involving these body parts. RX 2, p. 13. On left shoulder examination, he noted a good range of motion with complaints of pain at the end ranges of all motions. Her strength was normal and she exhibited no instability. On cervical spine examination, he noted a full range of motion and a complaint of pain at the base of the neck over the trapezius area. RX 2, p. 14.

Dr. Bare testified he reviewed the report concerning the June 21, 2013 left wrist MRI. The report documented no abnormalities. RX 2, p. 15.

Dr. Bare described Petitioner's diagnosis as "vague." It was possible Petitioner's symptoms emanated from the neck, not the shoulder. "It could be what we call myofascial pain where you have tenderness over a muscle at the base of the neck." He did not view the wrist as the source of the pain. If the wrist is the source, "very rarely will you have neck pain or shoulder pain." RX 2, p. 15. Petitioner complained of a lot of pain but he did not decipher any objective findings other than a complaint of tenderness to palpation. He believed Petitioner's prognosis for recovery was very good. RX 2, p. 16. The treatment Petitioner underwent prior to his examination was "good, within the standard of care." RX 2, p. 16. He believed Petitioner's symptoms could be stemming from a neck problem so he recommended EMG/NCV testing and a short course of therapy. If the testing did not show any definitive structural problem requiring surgery, he "would recommend physical therapy, anti-inflammatories and return to work." RX 2, p. 18. He "believes that causation existed, linking [Petitioner's] current condition to the

work injury as he had no reports or reason to believe that there was a pre-existing problem." He recommended that Petitioner continue using the wrist brace, avoid lifting above chest level and lift no more than ten pounds to chest level. RX 2, p. 19. He saw no indication that Petitioner would require permanent restrictions.

Dr. Bare testified he re-examined Petitioner on May 18, 2016. RX 2, p. 20. In connection with this re-examination, he reviewed his initial report, a left shoulder MRI report, a left wrist MRI report, a left arm EMG report, a left shoulder MR arthrogram report and Dr. O'Keefe's records. RX 2, p. 22. Petitioner reported another accident in 2013 in which she was struck in the arm by an object, which might have been part of a conveyor belt, after the belt broke. RX 2, p. 23. Petitioner complained of pain in her left wrist, left arm, left shoulder and neck. He viewed her complaints as very similar to those she voiced at the initial examination. RX 2, p. 24. His neck examination was normal. His left shoulder examination was also normal, except that Petitioner complained of pain with virtually every movement. The left wrist examination was normal except that Petitioner complained of pain with range of motion. RX 2, pp. 25-26. He read the left shoulder MRI and MR arthrogram as essentially normal, with the arthrogram showing only "some signal changes around the labrum which are very common for an individual" of Petitioner's age. The EMG from October 2013 showed "some very mild abnormalities." RX 2, p. 26. The likelihood of Petitioner remaining symptomatic was high, given the duration of the complaints. Objectively, however, Petitioner's prognosis was good, since there were no structural abnormalities. RX 2, p. 28. He recommended that Petitioner take over the counter anti-inflammatory medication, perform home exercises and return to work. He did not recommend surgery. The last accident, occurring in 2013, appeared to be a temporary aggravation. RX 2, p. 29. The care to date was reasonable and necessary. Petitioner had reached maximum medical improvement. RX 2, p. 29. It might take a month after the 2013 accident, which was "essentially a bruise," for Petitioner to feel better. He saw no indication of permanent impairment. RX 2, p. 30.

Under cross-examination, Dr. Bare testified that, when he first saw Petitioner, in June 2013, he causally related her condition to her work injuries, found the treatment to date to be reasonable and necessary and recommended treatment and work restrictions. RX 2, p. 32. At that time, he reviewed only an MRI report. When he re-examined Petitioner, in 2016, he saw the actual MRI images. RX 2, p. 33. The left shoulder MRI and the EMG were not definitively normal. RX 2, p. 34. He has limited experience interpreting wrist MRIs. A trauma can render a degenerative condition symptomatic. He performs a maximum of 8 IMEs per month. RX 2, p. 35. He performs more examinations for respondents than claimants. RX 2, p. 36.

On redirect, Dr. Bare testified the MRI abnormalities he noted were very mild. Most people who are over 40 have some signals around the labrum. Those signals are not necessarily indicative of a work accident. RX 2, p. 37.

On July 18, 2017, Petitioner's counsel sent twelve outstanding medical bills and a fee schedule analysis to Respondent's counsel. PX 23.

Dr. Dean, an anesthesiologist and pain management physician who provided utilization review services to Rising Medical Solutions, testified by way of evidence deposition on December 19, 2017. RX 4. Dr. Dean testified he used to be licensed in Illinois but did not renew his license when it expired in July 2017. RX 4, pp. 6-7. He is licensed in Wisconsin, Michigan, New York, Virginia, Florida and Texas. RX 4, p. 7. He is board certified and fellowship-trained in pain management. RX 4, p. 7. He authored a report concerning Petitioner's care on October 3, 2016. He did not speak with any treating physician

before preparing the report. RX 4, p. 13. He never examined Petitioner. RX 4, p. 15. The pain management consultation of April 21, 2015 was medically necessary, based on the records he reviewed and the ODG guidelines, but the cervical spine nerve block performed on May 8, 2015 was not. The block is "usually diagnostic". It is "not therapeutic." The block was not appropriate for Petitioner's radicular symptoms. The Keterolac injection of May 21, 2015 was also not medically necessary. The provider did not explain why he performed this injection. RX 4, p. 19.

Under cross-examination, Dr. Dean testified a patient can suffer from both radicular and facet pain. The facet injections were not supported by any documentation of failed conservative care. RX 4, p. 21. He did not review any radiographic films. He relied on the radiology reports. RX 4, p. 22. As a treating physician, he sometimes treats patients outside of ODG guidelines. Reasonable physicians can disagree as to diagnosis and treatment needs. RX 4, p. 23.

On redirect, Dr. Dean testified that none of the records he reviewed supported a deviation from ODG guidelines. RX 4, p. 23.

Under re-cross, Dr. Dean reiterated he did not examine Petitioner. RX 4, p. 23.

Dr. Brecher, another utilization review physician, also testified by way of evidence deposition on December 19, 2017. RX 3. Dr. Brecher testified he is a general orthopedic surgeon who works, on an independent contractor basis, with Rising Medical Solutions. RX 3, p. 6. He issued a report on October 3, 2016 concerning his review of certain of Petitioner's treatment. RX 3, pp. 7-10. He reviewed records from Dr. O'Keefe, certain physical therapy notes and radiographic reports in preparing his own report. He never examined Petitioner. RX 3, p. 11. In his opinion, the range of motion measurements with orthopedic follow-ups from March 6, 2014 through March 24, 2016 were not medically necessary. The CPT code of 95851 used by the biller was a "separate evaluation and management code" which was "redundant" because range of motion measurements are part of a physical examination. This resulted in "split billing" which is not allowed. RX 3, pp. 15-16.

Dr. Brecher opined that the left shoulder and left wrist X-rays performed on March 19, 2015 were medically necessary but the cervical spine MRI of March 21, 2015 and left shoulder MR arthrogram of September 22, 2015 were not. He did not certify the cervical spine MRI because he did not have the X-rays that would have had to be performed beforehand. He did not certify the arthrogram because Petitioner had already undergone a left shoulder MRI in 2013 and her clinical picture had not changed. The five therapy sessions performed to the left shoulder through September 15, 2015 were medically necessary "because therapy is indicated for acute problems." RX 3, pp. 16-17.

Under cross-examination, Dr. Brecher testified a cervical spine MRI can be diagnostic. He non-certified the MRI because he saw no evidence of pre-MRI X-rays. He does not mean to say Petitioner would not be a candidate for an MRI in the future. RX 3, p. 19. He is not a certified bill coder. He did not review any health insurance claim forms. RX 3, p. 19. An MR arthrogram is a more sensitive test than an MRI. RX 3, pp. 19-20. He tries to treat his own patients within ODG guidelines. RX 3, p. 20. He might occasionally treat outside those guidelines, depending on a patient's needs. RX 3, p. 20. Reasonable physicians can differ as to diagnosis and treatment needs. He performs about 25 utilization reviews per week. He charges $50 per review. RX 3, p. 21.

On redirect, Dr. Brecher testified he saw no basis for Dr. O'Keefe to stray from the ODG guidelines. RX 3, p. 21.

Under re-cross, Dr. Brecher reiterated he did not examine Petitioner. RX 3, p. 22.

On January 19, 2018, Respondent filed responses to Petitioner's petition for penalties and fees. RX 6.

Respondent did not call any witnesses to testify at the hearing. Respondent offered into evidence wage records (RX 1), the evidence depositions of Drs. Bare, Brecher and Dean (RX 2-4), a print-out of claimed medical expenses that were disallowed or downcoded (RX 5 – rejected by the Arbitrator based on Petitioner's objection, T. 123-125) and its written responses to Petitioner's petition for penalties and fees (RX 6).

Arbitrator's Credibility Assessment Relative to All Cases

Petitioner exaggerated her work schedule. She was adamant that she routinely worked twelve hours a day, every day [or 84 hours per week] at Cloverhill Bakery for over a year before the first claimed accident of December 29, 2012. T. 22-25. The wage records (RX 1), to which Petitioner did not object, do not support this testimony. They show Petitioner began working at the bakery in early June 2012, about seven months before the first claimed accident. They do reflect overtime hours, in varying amounts and in many weeks, but they reflect only one week (the week ending December 15, 2012) in which Petitioner worked the kind of schedule she testified to.

This is not to suggest that the Arbitrator views Petitioner's job as slow-paced or undemanding. No one affiliated with the bakery took issue with Petitioner's testimony as to the duties she performed on the assembly line. The schedule, however, was clearly less demanding than Petitioner claimed.

Some of the providers at the Clearing Clinic described Petitioner's complaints as inconsistent with their clinical findings. PX 1. However, Dr. Shah, the hand specialist selected by the clinic, did not document any inconsistencies. When he examined Petitioner on February 8, 2013, he noted difficulty with extension and tenderness to palpation over the FCR tendon. He diagnosed FCR tendinitis and indicated Petitioner might require an injection. He viewed the elbow and neck symptoms as likely to resolve in six to eight weeks. He directed Petitioner to return to him in three weeks but she changed physicians and did not see him again.

The Arbitrator finds credible Petitioner's testimony as to the mechanics of the initial accident of December 29, 2012. That testimony is buttressed by the form she completed at the Clearing Clinic and by Dr. Shah's initial history. Both the form and the doctor's history reflect Petitioner experienced an abrupt onset of left wrist pain after lifting a specific box off the line. Petitioner's notice-related testimony was also credible. She testified she immediately reported the accident to Jose Perez and Juan Reyes. She also testified there was a delay in care because these individuals did not want to send her to the Clearing Clinic right away. The clinic records reflect that Jose Perez authorized Petitioner's initial visit to the clinic.

Also credible was Petitioner's testimony as to the mechanics of the September 23, 2013 accident. Petitioner was not entirely certain as to what struck her but she consistently described being struck with force. She identified a witness, Jorge Garcia, and testified she provided near immediate notice to the same individuals to whom she had given notice of the December 29, 2012 accident.

Dr. O'Keefe's diagnosis-related testimony was not persuasive. With respect to the left wrist, the doctor "hand picked" a radiologist, Dr. Goldstein, to read the MRI. He even indicated on the prescription form that he was looking for evidence of TFCC tearing. At his deposition, he acknowledged that an MRI "should" show such tearing. After Dr. Goldstein found no tearing, Dr. O'Keefe was forced to take a fallback position and say the doctor really did not know Petitioner's history.

Arbitrator's Conclusions of Law Relative to All Cases

Did Petitioner establish accident/repetitive trauma and timely notice?

In 13 WC 8312, the Arbitrator finds that Petitioner sustained an accident arising out of and in the course of her employment on December 29, 2012 and provided timely notice of said accident to Respondent. In so finding, the Arbitrator relies on the following: 1) Petitioner's credible testimony as to the accident and the notice she provided to her "bosses," Jose Perez and Juan Reyes (T. 27-28); 2) the "informacion ocupacional" form that appears in the Clearing Clinic records; 3) the "authorization for treatment" form that appears in the Clearing Clinic records (PX 1), with that form designating Jose Perez as the individual who authorized Petitioner's care; 4) Dr. Shah's history, which is consistent with Petitioner's account of lifting a box; and 5) the history Dr. Bare recorded in his initial report, which is also consistent with Petitioner's account.

In 13 WC 8313, the Arbitrator finds that Petitioner established repetitive trauma injuries manifesting on March 7, 2013, the date of her first visit to Dr. O'Keefe, and timely notice, via the filing of the Application on March 13, 2013. In finding repetitive trauma, the Arbitrator relies primarily on the opinions Dr. Bare expressed in his initial report of June 26, 2013. Bare Dep Exh B. Dr. Bare specifically stated that the neck and shoulder pain Petitioner developed after the initial left wrist injury was "reasonable and possible secondary to wrist injury lifting boxes." He did not find it unusual that only wrist complaints were recorded at the outset. The Arbitrator also notes that Petitioner continued working overtime after the December 29, 2012 accident, although her overtime hours began to taper off after January 10, 2013. Given that Petitioner worked 64 hours during the week after the accident and 58 hours the following week, based on RX 1, it is not surprising that her complaints would expand.

In 13 WC 32552, the Arbitrator finds that Petitioner sustained an accident arising out of and in the course of her employment on September 23, 2013 and provided timely notice of said accident to Jose Lopez and Juan Reyes. In so finding, the Arbitrator relies on the following: 1) Petitioner's credible testimony concerning the mechanics of the accident (T. 38-40); and 2) Petitioner's credible testimony concerning the near immediate oral reporting of the accident to Jose Lopez and Juan Reyes (T. 41). The Arbitrator recognizes that the history obtained by Respondent's examiner, Dr. Bare, on May 18, 2016, varies from Petitioner's testimony in that the doctor described Petitioner as being struck "on the side of the arm" rather than the upper back. The Arbitrator does not view this inconsistency as significant. Petitioner consistently described being struck by some component of the conveyor belt or other object, due to the belt breaking, and being propelled as a result.

Did Petitioner establish causal connection?

The Arbitrator views both the specific trauma of December 29, 2012 [13 WC 8312] and the repetitive work Petitioner performed thereafter [13 WC 8313] as contributing to left wrist, left shoulder and neck conditions of ill-being that required conservative care but not surgery. In so finding, the Arbitrator relies on the following: 1) Petitioner's credible denial of any left wrist, left shoulder or neck

problems before the December 29, 2012 accident; 2) the absence of any mention of pre-accident left wrist, left shoulder or neck problems; 3) the fact that Petitioner successfully worked long hours as a packer for Respondent before the accident; 4) Petitioner's credible testimony concerning the mechanics of the December 29, 2012 accident and the work she performed following this accident; 5) Petitioner's credible testimony that Respondent did not adhere to the restrictions imposed by various providers at the Clearing Clinic; 6) Respondent's wage records (RX 1), which reflect Petitioner continued working a substantial amount of overtime for about two weeks after the December 29, 2012 accident; 7) Dr. Sorokin's notes, which reflect elbow complaints as of Petitioner's second visit, on January 3, 2013; 8) the occupational therapist's note of January 7, 2013 (only ten days after the accident), which documents left shoulder and neck complaints; and 9) the opinions voiced by Dr. Bare, Respondent's examiner (Bare Dep Exh B).

The Arbitrator views the specific trauma of September 23, 2013 [13 WC 32552] as aggravating Petitioner's existing symptoms but not bringing about any substantial change in her underlying conditions. In so finding, the Arbitrator relies on Drs. O'Keefe and Bare. Neither of these physicians viewed the September 23, 2013 accident as significantly altering Petitioner's presentation.

Is Petitioner entitled to temporary total disability benefits?

Petitioner seeks two intervals of temporary total disability benefits: 1) from March 7, 2013 (the date Dr. O'Keefe first took her off work) through September 22, 2013; and 2) from September 26, 2013 (the date Dr. O'Keefe took her off work following the September 23, 2013 accident) through the hearing of February 14, 2018. Arb Exh 1-3.

In general, the Arbitrator finds Dr. O'Keefe's opinions as to Petitioner's diagnoses and treatment needs unpersuasive. The Arbitrator relies on the opinions rendered by Dr. Shah and Dr. Bare in assessing the stability of Petitioner's conditions and her entitlement to temporary total disability. Dr. Shah, a hand surgeon selected by Respondent's chosen medical facility, recommended treatment and did not find Petitioner capable of full duty. When Dr. Bare first examined Petitioner, on June 26, 2013, he recommended EMG/NCV testing, therapy and work restrictions. Bare Dep Exh B. He next examined Petitioner almost three years later, on May 18, 2016, at which point he found her to be at maximum medical improvement and capable of full duty. Bare Dep Exh C.

The Arbitrator finds that Petitioner was temporarily totally disabled from March 7, 2013 through September 22, 2013 and from September 26, 2013 through May 18, 2016 [the date of Dr. Bare's re-examination]. These two intervals total 166 3/7 weeks. The Arbitrator opts to award temporary total disability benefits in the case numbered 13 WC 8312, which involves the initial accident of December 29, 2012. Drs. O'Keefe and Bare did not view the accident of September 26, 2013 as substantially altering Petitioner's conditions.

Is Petitioner entitled to reasonable and necessary medical expenses?

Petitioner claims fee schedule and prescription expenses totaling $64,618.35 in all three cases. Arb Exh 1-3. PX 3.

The Arbitrator awards the fee schedule expenses of $26,995.24 from Central Medical Specialists and the fee schedule facility expenses of $3,101.10 from the same provider, except to the extent that these expenses include transportation-related costs. Early on, Dr. O'Keefe found Petitioner to be a

candidate for transportation but the bills are not coded in such a way as to show which charges might be for transportation. The Arbitrator sees no valid reason for Petitioner needing non-emergency transportation to routine doctor's visits. The Arbitrator also awards the fee schedule expenses of Marian Orthopedics and Rehabilitation Center through Dr. Bare's re-examination of May 18, 2016, with the same exclusion of any transportation-related expenses. Dr. Bare, Respondent's only Section 12 examiner, found all of the treatment through his 2016 re-examination to be reasonable and necessary, although he disagreed with Dr. O'Keefe's diagnoses and surgical recommendations. The Arbitrator has considered the coding-based opinions rendered by Dr. Brecher, one of the utilization review physicians, in making this award. Those opinions were not well-explained. The doctor did not take issue with the underlying care.

The Arbitrator also awards the $6,517.82 in expenses from EQMD. PX 10. These expenses relate to medication prescribed by Dr. O'Keefe between March 7, 2013 and May 12, 2015. Respondent's examiner, Dr. Bare, characterized all of the treatment to date as reasonable in his 2013 and 2016 reports. He took no issue with the medication Dr. O'Keefe prescribed and, in fact, recommended in his second report that Petitioner continue using anti-inflammatories. Bare Dep Exh C.

The Arbitrator also awards the fee schedule expenses of $1,134.39 relating to the left wrist MRI performed at MRI Lincoln Imaging Center on June 21, 2013. PX 11. While the Arbitrator finds Dr. O'Keefe's interpretation of this MRI to be unpersuasive, she finds it reasonable for the doctor to have prescribed an MRI given Petitioner's left wrist complaints, which were also noted by Dr. Shah. Furthermore, Dr. Bare expressed no criticism of the treatment to date when he first examined Petitioner on June 26, 2013. He relied on the June 21, 2013 MRI results in formulating his opinions. Bare Dep Exh B.

The Arbitrator also awards the fee schedule expenses of $2,301.22 relating to the cervical spine MRI of March 16, 2013 and the left shoulder MRI of April 23, 2013 performed at Advantage MRI. PX 4. It was reasonable for Dr. O'Keefe to have ordered these studies, given Petitioner's neck and left shoulder complaints. Dr. Bare relied on the left shoulder MRI in formulating his opinions.

The Arbitrator also awards the fee schedule expenses of $2,401.57 concerning the left shoulder MR arthrogram performed at Preferred Open MRI on September 22, 2015. The Arbitrator recognizes that Dr. Brecher did not view this study as medically necessary, since Petitioner had previously undergone a left shoulder MRI. The Arbitrator notes that the MRI was performed more than two years earlier. The Arbitrator also notes Dr. Brecher's concession, under cross-examination, that an arthrogram is a more sensitive study. Finally, Dr. Bare relied on the arthrogram in formulating his opinions.

The Arbitrator awards the foregoing expenses in the case numbered 13 WC 8312.

The Arbitrator declines to award the claimed fee schedule expenses of $1,204.71 relating to the repeat cervical spine MRI performed at Advantage MRI on March 21, 2015. PX 4. The Arbitrator notes that the first cervical MRI, performed in 2013, was negative, as noted by Dr. Chunduri, a referral from Dr. O'Keefe. Dr. Chunduri saw no need for cervical spine treatment when he examined Petitioner at Dr. O'Keefe's request.

The Arbitrator declines to award the claimed fee schedule expenses of $1,979.04 from Electronic Waveform Lab. These expenses relate to a one-year service plan for an H-wave device. The bill is dated September 6, 2013. PX 13. Dr. O'Keefe testified to prescribing such a device on November

7, 2013. He further testified the device is intended to address neuritic pain. He acknowledged the science behind the device is not understood. He described the device as "probably scrambling pain signals to the brain." PX 22, p. 39. Petitioner testified the device helped only while she was wearing it. T. 42-43. It is not clear which body part(s) the device was intended to address. Petitioner did not testify as to this. Nor did she testify to using the device over any particular period.

With respect to the various bills relating to the spine-related treatment rendered by Dr. Abdellatif, the Arbitrator awards only the $79.85 in fee schedule expenses (see PX 15, Proclinics billing and the fee schedule exhibit attached to the stipulation sheets) associated with the doctor's initial consultation of April 21, 2015. The Arbitrator relies primarily on Dr. Chunduri, a physician of Petitioner's selection, and Dr. Dean, one of Respondent's utilization review physicians, in making this award. Dr. Chunduri, to whom Petitioner was referred by Dr. O'Keefe, read the 2013 cervical spine MRI as negative and recommended no spine-related care. Dr. Dean testified Petitioner's initial consultation with Dr. Abdellatif was medically necessary but the facet and Keterolac injections that followed were not. RX 4. He opined that the facet injections administered on May 8, 2015 were not appropriate for Petitioner's reported radicular symptoms. The Arbitrator also notes that Petitioner testified to deriving only temporary relief from the injections. Additionally, Dr. Abdellatif's procedure notes can aptly be described as rambling and inaccurate, in that they document bilateral complaints. Petitioner never complained of any right-sided symptoms. Moreover, there is no evidence indicating Dr. Abdellatif asked to confer with Dr. Dean or appealed the non-certification. The Arbitrator specifically declines to award the fee schedule expenses associated with the Proclinics billing of May 21, 2015, the DuPage Immediate Care billing of May 8, 2015, the Advanced Spine Pain Clinics billing of May 8, 2015 and the DuPage Immediate Care Anesthesia of May 8, 2015.

Is Petitioner entitled to prospective left wrist and left shoulder surgery?

Petitioner last saw Dr. O'Keefe on November 29, 2016, more than a year before the hearing. At that point, the doctor was still recommending left wrist and left shoulder arthroscopies. Petitioner testified she remains symptomatic and wants to undergo these procedures.

Dr. O'Keefe's opinions concerning Petitioner's wrist diagnosis and need for surgery were not persuasive, as noted earlier. He personally designated Dr. Goldstein as the radiologist he wanted to have read the left wrist MRI and informed him, via his prescription, that he was looking for a TFCC tear. After Dr. Goldstein saw no tear on the MRI, Dr. O'Keefe was forced to say the doctor's interpretation was less likely to be correct than his own because only he had the benefit of examining Petitioner. He went on to perform a diagnostic injection that showed extravasation of dye. He viewed this finding as indicative of a TFCC tear. Dr. Shah, a hand surgeon who saw Petitioner early on, noted no tenderness over the TFCC. Dr. Shah did note other abnormalities, for which he prescribed care, but Petitioner switched to Dr. O'Keefe before this care could be provided. Petitioner had the right to choose her own doctor but her choice, in this case, was ultimately not beneficial. Like Dr. Shah, Dr. Bare never noted any specific TFCC abnormalities, although he conceded he is not a wrist specialist.

Dr. O'Keefe's opinions and treatment recommendations concerning the left shoulder were equally unpersuasive. At his deposition, he oddly characterized Petitioner's left shoulder pathology as both a sprain and a tear. He claimed that the MR arthrogram, performed on September 22, 2015, was consistent with tearing, in that it showed a "small amount of subacromial/subdeltoid bursal fluid," but the radiologist who interpreted the study described the rotator cuff, biceps, labrum and acromioclavicular joint as normal. PX 7.

The Arbitrator declines to award prospective care in the form of the left wrist and left shoulder arthroscopies recommended by Dr. O'Keefe.

Is Respondent liable for penalties and fees?

Under Illinois law, an employer bears the burden of proof when it comes to the issue of penalties and fees. The employer must establish it acted in an objectively reasonable manner in denying benefits under all of the existing circumstances. Board of Education of the City of Chicago v. Industrial Commission, 93 Ill.2d 1, 9-10 (1982). While an employer can frequently point to its Section 12 examiner as a basis for denial, Respondent cannot do so here. Its examiner, Dr. Bare, found causation and characterized all of the treatment through his May 18, 2016 re-examination as reasonable and necessary. Regardless, Respondent paid no medical expenses other than those associated with Petitioner's initial care at the Clearing Clinic. Respondent also paid no temporary total disability benefits, even though Dr. Bare recommended work restrictions at the first examination, on June 26, 2013, and did not find Petitioner to be at maximum medical improvement until May 18, 2016. Respondent took the additional step of obtaining utilization review, but only as to some aspects of Petitioner's care. Even though the reviewing physicians certified certain treatment, including X-rays performed in 2015, Respondent did not pay for it.

Respondent maintains that, regardless of the opinions of Drs. Bare, Brecher and Dean, it acted reasonably in denying all of the claimed accidents because the histories in the records vary somewhat. Respondent also maintains it had particular reason to question the last accident, of September 23, 2013, because that accident occurred on the same day Petitioner resumed working after being off for months.

The Arbitrator, having reviewed the foregoing, finds that Respondent's denial of the first claim [13 WC 8312] was not objectively reasonable. The records of Respondent's selected providers, the Clearing Clinic and Dr. Shah, corroborate Petitioner's testimony as to the mechanics of the accident. The clinic records also corroborate Petitioner's notice-related testimony. While Dr. Sorokin's initial note mentions only the left wrist, subsequent notes, created within days of the accident, document complaints to the left arm and neck. All of the providers who saw Petitioner at the clinic described her complaints as "probably" related to the work accident. Dr. Shah, a referral from the clinic, recommended treatment and work restrictions. Respondent's examiner, Dr. Bare, did not find it unusual that Petitioner's left arm and neck complaints surfaced after the left wrist injury.

In 13 WC 8312, the Arbitrator finds Respondent liable for Section 19(l) penalties in the amount of $6,360.00, with this amount representing $30/day multiplied by the 212 days between Petitioner's counsel's "demand for payment," i.e., transmission of the bills, on July 18, 2017 (PX 23) and the hearing of February 14, 2018. The Arbitrator also finds Respondent liable for Section 19(k) penalties in the amount of $2,640.00, representing 50% of the awarded temporary total disability benefits from March 7, 2013 through June 26, 2013 [$330/week x 16 weeks, or $5,280.00], and Section 16 attorney fees in the amount of $1,056.00, representing 20% of $5,280.00. The Arbitrator also finds Respondent liable for additional Section 19(k) penalties in the amount of $1,717.80, representing 50% of the awarded MRI-related fee schedule expenses of $3,435.61, and additional Section 16 attorney fees in the amount of $687.12, representing 20% of $3,435.61.

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

Belen Trujillo,

Petitioner,

vs.

NO: 13 WC 8313

20IWCC0039

Labor Network, Inc., Loaning Employer and Cloverhill Bakery, Inc., Borrowing Employer,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 2, 2018, 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

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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: JAN 21 2020
TJT:yl
o 11/19/19
51

Thomas J. Tyrrell

Maria E. Portela

DISSENT

I disagree with the majority's award of penalties and attorney's fees.

The Arbitrator awarded Section 19(l) penalties for the 212 days between Petitioner's counsel's demand for payment of medical bills, on July 18, 2017, and the hearing date of February 14, 2018. The Arbitrator awarded Section 19(k) penalties for 50% of the awarded TTD benefits, awarded from March 7, 2013, through June 26, 2013, and Section 16 attorney's fees for said period, additional Section 19(k) penalties for 50% of the awarded MRI-related fee schedule expense, and additional Section 16 attorney's fees for non-payment of said medical expense.

The relevant provisions of the Workmen's Compensation Act, pursuant to which the penalties were imposed, are:

Attorneys' Fees under Section 16

> Whenever 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 the provisions of paragraph (c) of Section 4 of this Act; or

has been guilty of unreasonable or vexatious delay, intentional underpayment 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 insurance carrier. *820 ILCS 305/16(2013).*

Penalties under Section 19(k)

In case where there has been any unreasonable or vexatious delay of payment 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. Failure to pay compensation in accordance with the provisions of Section 8, paragraph (b) of this Act, shall be considered unreasonable delay." *820 ILCS 305/19(k)(2013).*

Penalties under Section 19(*l*)

If the employee has made written demand for payment of benefits under Section 8(a) or Section 8(b), the employer shall have 14 days after receipt of the demand to set forth in writing the reason for the delay. In the case of demand for payment of medical benefits under Section 8(a), the time for the employer to respond shall not commence until the expiration of the allotted 30 days specified under Section 8.2(d). In case the employer or his or her insurance carrier shall without good and just cause fail, neglect, refuse, or unreasonably delay the payment of benefits under Section 8(a) or Section 8(b), the Arbitrator or the Commission shall allow to the employee additional compensation in the sum of $30 per day for each day that the benefits under Section 8(a) or Section 8(b) have been so withheld or refused, not to exceed $10,000. A delay in payment of 14 days or more shall create a rebuttable presumption of unreasonable delay. *820 ILCS 305/19(l)(2013).*

As the Illinois Supreme Court stated:

Although the statutory language is not uniform, it is apparent that the legislative intent is to implement the Act's purpose, *i.e.* to expedite the compensation of industrially injured workers and penalize an employer who unreasonably, or in bad faith, delays or withholds compensation due an employee. Similar provisions exist in other jurisdictions. (See 3 A. Larson, Workmen's Compensation sec. 83.40 (1980).) Penalties for delayed payment are not intended to inhibit contests of liability or appeals by employers who honestly believe an employee not entitled to

Bibliography

compensation; they are intended to promote the prompt payment of compensation where due and to deter those occasional employers or insurance carriers who might withhold payment from other than legitimate motives.

The prevailing rule is stated in 3 A. Larson, Workmen's Compensation sec. 83.40, at 15 -- 632 (1980):

"[G]enerally a failure to pay because of a good faith belief that no payment is due will not warrant a penalty."

As long as the insurer "had a legitimate doubt, from a legal standpoint, of its liability, its conduct [refusing payment] was not unreasonable." *Bourgeois v. Brown & Root, Inc.* (La. App. 1974), 303 So. 2d 217; see also *Mayes v. Genesco, Inc.* (Tenn. 1974), 510 S.W.2d 882; *Showalter v. Campbell Soup Co.* (Minn. 1977), 253 N.W.2d 154.

Avon Prods. v. Indus. Comm'n, 82 Ill. 2d 297, 412 N.E.2d 468 (1980).

In *Jacobo v. Ill. Workers" Comp. Comm'n*, the Court reviewed Illinois precedent for assessing penalties and attorneys' fees, finding penalties under Section 19(k) and attorneys' fees under Section 16 to be reserved for situations where the delay is premised on bad faith. Penalties under Section 19(l) are given heightened scrutiny and considered mandatory if the employer does not meet its burden of proving a justifiable delay. The *Jacobo* Court explained:

Penalties under Section 19(*l*) are in the nature of a late fee. *Mechanical Devices v. Industrial Comm'n*, 344 Ill. App. 3d 752, 763, 800 N.E.2d 819, 828 (2003). In addition, the assessment of a penalty under Section 19(*l*) is mandatory "[i]f the payment is late, for whatever reason, and the employer or its carrier cannot show an adequate justification for the delay." *McMahan v. Industrial Comm'n*, 183 Ill. 2d 499, 515, 702 N.E.2d 545, 552 (1998). The standard for determining whether an employer has good and just cause for a delay in payment is defined in terms of reasonableness. *Mechanical Devices*, 344 Ill. App. 3d at 763, 800 N.E.2d at 829. The employer has the burden of justifying the delay, and the employer's justification for the delay is sufficient only if a reasonable person in the employer's position would have believed that the delay was justified. *Board of Education of the City of Chicago v. Industrial Comm'n*, 93 Ill. 2d 1, 9-10, 442 N.E.2d 861, 865, 66 Ill. Dec. 300 (1982).

An award of penalties and attorney fees pursuant to Sections 19(k) and 16 are "intended to promote the prompt payment of compensation where due and to deter those occasional employers or insurance carriers who might withhold payment from other than legitimate motives." *McMahan v. Industrial Comm'n*, 289 Ill. App.

3d 1090, 1093, 683 N.E.2d 460, 463 (1997), *aff'd*, 183 Ill. 2d 499, 702 N.E.2d 545 (1998).

The standard for awarding penalties and attorney fees under Sections 19(k) and 16 of the Act is higher than the standard for awarding penalties under Section 19(*l*) because Sections 19(k) and 16 require more than an "unreasonable delay" in payment of an award. *McMahan v. Industrial Comm'n*, 183 Ill. 2d 499, 514-15, 702 N.E.2d 545, 552 (1998). It is not enough for the claimant to show that the employer simply failed, neglected, or refused to make payment or unreasonably delayed payment without good and just cause. *McMahan*, 183 Ill. 2d at 515, 702 N.E.2d at 552. Instead, Section 19(k) penalties and Section 16 fees are "intended to address situations where there is not only a delay, but the delay is deliberate or the result of bad faith or improper purpose." *McMahan*, 183 Ill. 2d at 515, 702 N.E.2d at 553. In addition, while Section 19(*l*) penalties are mandatory, the imposition of penalties and attorney fees under Sections 19(k) and Section 16 fees is discretionary. *Id.*

Jacobo v. Ill. Workers' Comp. Comm'n, 2011 IL App (3d) 100807WC, 959 N.E.2d 772, 777-778.

In the instant case, Petitioner complained solely of left-hand pain at her initial treatment at Clearing Clinic after the first accident. In subsequent visits, several different providers noted that Petitioner's symptoms were out of proportion to their objective findings. By the time of Petitioner's last visit with Dr. O'Keefe and after a myriad of diagnostics, it is apparent that the initial medical observations were credible. Based upon the unreliability of Petitioner's testimony, pain complaints, and inconsistencies in the record, I find that Respondent's non-payment of temporary total disability and medical bills was based on a good faith defense including Dr. Bare's June 23, 2013, and May 18, 2016, Section 12 opinion reports, Utilization Reviews, and responses to the Petitioner's Petitions for Immediate Hearing and Penalties and Fees. I do not find penalties under Section 19(l) or Section 19(k) or attorney's fees under Section 16 were warranted for the reasons explained below.

Section 19(k) penalties were awarded for 50% of the awarded TTD benefits for the period March 7, 2013, the Petitioner's second accident date, through June 26, 2013, the date of Dr. Bare's first Section 12 evaluation and contemporaneous report. In addition, Section 16 attorney's fees were awarded for said period. By this finding, the Arbitrator, and the majority, contend that the Respondent's delay of payment of these benefits was "deliberate or the result of bad faith or improper purpose." *McMahan*, 183 Ill. 2d at 515. To the contrary, I find that the Respondent's non-payment of TTD benefits is based on a good faith defense that was due, in part, to misrepresentations Petitioner made to her treating doctor that conflated the first and second accidents.

Petitioner testified she sustained a work injury at 8:00 p.m. on December 29, 2012, when she grabbed a box to put on the assembly line and she felt pain in her left hand. (T. pp. 26, 27)

Abstracts

Petitioner testified she reported the accident as soon as it happened because she was not able to continue working. Under cross-examination, she conceded that she completed her shift after the accident and worked the next day before she sought any medical treatment on December 31, 2012, with Dr. Sorokin at MacNeal Occupation Health. (T. pp. 27-30, 58)

On December 31, 2012, Petitioner reported to Dr. Sorokin at Clearing Clinic that "while packing, I felt pain in my left hand, the line was too fast." Dr. Sorokin noted the absence of bruising and clicking on wrist motion. He diagnosed a wrist sprain. (PX1) She never reported left arm, left shoulder or neck pain on that date. On January 3, 2013, Dr. Sorokin noted that Petitioner's symptoms appeared out of proportion to and inconsistent with the findings. Nonetheless, he released Petitioner to work with a 5 pound lifting restriction. (PX1) Respondent maintains they accommodated and could continue to accommodate her restrictions.

On January 9, 2013, Petitioner saw Dr. Carani at Clearing Clinic. Petitioner complained of pain all over her arm but she had no pain in her hand. On exam, she had no pain over her elbow on wrist flexion/extension against resistance and, notably, had no pain in her wrist at all. Her effort was noted to be poor and again her symptoms out of proportion to the findings and were noted to be inconsistent. Petitioner asked to be taken off work. She was given a 10 pound lifting restriction, analgesic balm and advised to continue Meloxicam.

On January 25, 2013, Petitioner still reported symptomatic diffuse left arm pain from the elbow down and she also reported left cervical pain. She was referred to Midwest Hand Surgery. Petitioner underwent a cervical spine x-ray at MacNeal Hospital on January 25, 2013, which was negative and showed no evidence of degenerative joint disease. (PX1)

At physical therapy on February 7, 2013, Petitioner complained of pain, numbness and tingling in her entire left arm. Petitioner saw Dr. Shah of Midwest Hand Surgery on February 8, 2013, and told him the accident occurred "while she was moving approximately a ten pound box from the conveyor belt, she felt that her wrist had bent and then she immediately noticed the symptoms." (PX2) Dr. Shah opined that her pain was likely related to flexor carp radialis (FCR) tendinitis. On exam, Petitioner exhibited no wrist instability and she reported that her elbow and neck pain improved with therapy. His office note reflects that she had a self-limiting condition that improves with splinting and anti-inflammatory medication. (PX2)

Petitioner continued to treat at MacNeal Occupational Health until February 28, 2013, and never complained of left shoulder pain. (PX1)

The Petitioner next opted to treat with Dr. John O'Keefe of Central Medical Specialist on March 7, 2013. Petitioner told Dr. O'Keefe that her injury on December 29, 2012 occurred seven hours into her shift, approximately 12:00 a.m., when she was lifting a large container weighing 20-30 pounds, filled with bread loaves, at a very fast pace (120 boxes/hour) when she felt a pop and had intense pain in her nondominant wrist.

Petitioner testified at trial she sought treatment from Dr. O'Keefe because her health had gotten worse. (T, p. 34) At the March 7, 2013, office visit Dr. O'Keefe noted that Petitioner had restrictions from the December 29, 2012, accident and her employer had her cleaning a production machine. He noted that this light duty task caused her to have intense pain in the neck, shoulder and arm. (PX3A)

Dr. O'Keefe's notes also indicate she was referred by a relative for "severe overuse symptoms" yet, according to the same office note, she was working light-duty. Petitioner testified that she decided to treat with Dr. O'Keefe because she received a pamphlet at her home; she denied that she had any relatives that treated with Dr. O'Keefe. Petitioner testified Dr. O'Keefe's records would be wrong if he stated that she was referred by a relative. (T. pp. 34, 67-68)

Petitioner testified that she was lifting repetitively after the first accident, again, contrary to what she told Dr. O'Keefe. Petitioner testified she was lifting 300 boxes per hour at her job at the time of the second accident. (T. p. 70) Petitioner further testified she was not working light duty after December 29, 2012, she was lifting the same amounts. (T. p. 72) Petitioner testified that even if Dr. O'Keefe's record reflected that she told him she was lifting lighter material, that was wrong. If Dr. O'Keefe's record indicated that her job consisted of cleaning a machine, she would not agree that was correct. She was on a packing line. (T. p. 74)

Dr. O'Keefe testified on November 17, 2016, by way of evidence deposition. (PX22) He testified that Petitioner reported she often worked 60-hour weeks, 12-hour shifts. (PX22, p. 7) The Arbitrator noted that the Petitioner's wage records did not support her testimony or this history. Petitioner reported she was working for Respondent for one year, also unsupported. Thus, the foundation of Dr. O'Keefe's understanding of the Petitioner's job is unsubstantiated.

In each of his next office visits on March 13, 2013, April 16, 2013 and on May 16, 2013, Dr. O'Keefe refers all of Petitioner's conditions to the accident on December 29, 2012, an accident that was reported to Respondent as an injury solely to her left wrist.

Dr. O'Keefe kept Petitioner off work but related her off-work status to the first accident, which was the injury reported to the left wrist. He then ordered a cervical spine MRI that was done at Advantage MRI on March 16, 2013, only days after Petitioner reported a second accident. The radiologist's impression was "cervical neural foramina and spinal canal are patent." (PX4) On April 16, 2013, Dr. O'Keefe's notes confirm the MRI of the cervical spine was ordered on March 16, 2013, and was negative for any abnormalities.

At the April visit, Dr. O'Keefe ordered an MRI of the left shoulder which revealed tendinopathy/mild partial tearing of the distal supraspinatus tendon, no full-thickness rotator cuff tear and mild subacromial bursal fluid collection suggestive of bursitis. (PX4) Three views of the left navicular performed on May 16, 2013, showed an intact wrist without fracture or subluxation. (PX3)

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When Petitioner saw Dr. Bare for the first Section 12 evaluation on June 26, 2013, he documented that Petitioner reported two separate injuries. The first was reportedly sustained on December 29, 2012, when she was packing bread when she felt a "sharp pain" to her wrist. Dr. Bare's report states that she subsequently developed neck pain and shoulder pain. Then, on March 7, 2013, she reported an injury again where repetitive reaching and lifting caused pain in the arm. Dr. Bare opined it was apparent on clinical examination that her shoulder was not the source of pain. He opined that it could be her neck or wrist noting that the original diagnosis was a wrist sprain. He recommended the EMG/NCV to rule out nerve impingement or neuropathology. He opined that she did not need any other diagnostic tests except an EMG/NCS. Further, Petitioner did not require any temporary or permanent restrictions. (RX2, p. 3) He imposed a 10 pound lifting restriction due to her wrist splint.

When Dr. Bare testified, he described Petitioner's diagnosis as "vague" when he examined her on June 26, 2013. He testified that Petitioner complained of a lot of pain, but he did not note any objective findings other than a complaint of tenderness to palpation. (RX. pp. 15-16) This was consistent with Dr. Shah's findings.

In fact, on June 20, 2013, Petitioner underwent an EMG/NCS of the left upper extremity which revealed, "No evidence of left peripheral entrapment neuropathy or cervical radiculopathy present at this time." A second EMG/NCV was performed on October 9, 2013 that was again normal, with full recruitment pattern present and confirmed that there was no evidence of left cervical radiculopathy or peripheral entrapment neuropathy present.

The evidence shows that Petitioner initially complained of left wrist and forearm pain as a result of the accident of December 29, 2012. Approximately one month after the accident, Dr. Davidson at Clearing Clinic noted that Petitioner had diffuse left arm pain from the elbow down. She also reported cervical/thoracic pain, but this was not a result of the wrist injury. There is no medical evidence that she voiced shoulder complaints until March 7, 2013. Dr. Shah's February 8, 2013, office note history reflects that Petitioner told him that her neck pain as well as her elbow pain "is nearly resolved with therapy." Dr. Shah's assessment and plan also stated "I cannot for sure state that her current symptoms are completely related to her injury that she sustained at work. (PX2) The complaints when Petitioner saw Dr. O'Keefe on March 7, 2013, "for neck, left shoulder and left arm severe overuse symptoms" did not comport with the Petitioner's original left wrist and forearm complaints. The medical records from March 7, 2013, are inconsistent in that Petitioner describes her accident of December 29, 2012, but also the records relate she was reaching behind a machine. This inconsistency as to the mechanism of the second accident creates an adequate justification to deny TTD payments from March 7, 2013, through June 26, 2013. Thus, I disagree with the majority that Section 19(k) penalties and Section 16 attorney's fees are appropriate for non-payment of TTD benefits from March 7, 2013, through June 26, 2013.

Additional section 19(k) penalties were imposed for 50% of the awarded March 16, 2013 cervical spine MRI-related fee schedule expense, 50% of the June 21, 2013 left wrist MRI fee

Contents

schedule expense and 50% of the April 23, 2013, left shoulder MRI fee schedule expense, plus Section 16 attorney's fees were awarded for non-payment of said medical expenses.

I find that Respondent's non-payment of these bills was not vexatious or the result of bad faith for all the reasons referenced above. Imposition of section 19(k) penalties and section 16 attorney's fees is discretionary. *McMahan v. Industrial Comm'n*, 183 Ill. 2d 499, 515. Given the afore-referenced facts, penalties and fees are not warranted in this case. The very foundation of Dr. O'Keefe's opinions was flawed, and, therefore, not credible and entitled to little weight. *See, e.g.*, *Sunny Hill of Will County v. Ill. Workers' Comp. Comm'n*, 2014 IL App (3d) 130028WC, 14 N.E.3d 16 (Expert opinions must be supported by facts and are only as valid as the facts underlying them.) Dr. O'Keefe's surgical treatment recommendations have been rejected by the majority for this very reason. In retrospect, the diagnostics he ordered were deemed to be reasonable only to the extent that they supported the original diagnosis of a left wrist sprain and that Petitioner's subjective complaints were not supported by the objective findings.

Finally, by awarding Section 19(l) penalties for the 212 days between Petitioner's counsel's demand for payment of medical bills, on July 18, 2017, and the hearing date of February 14, 2018, the majority finds that the employer's justification for the delay in this case does not meet the standard where "a reasonable person in the employer's position would have believed that the delay was justified." I disagree.

Section 19(l) requires an employer to reply to Petitioner's demand for payment of benefits under Section 8(a) or 8(b) within 14 days in writing. The Respondent filed multiple responses comporting with the strictures of Section 19(l). The Petitioner entered into evidence Petitioner's Exhibit 23, a copy of an email that was sent to Respondent's attorney on July 18, 2017 that purports to have attached a copy of outstanding medical bills and corresponding fee schedule analysis. The email then lists the bills and the amounts allegedly owed per the fee schedule. I note, however, that the medical bills that were purportedly attached to the email were not included in the exhibit and thus not entered into evidence.

I also note that the Respondent's Response to Petitioner's Penalties and Fees Petition, filed on January 19, 2018, ten days after the Petitioner's Petition was filed, alleges that Respondent "does not possess all bills for medical treatment replete with the required data elements (*i.e.*, CPT codes) and therefore demands the same from Petitioner."

The Respondent had also filed multiple responses to Petitioner's Petitions for Immediate Hearing under Section 19(b) of the Act. (RX6) In each of those responses, Respondent's attorney noted that with respect to issue number 8, "Medical bills in dispute," there were no attachments with the Petition and that CPT codes were required. Similarly, the responses noted that no attachments from medical providers were included with the Petitions for Hearing, and no dates of treatment listed.

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Section 19(l) clearly states that in the case of demand for payment of medical benefits under Section 8(a), the time for the employer to respond shall not commence until the expiration of the allotted 30 days specified under Section 8.2(d). I find that Section 19(l) must be read and considered in conjunction with Section 8.2(d). Section 8.2(d)2 requires "If the claim does not contain substantially all the required data elements necessary to adjudicate the bills, or the claim is denied for any other reason, in whole or in part, the employer or the insurer shall provide written notification, explaining the basis for the denial and describing any additional necessary data elements, to the provider within 30 days of receipt of the bill." *820 ILCS 305/8.2(2013).*

In this case, the Respondent maintained that they never had all the required data necessary to adjudicate the bills. Further, many of the bills were denied based on Dr. Bare's June 26, 2013, opinion that no additional diagnostics were warranted. By not tendering the attachments to the email, there is no evidence in the record confirming which bills, if any, were tendered at the time of the email that contained the elements necessary to adjudicate the bills. Respondent's responses to Petitioner's Petitions for Immediate Hearing, and to the Petitioner's Petitions for Penalties and Fees maintain the data was not included.

Further, on October 16, 2016, Dr. Sammy Dean performed a Utilization Review regarding the Petitioner's treatment and non-certified treatment recommended by the pain management doctor. Dr. Dean's deposition was taken on December 19, 2017, and he testified consistent with his report that a cervical spine nerve block performed on May 8, 2015, and the Keterolac injection performed on May 21, 2015, were not medically necessary. (RX 4) Other treatment including specific charges for range of motion measurements, the March 21, 2015, cervical spine MRI, and the September 22, 2015, left shoulder MRI arthrogram, were non-certified as medically necessary by Dr. Brecher. (RX3) Under Section 8.7 of the Act, when payment for medical services had been denied pursuant to Utilization Review, the employee has the burden of proof to show by a preponderance of the evidence that a variance from the standards of care used by the person or entity performing the Utilization Review is reasonably required to cure or relieve the effects of the injury. *820 ILCS 305/8.7(2013).*

With respect to the Arbitrator's award of Section 19(l) penalties for the 212 days between Petitioner's counsel's demand for payment of medical bills, on July 18, 2017, and the hearing date of February 14, 2018, I disagree penalties are warranted.

Based on the foregoing, including disputes regarding accident, causal connection, reasonableness and necessity of medical treatment, and work restrictions, the Respondent's denial of benefits as referenced was premised on a good faith dispute and was reasonable.

Therefore, I respectfully disagree with the majority in awarding penalties under Section 19(l), Section 19(k) or attorney's fees under Section 16 as a result of any of the Petitioner's three cases.

Kathryn A. Doerries

50IACC038

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

TRUJILLO, BELEN
Employee/Petitioner

Case# **13WC008313**

13WC008312
13WC032552

LABOR NETWORK INC LOANING EMPLOYER AND CLOVERHILL BAKERY INC BORROWING EMPLOYER
Employer/Respondent

20IWCC0039

On 4/2/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.89% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

1922 SALK, STEVEN B & ASSOC LTD
ALEXANDRA BRODERICK
150 N WACKER DR SUITE 2570
CHICAGO, IL 60606

5001 GAIDO & FINTZEN
ALEX OTTENHEIMER
30 N LASALLE ST SUITE 3010
CHICAGO, IL 60602

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

20IWCC0039

☒ 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

Case # **13** WC **08313**

Belen Trujillo
Employee/Petitioner

v.

Consolidated cases: **13 WC 08312**
13 WC 32552

Labor Network, Inc., loaning employer and Clover Hill Bakery, borrowing employer

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 **Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **2/14/2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☒ 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**

20IWCC0039

FINDINGS

On **3/7/13**, 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.

For the reasons set forth in the attached decision, the Arbitrator finds that Petitioner established repetitive trauma injuries manifesting on March 7, 2013, the date of her first visit to Dr. O'Keefe.

Timely notice of these injuries ***was*** given to Respondent.

For the reasons set forth in the attached decision, the Arbitrator views the repetitive trauma injuries manifesting on March 7, 2013 as contributing to Petitioner's left wrist, left shoulder and neck conditions, with those conditions requiring conservative care through May 18, 2016, the date of Dr. Bare's re-examination. Bare Dep Exh C. The Arbitrator further finds Petitioner failed to establish causation as to the need for the left wrist and left shoulder surgeries recommended by Dr. O'Keefe.

Petitioner's average weekly wage was $**428.56**.

On the date of accident, Petitioner was **36** years of age, ***married*** with **5** dependent children.

Petitioner ***has in part*** received reasonable and necessary medical services.

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

Respondent shall be given a credit of $**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

See the decision in 13 WC 8312 for the Arbitrator's award.

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

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

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

Molly C Mason

Signature of Arbitrator

3/28/18
Date

APR 2 - 2018

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

Belen Trujillo,

Petitioner,

vs.

NO: 13 WC 32552

Labor Network, Inc., Loaning Employer and Cloverhill Bakery, Inc., Borrowing Employer,

Respondent.

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DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 2, 2018, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired

without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

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

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

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

DATED: JAN 2 1 2020
TJT:yl
o 11/19/19
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Thomas J. Tyrrell

Maria E. Portela

DISSENT

I disagree with the majority's award of penalties and attorney's fees.

The Arbitrator awarded Section 19(l) penalties for the 212 days between Petitioner's counsel's demand for payment of medical bills, on July 18, 2017, and the hearing date of February 14, 2018. The Arbitrator awarded Section 19(k) penalties for 50% of the awarded TTD benefits, awarded from March 7, 2013, through June 26, 2013, and Section 16 attorney's fees for said period, additional Section 19(k) penalties for 50% of the awarded MRI-related fee schedule expense, and additional Section 16 attorney's fees for non-payment of said medical expense.

The relevant provisions of the Workmen's Compensation Act, pursuant to which the penalties were imposed, are:

Attorneys' Fees under Section 16

> Whenever 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

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within the purview of the provisions of paragraph (c) of Section 4 of this Act; or has been guilty of unreasonable or vexatious delay, intentional underpayment 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 insurance carrier. *820 ILCS 305/16(2013).*

Penalties under Section 19(k)

In case where there has been any unreasonable or vexatious delay of payment 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. Failure to pay compensation in accordance with the provisions of Section 8, paragraph (b) of this Act, shall be considered unreasonable delay." *820 ILCS 305/19(k)(2013).*

Penalties under Section 19(*l*)

If the employee has made written demand for payment of benefits under Section 8(a) or Section 8(b), the employer shall have 14 days after receipt of the demand to set forth in writing the reason for the delay. In the case of demand for payment of medical benefits under Section 8(a), the time for the employer to respond shall not commence until the expiration of the allotted 30 days specified under Section 8.2(d). In case the employer or his or her insurance carrier shall without good and just cause fail, neglect, refuse, or unreasonably delay the payment of benefits under Section 8(a) or Section 8(b), the Arbitrator or the Commission shall allow to the employee additional compensation in the sum of $30 per day for each day that the benefits under Section 8(a) or Section 8(b) have been so withheld or refused, not to exceed $10,000. A delay in payment of 14 days or more shall create a rebuttable presumption of unreasonable delay. *820 ILCS 305/19(l)(2013).*

As the Illinois Supreme Court stated:

Although the statutory language is not uniform, it is apparent that the legislative intent is to implement the Act's purpose, *i.e.* to expedite the compensation of industrially injured workers and penalize an employer who unreasonably, or in bad faith, delays or withholds compensation due an employee. Similar provisions exist in other jurisdictions. (See 3 A. Larson, Workmen's Compensation sec. 83.40 (1980).) Penalties for delayed payment are not intended to inhibit contests of

OBJECTIVES

liability or appeals by employers who honestly believe an employee not entitled to compensation; they are intended to promote the prompt payment of compensation where due and to deter those occasional employers or insurance carriers who might withhold payment from other than legitimate motives.

The prevailing rule is stated in 3 A. Larson, Workmen's Compensation sec. 83.40, at 15 -- 632 (1980):

"[G]enerally a failure to pay because of a good faith belief that no payment is due will not warrant a penalty."

As long as the insurer "had a legitimate doubt, from a legal standpoint, of its liability, its conduct [refusing payment] was not unreasonable." *Bourgeois v. Brown & Root, Inc.* (La. App. 1974), 303 So. 2d 217; see also *Mayes v. Genesco, Inc.* (Tenn. 1974), 510 S.W.2d 882; *Showalter v. Campbell Soup Co.* (Minn. 1977), 253 N.W.2d 154.

Avon Prods. v. Indus. Comm'n, 82 Ill. 2d 297, 412 N.E.2d 468 (1980).

In *Jacobo v. Ill. Workers" Comp. Comm'n*, the Court reviewed Illinois precedent for assessing penalties and attorneys' fees, finding penalties under Section 19(k) and attorneys' fees under Section 16 to be reserved for situations where the delay is premised on bad faith. Penalties under Section 19(l) are given heightened scrutiny and considered mandatory if the employer does not meet its burden of proving a justifiable delay. The *Jacobo* Court explained:

Penalties under Section 19(*l*) are in the nature of a late fee. *Mechanical Devices v. Industrial Comm'n*, 344 Ill. App. 3d 752, 763, 800 N.E.2d 819, 828 (2003). In addition, the assessment of a penalty under Section 19(*l*) is mandatory "[i]f the payment is late, for whatever reason, and the employer or its carrier cannot show an adequate justification for the delay." *McMahan v. Industrial Comm'n*, 183 Ill. 2d 499, 515, 702 N.E.2d 545, 552 (1998). The standard for determining whether an employer has good and just cause for a delay in payment is defined in terms of reasonableness. *Mechanical Devices*, 344 Ill. App. 3d at 763, 800 N.E.2d at 829. The employer has the burden of justifying the delay, and the employer's justification for the delay is sufficient only if a reasonable person in the employer's position would have believed that the delay was justified. *Board of Education of the City of Chicago v. Industrial Comm'n*, 93 Ill. 2d 1, 9-10, 442 N.E.2d 861, 865, 66 Ill. Dec. 300 (1982).

An award of penalties and attorney fees pursuant to Sections 19(k) and 16 are "intended to promote the prompt payment of compensation where due and to deter those occasional employers or insurance carriers who might withhold payment

Introduction 1

Chapter 1 5

Chapter 2 12

Chapter 3 20

Chapter 4 28

Chapter 5 35

Chapter 6 42

Chapter 7 50

Chapter 8 57

Chapter 9 65

Chapter 10 73

Chapter 11 80

Chapter 12 88

Chapter 13 95

Chapter 14 103

Chapter 15 110

Chapter 16 118

Chapter 17 125

Chapter 18 133

Chapter 19 140

Chapter 20 148

Chapter 21 155

Chapter 22 163

Chapter 23 170

Chapter 24 178

Chapter 25 185

Chapter 26 193

Chapter 27 200

Chapter 28 208

Chapter 29 215

Chapter 30 223

Chapter 31 230

Chapter 32 238

Chapter 33 245

Chapter 34 253

Chapter 35 260

Chapter 36 268

Chapter 37 275

Chapter 38 283

Chapter 39 290

Chapter 40 298

Chapter 41 305

Chapter 42 313

Chapter 43 320

Chapter 44 328

Chapter 45 335

Chapter 46 343

Chapter 47 350

Chapter 48 358

Chapter 49 365

Chapter 50 373

Chapter 51 380

Chapter 52 388

Chapter 53 395

Chapter 54 403

Chapter 55 410

Chapter 56 418

Chapter 57 425

Chapter 58 433

Chapter 59 440

Chapter 60 448

Chapter 61 455

Chapter 62 463

Chapter 63 470

Chapter 64 478

Chapter 65 485

Chapter 66 493

Chapter 67 500

Chapter 68 508

Chapter 69 515

Chapter 70 523

Chapter 71 530

Chapter 72 538

Chapter 73 545

Chapter 74 553

Chapter 75 560

Chapter 76 568

Chapter 77 575

Chapter 78 583

Chapter 79 590

Chapter 80 598

Chapter 81 605

Chapter 82 613

Chapter 83 620

Chapter 84 628

Chapter 85 635

Chapter 86 643

Chapter 87 650

Chapter 88 658

Chapter 89 665

Chapter 90 673

Chapter 91 680

Chapter 92 688

Chapter 93 695

Chapter 94 703

Chapter 95 710

Chapter 96 718

Chapter 97 725

Chapter 98 733

Chapter 99 740

Chapter 100 748

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from other than legitimate motives." *McMahan v. Industrial Comm'n*, 289 Ill. App. 3d 1090, 1093, 683 N.E.2d 460, 463 (1997), *aff'd*, 183 Ill. 2d 499, 702 N.E.2d 545 (1998).

The standard for awarding penalties and attorney fees under Sections 19(k) and 16 of the Act is higher than the standard for awarding penalties under Section 19(*l*) because Sections 19(k) and 16 require more than an "unreasonable delay" in payment of an award. *McMahan v. Industrial Comm'n*, 183 Ill. 2d 499, 514-15, 702 N.E.2d 545, 552 (1998). It is not enough for the claimant to show that the employer simply failed, neglected, or refused to make payment or unreasonably delayed payment without good and just cause. *McMahan*, 183 Ill. 2d at 515, 702 N.E.2d at 552. Instead, Section 19(k) penalties and Section 16 fees are "intended to address situations where there is not only a delay, but the delay is deliberate or the result of bad faith or improper purpose." *McMahan*, 183 Ill. 2d at 515, 702 N.E.2d at 553. In addition, while Section 19(*l*) penalties are mandatory, the imposition of penalties and attorney fees under Sections 19(k) and Section 16 fees is discretionary. *Id.*

Jacobo v. Ill. Workers' Comp. Comm'n, 2011 IL App (3d) 100807WC, 959 N.E.2d 772, 777-778.

In the instant case, Petitioner complained solely of left-hand pain at her initial treatment at Clearing Clinic after the first accident. In subsequent visits, several different providers noted that Petitioner's symptoms were out of proportion to their objective findings. By the time of Petitioner's last visit with Dr. O'Keefe and after a myriad of diagnostics, it is apparent that the initial medical observations were credible. Based upon the unreliability of Petitioner's testimony, pain complaints, and inconsistencies in the record, I find that Respondent's non-payment of temporary total disability and medical bills was based on a good faith defense including Dr. Bare's June 23, 2013, and May 18, 2016, Section 12 opinion reports, Utilization Reviews, and responses to the Petitioner's Petitions for Immediate Hearing and Penalties and Fees. I do not find penalties under Section 19(l) or Section 19(k) or attorney's fees under Section 16 were warranted for the reasons explained below.

Section 19(k) penalties were awarded for 50% of the awarded TTD benefits for the period March 7, 2013, the Petitioner's second accident date, through June 26, 2013, the date of Dr. Bare's first Section 12 evaluation and contemporaneous report. In addition, Section 16 attorney's fees were awarded for said period. By this finding, the Arbitrator, and the majority, contend that the Respondent's delay of payment of these benefits was "deliberate or the result of bad faith or improper purpose." *McMahan*, 183 Ill. 2d at 515. To the contrary, I find that the Respondent's non-payment of TTD benefits is based on a good faith defense that was due, in part, to misrepresentations Petitioner made to her treating doctor that conflated the first and second accidents.

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Petitioner testified she sustained a work injury at 8:00 p.m. on December 29, 2012, when she grabbed a box to put on the assembly line and she felt pain in her left hand. (T. pp. 26, 27) Petitioner testified she reported the accident as soon as it happened because she was not able to continue working. Under cross-examination, she conceded that she completed her shift after the accident and worked the next day before she sought any medical treatment on December 31, 2012, with Dr. Sorokin at MacNeal Occupation Health. (T. pp. 27-30, 58)

On December 31, 2012, Petitioner reported to Dr. Sorokin at Clearing Clinic that "while packing, I felt pain in my left hand, the line was too fast." Dr. Sorokin noted the absence of bruising and clicking on wrist motion. He diagnosed a wrist sprain. (PX1) She never reported left arm, left shoulder or neck pain on that date. On January 3, 2013, Dr. Sorokin noted that Petitioner's symptoms appeared out of proportion to and inconsistent with the findings. Nonetheless, he released Petitioner to work with a 5 pound lifting restriction. (PX1) Respondent maintains they accommodated and could continue to accommodate her restrictions.

On January 9, 2013, Petitioner saw Dr. Carani at Clearing Clinic. Petitioner complained of pain all over her arm but she had no pain in her hand. On exam, she had no pain over her elbow on wrist flexion/extension against resistance and, notably, had no pain in her wrist at all. Her effort was noted to be poor and again her symptoms out of proportion to the findings and were noted to be inconsistent. Petitioner asked to be taken off work. She was given a 10 pound lifting restriction, analgesic balm and advised to continue Meloxicam.

On January 25, 2013, Petitioner still reported symptomatic diffuse left arm pain from the elbow down and she also reported left cervical pain. She was referred to Midwest Hand Surgery. Petitioner underwent a cervical spine x-ray at MacNeal Hospital on January 25, 2013, which was negative and showed no evidence of degenerative joint disease. (PX1)

At physical therapy on February 7, 2013, Petitioner complained of pain, numbness and tingling in her entire left arm. Petitioner saw Dr. Shah of Midwest Hand Surgery on February 8, 2013, and told him the accident occurred "while she was moving approximately a ten pound box from the conveyor belt, she felt that her wrist had bent and then she immediately noticed the symptoms." (PX2) Dr. Shah opined that her pain was likely related to flexor carp radialis (FCR) tendinitis. On exam, Petitioner exhibited no wrist instability and she reported that her elbow and neck pain improved with therapy. His office note reflects that she had a self-limiting condition that improves with splinting and anti-inflammatory medication. (PX2)

Petitioner continued to treat at MacNeal Occupational Health until February 28, 2013, and never complained of left shoulder pain. (PX1)

The Petitioner next opted to treat with Dr. John O'Keefe of Central Medical Specialist on March 7, 2013. Petitioner told Dr. O'Keefe that her injury on December 29, 2012 occurred seven hours into her shift, approximately 12:00 a.m., when she was lifting a large container weighing

20-30 pounds, filled with bread loaves, at a very fast pace (120 boxes/hour) when she felt a pop and had intense pain in her nondominant wrist.

Petitioner testified at trial she sought treatment from Dr. O'Keefe because her health had gotten worse. (T, p. 34) At the March 7, 2013, office visit Dr. O'Keefe noted that Petitioner had restrictions from the December 29, 2012, accident and her employer had her cleaning a production machine. He noted that this light duty task caused her to have intense pain in the neck, shoulder and arm. (PX3A)

Dr. O'Keefe's notes also indicate she was referred by a relative for "severe overuse symptoms" yet, according to the same office note, she was working light-duty. Petitioner testified that she decided to treat with Dr. O'Keefe because she received a pamphlet at her home; she denied that she had any relatives that treated with Dr. O'Keefe. Petitioner testified Dr. O'Keefe's records would be wrong if he stated that she was referred by a relative. (T. pp. 34, 67-68)

Petitioner testified that she was lifting repetitively after the first accident, again, contrary to what she told Dr. O'Keefe. Petitioner testified she was lifting 300 boxes per hour at her job at the time of the second accident. (T. p. 70) Petitioner further testified she was not working light duty after December 29, 2012, she was lifting the same amounts. (T. p. 72) Petitioner testified that even if Dr. O'Keefe's record reflected that she told him she was lifting lighter material, that was wrong. If Dr. O'Keefe's record indicated that her job consisted of cleaning a machine, she would not agree that was correct. She was on a packing line. (T. p. 74)

Dr. O'Keefe testified on November 17, 2016, by way of evidence deposition. (PX22) He testified that Petitioner reported she often worked 60-hour weeks, 12-hour shifts. (PX22, p. 7) The Arbitrator noted that the Petitioner's wage records did not support her testimony or this history. Petitioner reported she was working for Respondent for one year, also unsupported. Thus, the foundation of Dr. O'Keefe's understanding of the Petitioner's job is unsubstantiated.

In each of his next office visits on March 13, 2013, April 16, 2013 and on May 16, 2013, Dr. O'Keefe refers all of Petitioner's conditions to the accident on December 29, 2012, an accident that was reported to Respondent as an injury solely to her left wrist.

Dr. O'Keefe kept Petitioner off work but related her off-work status to the first accident, which was the injury reported to the left wrist. He then ordered a cervical spine MRI that was done at Advantage MRI on March 16, 2013, only days after Petitioner reported a second accident. The radiologist's impression was "cervical neural foramina and spinal canal are patent." (PX4) On April 16, 2013, Dr. O'Keefe's notes confirm the MRI of the cervical spine was ordered on March 16, 2013, and was negative for any abnormalities.

At the April visit, Dr. O'Keefe ordered an MRI of the left shoulder which revealed tendinopathy/mild partial tearing of the distal supraspinatus tendon, no full-thickness rotator cuff tear and mild subacromial bursal fluid collection suggestive of bursitis. (PX4) Three views of the

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left navicular performed on May 16, 2013, showed an intact wrist without fracture or subluxation. (PX3)

When Petitioner saw Dr. Bare for the first Section 12 evaluation on June 26, 2013, he documented that Petitioner reported two separate injuries. The first was reportedly sustained on December 29, 2012, when she was packing bread when she felt a "sharp pain" to her wrist. Dr. Bare's report states that she subsequently developed neck pain and shoulder pain. Then, on March 7, 2013, she reported an injury again where repetitive reaching and lifting caused pain in the arm. Dr. Bare opined it was apparent on clinical examination that her shoulder was not the source of pain. He opined that it could be her neck or wrist noting that the original diagnosis was a wrist sprain. He recommended the EMG/NCV to rule out nerve impingement or neuropathology. He opined that she did not need any other diagnostic tests except an EMG/NCS. Further, Petitioner did not require any temporary or permanent restrictions. (RX2, p. 3) He imposed a 10 pound lifting restriction due to her wrist splint.

When Dr. Bare testified, he described Petitioner's diagnosis as "vague" when he examined her on June 26, 2013. He testified that Petitioner complained of a lot of pain, but he did not note any objective findings other than a complaint of tenderness to palpation. (RX. pp. 15-16) This was consistent with Dr. Shah's findings.

In fact, on June 20, 2013, Petitioner underwent an EMG/NCS of the left upper extremity which revealed, "No evidence of left peripheral entrapment neuropathy or cervical radiculopathy present at this time." A second EMG/NCV was performed on October 9, 2013 that was again normal, with full recruitment pattern present and confirmed that there was no evidence of left cervical radiculopathy or peripheral entrapment neuropathy present.

The evidence shows that Petitioner initially complained of left wrist and forearm pain as a result of the accident of December 29, 2012. Approximately one month after the accident, Dr. Davidson at Clearing Clinic noted that Petitioner had diffuse left arm pain from the elbow down. She also reported cervical/thoracic pain, but this was not a result of the wrist injury. There is no medical evidence that she voiced shoulder complaints until March 7, 2013. Dr. Shah's February 8, 2013, office note history reflects that Petitioner told him that her neck pain as well as her elbow pain "is nearly resolved with therapy." Dr. Shah's assessment and plan also stated "I cannot for sure state that her current symptoms are completely related to her injury that she sustained at work. (PX2) The complaints when Petitioner saw Dr. O'Keefe on March 7, 2013, "for neck, left shoulder and left arm severe overuse symptoms" did not comport with the Petitioner's original left wrist and forearm complaints. The medical records from March 7, 2013, are inconsistent in that Petitioner describes her accident of December 29, 2012, but also the records relate she was reaching behind a machine. This inconsistency as to the mechanism of the second accident creates an adequate justification to deny TTD payments from March 7, 2013, through June 26, 2013. Thus, I disagree with the majority that Section 19(k) penalties and Section 16 attorney's fees are appropriate for non-payment of TTD benefits from March 7, 2013, through June 26, 2013.

Additional section 19(k) penalties were imposed for 50% of the awarded March 16, 2013 cervical spine MRI-related fee schedule expense, 50% of the June 21, 2013 left wrist MRI fee schedule expense and 50% of the April 23, 2013, left shoulder MRI fee schedule expense, plus Section 16 attorney's fees were awarded for non-payment of said medical expenses.

I find that Respondent's non-payment of these bills was not vexatious or the result of bad faith for all the reasons referenced above. Imposition of section 19(k) penalties and section 16 attorney's fees is discretionary. *McMahan v. Industrial Comm'n*, 183 Ill. 2d 499, 515. Given the afore-referenced facts, penalties and fees are not warranted in this case. The very foundation of Dr. O'Keefe's opinions was flawed, and, therefore, not credible and entitled to little weight. *See, e.g.*, *Sunny Hill of Will County v. Ill. Workers' Comp. Comm'n*, 2014 IL App (3d) 130028WC, 14 N.E.3d 16 (Expert opinions must be supported by facts and are only as valid as the facts underlying them.) Dr. O'Keefe's surgical treatment recommendations have been rejected by the majority for this very reason. In retrospect, the diagnostics he ordered were deemed to be reasonable only to the extent that they supported the original diagnosis of a left wrist sprain and that Petitioner's subjective complaints were not supported by the objective findings.

Finally, by awarding Section 19(l) penalties for the 212 days between Petitioner's counsel's demand for payment of medical bills, on July 18, 2017, and the hearing date of February 14, 2018, the majority finds that the employer's justification for the delay in this case does not meet the standard where "a reasonable person in the employer's position would have believed that the delay was justified." I disagree.

Section 19(l) requires an employer to reply to Petitioner's demand for payment of benefits under Section 8(a) or 8(b) within 14 days in writing. The Respondent filed multiple responses comporting with the strictures of Section 19(l). The Petitioner entered into evidence Petitioner's Exhibit 23, a copy of an email that was sent to Respondent's attorney on July 18, 2017 that purports to have attached a copy of outstanding medical bills and corresponding fee schedule analysis. The email then lists the bills and the amounts allegedly owed per the fee schedule. I note, however, that the medical bills that were purportedly attached to the email were not included in the exhibit and thus not entered into evidence.

I also note that the Respondent's Response to Petitioner's Penalties and Fees Petition, filed on January 19, 2018, ten days after the Petitioner's Petition was filed, alleges that Respondent "does not possess all bills for medical treatment replete with the required data elements (*i.e.*, CPT codes) and therefore demands the same from Petitioner."

The Respondent had also filed multiple responses to Petitioner's Petitions for Immediate Hearing under Section 19(b) of the Act. (RX6) In each of those responses, Respondent's attorney noted that with respect to issue number 8, "Medical bills in dispute," there were no attachments with the Petition and that CPT codes were required. Similarly, the responses noted that no attachments from medical providers were included with the Petitions for Hearing, and no dates of treatment listed.

Uncontrolled

20IWCC0040

Section 19(l) clearly states that in the case of demand for payment of medical benefits under Section 8(a), the time for the employer to respond shall not commence until the expiration of the allotted 30 days specified under Section 8.2(d). I find that Section 19(l) must be read and considered in conjunction with Section 8.2(d). Section 8.2(d)2 requires "If the claim does not contain substantially all the required data elements necessary to adjudicate the bills, or the claim is denied for any other reason, in whole or in part, the employer or the insurer shall provide written notification, explaining the basis for the denial and describing any additional necessary data elements, to the provider within 30 days of receipt of the bill." *820 ILCS 305/8.2(2013).*

In this case, the Respondent maintained that they never had all the required data necessary to adjudicate the bills. Further, many of the bills were denied based on Dr. Bare's June 26, 2013, opinion that no additional diagnostics were warranted. By not tendering the attachments to the email, there is no evidence in the record confirming which bills, if any, were tendered at the time of the email that contained the elements necessary to adjudicate the bills. Respondent's responses to Petitioner's Petitions for Immediate Hearing, and to the Petitioner's Petitions for Penalties and Fees maintain the data was not included.

Further, on October 16, 2016, Dr. Sammy Dean performed a Utilization Review regarding the Petitioner's treatment and non-certified treatment recommended by the pain management doctor. Dr. Dean's deposition was taken on December 19, 2017, and he testified consistent with his report that a cervical spine nerve block performed on May 8, 2015, and the Keterolac injection performed on May 21, 2015, were not medically necessary. (RX 4) Other treatment including specific charges for range of motion measurements, the March 21, 2015, cervical spine MRI, and the September 22, 2015, left shoulder MRI arthrogram, were non-certified as medically necessary by Dr. Brecher. (RX3) Under Section 8.7 of the Act, when payment for medical services had been denied pursuant to Utilization Review, the employee has the burden of proof to show by a preponderance of the evidence that a variance from the standards of care used by the person or entity performing the Utilization Review is reasonably required to cure or relieve the effects of the injury. *820 ILCS 305/8.7(2013).*

With respect to the Arbitrator's award of Section 19(l) penalties for the 212 days between Petitioner's counsel's demand for payment of medical bills, on July 18, 2017, and the hearing date of February 14, 2018, I disagree penalties are warranted.

Based on the foregoing, including disputes regarding accident, causal connection, reasonableness and necessity of medical treatment, and work restrictions, the Respondent's denial of benefits as referenced was premised on a good faith dispute and was reasonable.

20IWCC0040

Therefore, I respectfully disagree with the majority in awarding penalties under Section 19(l), Section 19(k) or attorney's fees under Section 16 as a result of any of the Petitioner's three cases.

Kathryn A. Doerries

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

TRUJILLO, BELEN
Employee/Petitioner

Case# **13WC032552**

13WC008312
13WC008313

LABOR NETWORK INC LOANING EMPLOYER AND CLOVERHILL BAKERY INC BORROWING EMPLOYER
Employer/Respondent

20IWCC0040

On 4/2/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.89% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

1922 SALK, STEVEN B & ASSOC LTD
ALEXANDRA BRODERICK
150 N WACKER DR SUITE 2570
CHICAGO, IL 60606

5001 GAIDO & FINTZEN
ALEX OTTENHEIMER
30 N LASALLE ST SUITE 3010
CHICAGO, IL 60602

20 IWCC0040

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
19(B) ARBITRATION DECISION

Case # **13** WC **32552**

Belen Trujillo
Employee/Petitioner

v.

Consolidated cases: **13 WC 08312**
13 WC 08313

Labor Network, Inc., loaning employer and Clover Hill Bakery, borrowing employer

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 **Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **2/14/2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **9/23/13**, 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.

For the reasons set forth in the attached decision, the Arbitrator finds that the accident of September 23, 2013 did not substantially change Petitioner's already existing left wrist, left shoulder and neck conditions.

Petitioner's average weekly wage was $**428.56**.

On the date of accident, Petitioner was **36** years of age, ***married*** with **5** dependent children.

Petitioner ***has in part*** received reasonable and necessary medical services.

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

Respondent shall be given a credit of $**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

See the Arbitrator's award in the decision numbered 13 WC 8312.

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

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

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

Molly C Mason

Signature of Arbitrator

3/28/18
Date

APR 2 - 2018

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

Larry Lewis,
Petitioner,

vs.

NO: 18WC 5509

20IWCC0041

Palmer House Hilton,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 17, 2019, 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 $7,200.00. 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: JAN 21 2020

D Douglas McCarthy
Douglas McCarthy

o011520
DDM/jrc 052

L Elizabeth Coppoletti
Elizabeth Coppoletti

Stephen J. Mathis
Stephen Mathis

SOLUCIONES

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

LEWIS, LARRY
Employee/Petitioner

Case# **18WC005509**

PALMER HOUSE HILTON
Employer/Respondent

20IWCC0041

On 4/17/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.39% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in 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
RICHARD VICTOR
351 W HUBBARD ST SUITE 810
CHICAGO, IL 60654

1139 NOBLE & ASSOCIATES
BRADLEY D MELZER
387 SHUMAN BLVD SUITE 210E
NAPERVILLE, IL 60563-8472

SOINCC0041

20IWCC0041

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

Larry Lewis
Employee/Petitioner

v.

Palmer House Hilton
Employer/Respondent

Case # **18** WC **5509**

Consolidated cases: **D/N/A**

20IWCC0041

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Molly Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **3/18/19**. 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. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [x] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD
L. [x] What is the nature and extent of the injury?
M. [x] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

FINDINGS

On **2/8/18**, Respondent ***was*** operating under and subject 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.

For the reasons set forth in the attached decision, the Arbitrator finds that Petitioner established causation as to a low back strain that required a course of conservative treatment through March 8, 2018.

In the year preceding the injury, Petitioner earned $**28,719.08** ; the average weekly wage was $**552.29**.

On the date of accident, Petitioner was **39** years of age, ***married*** with **5** dependent children.

The back-related treatment was reasonable, necessary and causally related to the accident.

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

Medical benefits

Respondent shall pay reasonable and necessary medical expenses of $3,270.29 (Midwest Specialty Pharmacy, PX 2) and $2,522.77 (ION, 2/12/18 – 3/8/18), as provided in Sections 8(a) and 8.2 of the Act. For the reasons set forth in the attached decision, the Arbitrator declines to award the claimed $82.43 in ION expenses stemming from Dr. Wiesman's hernia-related consultation of March 16, 2018. PX 2.

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $368.19/week for 3 4/7 weeks, commencing 2/12/18 through 3/8/18, as provided in Section 8(b) of the Act.

Permanent Partial Disability

The Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 2% loss of use of person, representing 10 weeks of benefits, pursuant to §8-d-2 of the Act.

Penalties/Fees

For the reasons set forth in the attached decision, the Arbitrator declines to impose penalties or fees.

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

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

Molly C Mason

Signature of Arbitrator

4/12/19
Date

APR 17 2019

EP0333109

Larry Lewis v. Palmer House Hilton
18 WC 5509

Summary of Disputed Issues

Petitioner, a longtime houseman at Respondent's hotel, claims a work accident of February 8, 2018 involving his low back and groin. The disputed issues include accident, notice, causal connection, medical expenses, temporary total disability, nature and extent and penalties/fees.

Arbitrator's Findings of Fact

Petitioner testified he began working for Respondent 19 years before his claimed accident of February 8, 2018. He worked as a houseman. His regular duties consisted of picking up linen, dusting, mopping and maintaining the floors. He denied having to assist with deliveries from time to time. T. 3/18/19, pp. 10-11.

Petitioner acknowledged sustaining two work injuries prior to February 8, 2018. On May 1, 2013, he injured his right shoulder. On October 2, 2014, he injured his lower back. He testified he underwent treatment at Illinois Orthopedic Network for about six weeks following the October 2, 2014 injury. He was discharged from care on November 4, 2014. He denied sustaining any other back injuries or undergoing any additional back treatment between November 2014 and the accident of February 8, 2018. T. 3/18/19, pp. 10-12. During this period, he had no back problems and worked full-time for Respondent. T. 3/18/19, p. 27.

Records in PX 2 reflect that Petitioner underwent conservative care at Illinois Orthopedic Network between October 14 and November 4, 2014 secondary to a lifting-related work injury of October 2, 2014. The records document complaints of low back and right-sided cervical pain stemming from lifting a large pile of linens. Following seven therapy sessions, Dr. Murtaza released Petitioner to full duty and discharged him from care on November 4, 2014. He described Petitioner's lumbar strain as having fully resolved. PX 2.

Petitioner denied having any back or groin problems during the weeks leading up to the February 8, 2018 accident. T. 3/18/19, p. 27.

Petitioner testified his shift started at 8:30 AM on February 8, 2018. He attended a "pre shift" meeting during which he and another houseman were assigned to the task of transferring 800 mini-refrigerators from Respondent's dock area to the 24th floor of the hotel. T. 3/18/19, pp. 13-14. This was a "special project." T. 3/18/19, p. 19. Petitioner testified he and his co-worker used a "pull dolly" to transport loads from the dock to the 24th floor. It took them about 30 to 35 minutes to complete each load. T. 3/18/19, p. 14. The accident happened at about 10:45 or 11:00 AM, at which point they were about halfway finished. They worked for 2 or 2 ¼ hours before the accident. T. 3/18/19, pp. 15-16. Petitioner testified he was unloading the mini-refrigerators from the dolly on the 24th floor when he experienced a sharp pain shooting from his thigh to the left side of his groin. T. 3/18/19, p. 14. The pain then traveled to his lower back. Petitioner testified that Macaria Delgado, who supervised the housemen, happened to be "right there" when he was injured. He reported the pain to Delgado within a few seconds of the accident. No one else was present at that time. He told Delgado he was experiencing sharp pain in his lower groin and back. She directed him the security department, which was in the hotel's dock area. T. 3/18/19, pp. 16-17.

Petitioner identified RX A as an accident report completed by the manager of the security department. He testified he described the accident to this manager. The report incorrectly states that the accident occurred on the 21st floor. It happened on the 24th floor. T. 3/18/19, pp. 17-19. The report is also incorrect in that it mentions only back pain. He told the manager he was experiencing pain in his groin and back.

Petitioner testified he read the accident report before he signed it but, at that point, someone was waiting outside to transport him to Concentra. The manager told Petitioner that the report was "going to be filled out" and that he should sign it and come back later. The manager also indicated he was going to provide Petitioner with a copy of the report but this never occurred. T. 3/18/19, pp. 18-19. Petitioner testified he first realized the report mentioned only his back when he looked at the report during the hearing. T. 3/18/19, p. 19.

Petitioner identified a document (RX C2-3) as a different accident report. He completed this report and signed it. T. 3/18/19, p. 20.

Petitioner testified he underwent treatment at Concentra on February 8, 2018. T. 3/18/19, pp. 20-21. Petitioner also testified he told Concentra personnel he had pain in both his back and his groin. T. 3/18/19, p. 21. He was not aware that the records mention only his back. T. 3/18/19, p. 21.

The Concentra records (PX 1) reflect that Petitioner saw Dr. Al-Saraf on February 8, 2018. The records set forth the following account of the accident:

> "Chief Complaint: The patient presents today with [sic] 2/8/2018 @11:10 a.m. Patient was working on the 21st floor. He was picking up a mini refrigerator. At the time he felt sharp pain 7/10. Self reported. Patient was seen in the Emergency Department prior to visit. Workers Compensation. Patient's Occupation: houseman."

The records reflect that Petitioner complained of constant, bilateral, non-radiating lower back pain, rated 7/10, with associated stiffness and a decreased range of motion. The records state that Petitioner denied abdominal and suprapubic pain. Petitioner's past history is described as "non-contributory."

On initial examination, Dr. Al-Saraf noted bilateral paraspinal tenderness, a reduced and painful range of motion and negative straight leg raising bilaterally. The doctor described Petitioner's gait as normal. There is no indication that he appreciated or palpated a hernia.

Dr. Al-Saraf diagnosed a lumbar strain. He prescribed medication and three weeks of physical therapy. He directed Petitioner to remain off work for the rest of his shift and begin light duty the following day, with occasional lifting up to 10 pounds, occasional pushing/pulling up to 20 pounds occasionally, occasional bending, frequent standing and walking, occasional activities requiring trunk rotation and no ladder climbing. PX 1.

A note in PX 1 reflects that Petitioner saw a physical therapist, Jonathan J. Kissane, DPT, at Concentra on February 8, 2018. Kissane described Petitioner as having injured his back when he lifted a mini fridge earlier that day. He noted that Petitioner reported "left PSIS pain that increases with prolonged sitting and standing." He indicated that Petitioner denied lower extremity pain.

Under cross-examination, Petitioner initially denied seeing a physical therapist at Concentra on February 8, 2018. He went on to explain that he became upset at Concentra because he was given medication with Codeine in it despite the fact that no X-rays had been taken. T. 3/18/19, p. 33. He then acknowledged seeing a physical therapist but denied undergoing any "hands-on" treatment that day. Under cross-examination, and on redirect, he indicated that the therapist tried to "pop" his leg and "physically grab" or "bear hug" him, at which point he told the therapist to "let him go" because it hurt too much. He was "asking [the therapist] for an X-ray" and "had to make a scene at Concentra so [the therapist] wouldn't touch [him]." T. 3/18/19, pp. 40-41, 52, 59.

Petitioner identified RX B as a document he signed, declining an offer of light duty. He declined the offer because it would have involved him working a different shift. He could not agree to this because he has five children and has to take care of them at night, because his wife works from 11:00 to 7:00. He and his wife do not have a babysitter. T. 3/18/19, pp. 21-22.

Petitioner testified he felt worse, in terms of his back and groin pain, after his February 8, 2018 visit to Concentra. He decided to go to Illinois Orthopedic Network, where he had undergone treatment following his 2014 back injury. T. 3/18/19, p. 22.

Records in PX 2 reflect that Petitioner saw Dr. Murtaza, a physiatrist, at Illinois Orthopedic Network on February 12, 2018. The doctor noted a "chief complaint" of "right groin pain and low back pain" secondary to lifting a 35-pound refrigerator at work on February 8, 2018. He indicated that Petitioner reported experiencing acute pain in his right testicle, as well as some low back pain, when he lifted the refrigerator. He also indicated that Petitioner's pain had "failed to improve over the past week and a half" and that Petitioner had undergone one therapy session at Concentra for the low back.

Dr. Murtaza described Petitioner's past medical history as non-contributory. He indicated that Petitioner was off work and taking Ibuprofen and Flexeril.

On initial examination, Dr. Murtaza noted an "obvious bulge in the right side of the testicle" and a "palpable direct hernia that is easily reduced without evidence of strangulation or incarceration." He started Petitioner on Ibuprofen 800 mg and indicated he should continue therapy for his low back. He directed Petitioner to return in a few weeks to see whether his groin pain had improved. PX 2.

Petitioner underwent an initial therapy evaluation at Illinois Orthopedic Network on February 19, 2018. The evaluating therapist, Marissa Bolsen, PT, recorded the following history:

> "Patient works as a house person at the Palmer House. States on the DOI, he lifted a fridge that weighed approximately 35# onto a transport cart/trolley. He was then pushing the cart when he began to experience pain at his (R) lower back/buttocks area. He went to Concentra, where he was issued physical therapy. States during that session, the PT pushed on one leg and pulled on the other and he felt a pop and had pain at his (R) groin. States he left and refused to return to that clinic. He came here to ION for further care, as he has been here in the past for another case. It was here that he was diagnosed with a (R) hernia."

Following the evaluation, Petitioner participated in therapy through March 8, 2018. In her progress note of February 22, 2018, Bolsen noted that Petitioner was "still feel[ing] a catch at the right hip and lower back." In her note of March 7, 2018, Bolsen described Petitioner as complaining of groin soreness while performing squats, secondary to home exercises performed the previous night. She commented: "wall squats do seem to be aggravating [Petitioner's] left groin strain and it seems appropriate to hold this these ex until his groin is less painful." In her last note, dated March 8, 2018, Bolsen indicated that Petitioner was still experiencing "quad soreness" with Swiss ball wall squats but was progressing overall. PX 2.

Petitioner returned to Dr. Murtaza on March 8, 2018. In his note of that date, the doctor described Petitioner's symptoms as "nearly resolved." He noted that Petitioner was still experiencing mild groin and low back pain but felt able to return to work. On re-examination, he noted a normal gait, no lumbar or groin tenderness to palpation and negative straight leg raising bilaterally. He released Petitioner to full duty and instructed him to return as needed. PX 2.

On March 16, 2018, Petitioner saw Dr. Wiesman for a "hernia evaluation." Dr. Wiesman noted that Dr. Chunduri had already discharged Petitioner from care with respect to the lower back. He also noted that Petitioner denied any groin pain during the preceding two weeks and was "slated to return to full duty on Monday." On examination, he noted no testicular abnormalities and no obvious bulging in the groin. He described Petitioner as having a "resolved" right groin strain. He agreed with Dr. Chunduri's full duty release. PX 2.

Petitioner testified that the treatment he underwent at Illinois Orthopedic Network was helpful. He further testified he was kept off work from February 12 through March 12, 2018. He resumed full duty thereafter. T. 3/18/19, pp. 29-30. He provided the "off work" notes to Jennifer Hildebrand of Respondent. He did not receive any temporary total disability benefits while he was off work. T. 3/18/19, p. 23.

Petitioner testified he applied for short-term disability because Respondent would not pay him workers' compensation benefits. His claim for short-term disability was denied "because it was a workers' comp case." He identified RX D as the application for short-term disability benefits he signed. T. 3/18/19, pp. 23-24. RX D is a one-page pre-printed form entitled "Short Term Disability Claim Form." The top section bears Petitioner's signature and the date March 6, 2018. It describes the accident of February 8, 2018. The words "left groin pain, inguinal hernia" appear after the words: "accident details." The form reflects that Petitioner's disability was due to employment, but not an accident, and that he had "filed for workers' comp." The second section appears to bear the signature of Dr. Murtaza and the date March 8, 2018. This section reflects a diagnosis of "left groin pain, inguinal hernia." It also reflects that Petitioner remained off work at the doctor's recommendation and that Petitioner's disability was not due to an accident. The bottom section appears to bear the signature of Jennifer Hildebrand, Respondent's human resources manager, and the date March 9, 2018. It reflects that Petitioner last worked on February 8, 2018.

Petitioner denied telling anyone at Respondent that he did not want to pick up the mini refrigerators because he felt this task was outside the scope of his regular houseman duties. T. 3/18/19, pp. 26-27.

Petitioner denied experiencing any back injuries other than those occurring on October 2, 2014 and February 8, 2018. T. 3/18/19, p. 27.

Petitioner testified he continues to experience "little sharp pains" in his groin. His back improved with the medication he received. His back sometimes bothers him at the end of a workday or when he sits too long. He takes aspirin for his symptoms. T. 3/18/19, pp. 28-29.

Under cross-examination, Petitioner testified he last underwent treatment for his groin and back in March 2018. He agrees it is important for a patient to be truthful with his doctor. He was truthful with his doctors throughout the course of his care. T. 3/18/19, p. 31. He denied telling providers at Concentra that he felt a sharp pain when he picked up a mini fridge on the 21st floor. He did not say this. He also denied saying that his back pain was bilateral. He indicated his pain was on the left side and traveled up through his groin into the lower back. He did not describe the pain as dull. Concentra took him through its normal process on February 8, 2018. He completed paperwork but ultimately told them he wanted to see his own doctor instead. He became upset because "they tried to prescribe some pills with Codeine" without obtaining any X-rays. He asked how this could be. He did see a therapist but no "hands on" therapy took place. T. 3/18/19, pp. 33-34. The therapist tried to "pop" his leg and grab his back. He told the therapist "don't touch me" because he was in pain and the therapist was "too physical." He (Petitioner) was "asking him for an X-ray." He "had to make a scene at Concentra so [the therapist] wouldn't touch [him]." He did not tell anyone at Concentra about the back issue he experienced in 2014. He did tell them about his groin pain. T. 3/18/19, pp. 34-35. When he first went to Illinois Orthopedic Network, on February 12, 2018, he told the doctor he was injured while lifting a 35-pound refrigerator. He did not say his pain had failed to improve over the previous week and a half. He did not mention his 2014 back treatment because the treatment occurred at their facility and he assumed they knew about it. When he first met with a physical therapist at Illinois Orthopedic Network, no actual therapy took place. The therapist explained the schedule. He told the therapist how he was injured. He does not recall telling the therapist that he began experiencing lower back and buttocks pain while pushing a cart that had refrigerators on it. He cannot remember everything he said to the therapist. He experienced the pain while lifting refrigerators off the cart, not while pushing the cart. He told the therapist that he felt a pop in his groin after the therapist at Concentra pushed one of his legs and pulled the other. T. 3/18/19, p. 40. He does not remember telling the therapist at Illinois Orthopedic Network that he had moderate to severe pain in the right side of his back radiating to his right thigh. T. 3/18/19, p. 42.

Petitioner testified he was not upset about being asked to move the refrigerators. T. 3/18/19, p. 43. He denied talking with Michelle Jones, a Respondent human resources employee, about the refrigerator project on the morning of February 8, 2018, before the accident. Jones works on the fifth floor and he works from the eighth floor up so they do not see one another regularly. For the last two years, as part of the union grievance process, they have been discussing refrigerators, microwaves and mattresses. He is of the belief that moving such items was not part of the houseman job. T. 3/18/19, p. 46. His supervisor, Miss Delgado, just happened to be walking by him on the 24th floor after the accident occurred. There is a constant flow of traffic on that floor because the office is up there. T. 3/18/19, p. 46. He told her what happened and she sent him to security. He went to the security office, which is on street level at the dock and completed a report. With respect to the documents in RX A, he completed pages 2, 3, 4 and 9 while "the company" completed pages 1, 5, 6, 7 and 8. On page 2, he wrote that the accident occurred on the 21st floor but he "might have miss think." The accident occurred on the 24th floor. Everybody in the building knew this. There are offices, a sample room and a "constant traffic flow" on the 24th floor. T. 3/18/19, p. 46. He would have had "no reason to take 800 refrigerators to 21." T. 3/18/19, p. 51. On the day of the accident, only he and William Mulon, another houseman, moved refrigerators. On page 2, he wrote that he picked up a refrigerator and hurt his back. The form

contained additional space in which he could have written additional information but he is not a doctor. He would not have known about the hernia until he saw a doctor. Both Concentra and ION told him that he had a hernia, based on what he described. When he completed page two, he only knew that it "was hurting down there" and in his back. He refused to sign page 9, entitled "workers' compensation guidelines," because he did not want to be "documented for hurting [himself] on company property." He did not want to get written up for a company accident. He provided Jennifer Hildebrand, who handles workers' compensation for Respondent, with all of the documents he received from doctors. T. 3/18/19, pp. 53-54.

Petitioner testified he signed page 8 of the accident report of May 3, 2018 marked as RX C. He also completed part of page 2, indicating he hurt himself a month or two earlier and did not recall the exact date. Otherwise, "the company" completed the pages in RX C. T. 3/18/19, pp. 55-57.

On redirect, Petitioner testified that, while he did not believe a houseman's duties included delivering refrigerators, he delivered the refrigerators as part of a special project on February 8, 2018, as Respondent directed him to do. It was Mark Celestin, the director of housekeeping, who directed him to perform this project. Any paperwork indicating the refrigerators were delivered to the 21st floor is not correct. They took the refrigerators up to the 24th floor. He spoke with Macaria Delgado after the accident and told her where he was experiencing pain. At Concentra, on February 8, 2018, a therapist started to assess him but he told this person not to touch him. At Illinois Orthopedic Network, he told the providers his groin pain started on the left. Eventually, he had pain in both sides of his groin but it was worse on the left than the right. He refused to sign the last page of RX C because he was written up after he hurt his back at work in 2014. He was given a "verbal," saying that he did not lift items properly, and he had to take a training class with Merrill Malinky. As a union shop steward, he knew he should not have been written up for this and he "wasn't going to take no more documents for hurting [him]self at a company." T. 3/18/19, pp. 58-61.

Under re-cross, Petitioner acknowledged being disciplined at various times during his 19 years with Respondent. In March 2017, he "was documented" after he went to human resources and reported racism. He made this report after a manager referred to him as "boy" and complained of "you people." Human resources wrote him up for reporting racism. After he was written up, he filed an EEOC claim. He has a pending charge against Respondent "for racism, harassment and bullying because [he is a] shop steward and took 26 hotels out on strike." The strike took place in August or September 2018, after he filed this charge. T. 3/18/19, pp. 62-64.

In response to a question posed by the Arbitrator, Petitioner testified that the reference in RX C, page 1, to an incident occurring in a 12th floor linen room is a reference to his 2014 back injury. T. 3/18/19, pp. 64-65.

Brendan Byrne testified on behalf of Respondent. Byrne testified he has worked for Respondent for about 13 years. He has worked in the security department for the last 9 years. His current job title is security dispatch. As of February 8, 2018, he was the security supervisor. T. 3/18/19, p. 69. His duties in that job included supervising multiple officers, responding to hotel guest complaints and handling employee injuries and disputes. Any employee who claims a work injury is sent down to his department. If the employee requires immediate attention, his department administers first aid. The employee's supervisor is called down and the employee contacts the "nurse hotline." The employee completes part of a 7-page report and his department also prepares a report that is sent via E-

mail to human resources and various department heads. If the nurse recommends that the employee go to Concentra, his department transports the employee to that facility. T. 3/18/19, pp. 70-71.

Byrne testified he is familiar with Petitioner. He identified Petitioner in the hearing room. Petitioner has worked at Respondent's hotel for quite some time. On February 8, 2018, Petitioner came down to his department and reported having injured his back while lifting a mini fridge. T. 3/18/19, pp. 71-72. Petitioner indicated he needed to have his back looked at. Byrne testified he directed Petitioner to begin completing the report and then got him on the phone with a nurse via the "hotline." T. 3/18/19, p. 73. Byrne identified RX A as the report he is referring to. He completed the first page and signed it. Petitioner completed the second page. T. 3/18/19, p. 74.

In response to a question asking whether Petitioner reported groin pain to him on February 8, 2018, Byrne testified as follows: "I do not recall. I do not believe so." T. 3/18/19, p. 74. Had Petitioner mentioned groin pain, he would have noted this in his report. Petitioner refused to sign pages 8 and 9 of RX A. Petitioner told him he would not sign these pages because he believed that the injury occurred outside the scope of his houseman job. T. 3/18/19, p. 75.

Byrne identified RX E as the E-mail he sent to human resources and others shortly after Petitioner reported his injury. This E-mail is time-stamped 11:15 AM. T. 3/18/19, p. 76. In the E-mail, Byrne indicated that Petitioner came to security at about 11:15 AM on February 8, 2018 and reported feeling pain in his lower back when he lifted a mini fridge on the 21st floor. Byrne also indicated that Petitioner refused to sign "the workers' compensation paperwork because he felt that picking up a mini fridge wasn't in the scope of his work." Byrne went on to state that Petitioner "spoke to the nurse hotline" and "they suggested that he go to Concentra for further evaluation of his lower back and transportation was provided."

Byrne testified he saw Petitioner again on May 3, 2018. Petitioner came down to security on that date to complete another accident report. Byrne identified this report as RX C. The first page of RX C describes the location of the accident as the 12th floor linen room. It also mentions pain from a pre-existing hernia. It appears as if Petitioner was reporting an injury occurring on a previous date in another location. T. 3/18/19, p. 78.

Byrne testified he could not recall whether Petitioner went to Concentra on May 3, 2018. T. 3/18/19, p. 79.

Byrne testified he has seen Petitioner in security on occasions other than February 8 and May 3, 2018. These visits could have been injury-related or secondary to "management issues where we're getting called." T. 3/18/19, p. 79.

Byrne testified that he investigated or reported at least 50 accidents during his tenure as security supervisor. When an individual reports an accident to him, he forms an opinion as to whether the individual is telling the truth. If the individual is claiming a recent event, he looks for physical evidence such as a laceration or contusion. When it comes to a back strain, however, it is "harder to judge" credibility. As of February 8, 2018, "we were questioning the validity of" Petitioner's claim, based in part on prior experience with Petitioner. T. 3/18/19, p. 81.

Under cross-examination, Byrne testified he signed but did not complete all of page 1 of RX C. This page references a pre-existing injury taking place in the 12th floor linen room. Byrne acknowledged

he does not know whether this injury occurred on February 8th or some prior date. He did not write the narrative section of page 1 but he did write the section referring to the location of the accident. T. 3/18/19, pp. 83-84. With respect to the other report, RX A, it was his impression that Petitioner came down to security on February 8, 2018, within minutes of the accident he described that day. T. 3/18/19, p. 84. Groin pulls are more difficult to assess than finger lacerations, where you can observe bleeding. If an employee reports an injury and completes a report within minutes of the event, that can add credibility to the report, especially when the injury is not visible. T. 3/18/19, p. 85.

In response to questions posed by the Arbitrator, Byrne clarified that, with respect to the first page of RX C, the sections concerning the location of the accident and the narrative are in his writing. However, the portion stating that "this is an injury previously reported" is not. T. 3/18/19, p. 87.

In addition to the exhibits previously described, Petitioner offered into evidence the petition for penalties and fees his counsel filed on January 7, 2019. PX 3. Respondent filed a response to this petition on January 15, 2019, arguing, inter alia, that the petition is deficient, that Petitioner declined its offer of light duty, that Petitioner reported a back injury but later sought treatment for a hernia at Illinois Orthopedic Network, that it had "uncovered credible evidence to establish an accident defense" and that it had a reasonable basis for denying benefits. RX F.

Arbitrator's Credibility Assessment and Conclusions of Law as to the Issue of Accident

Petitioner was an excitable witness but the Arbitrator found him absolutely believable on the most important aspect of what ultimately amounts to a minor claim, namely, did he sustain an injury while working? His lengthy tenure with Respondent weighs in his favor, credibility-wise. His testimony concerning the assignment and performance of the refrigerator project was very detailed and, for the most part, unrebutted. While he clearly believed the project was not within his job description, he took it on anyway. The fact that he, as a union representative, had a tendency to focus on labor-related issues does not mean the accident did not occur. He immediately reported the accident to his supervisor (who Respondent did not call), conversed with a nurse via Respondent's "hotline" and went to Concentra, at Respondent's direction. He was not happy with the treatment he received at Concentra and opted to seek care elsewhere, as was his statutory right. The treatment was anything but excessive and he returned to full duty within a month of the accident.

There are inconsistencies between Petitioner's testimony and the accident reports in evidence, to be sure, but Petitioner's explanation of one of these inconsistencies ultimately enhanced his credibility. While several documents, including one authored by Petitioner, reflect that the accident occurred on the 21st floor, Petitioner insisted at the hearing that it really took place on the 24th floor, since there was "no reason to take 800 refrigerators to 21." T. 3/18/19, pp. 50-51. If Petitioner had invented the entire scenario, as Respondent seems to suggest, he would have had absolutely no motivation to testify in this fashion. The Arbitrator concludes that the accident did occur on the 24th floor and that Petitioner simply made a mistake on the report he completed, as he acknowledged.

Respondent asserts that Petitioner's credibility was undermined by what it characterizes as an untoward delay between the initial treatment at Concentra, on February 8, 2018, the date of the accident, and the subsequent care at Illinois Orthopedic Network, which began on February 12, 2018. The Arbitrator notes that, in 2018, February 8th fell on a Thursday and February 12th fell on a Monday. A delay of four days, over a weekend, does not undermine Petitioner's credibility.

Respondent also maintains that accident should be denied because, while Petitioner claimed back and groin injuries, the initial documents mention only the back. The Arbitrator notes that, of the first three Respondent representatives (Macaria Delgado, Brendan Byrne and the "hotline" nurse) with whom Petitioner communicated, only one testified and he (Byrne) readily confirmed that Petitioner reported a lifting-related work accident. He also confirmed that Petitioner reported injuring his back. As to the other claimed injury, he said both that he did not recall Petitioner reporting groin pain and that he did not believe Petitioner did so. While the available medical records do not allow the Arbitrator to find causation as to a groin or hernia injury (see further below), the Arbitrator finds Petitioner credible on the threshold issue of whether an accident occurred. Petitioner was injured onsite, during his shift, while performing a task that benefited Respondent.

Arbitrator's Conclusions of Law as to Remaining Disputed Issues

Did Petitioner provide Respondent with timely notice of the accident?

The Arbitrator finds in Petitioner's favor on the issue of notice.

An accident must be reported to the employer within 45 days. 820 ILCS 305/6(c). The purpose of the notice requirement is to enable the employer to investigate the alleged accident. Seiber v. Industrial Commission, 82 Ill.2d 87 (1980). "Compliance with the requirement is accomplished by placing the employer in possession of the known facts related to the accident within the statutory period."

Petitioner credibly testified he provided near-immediate oral notice of his injury to his supervisor, Macaria Delgado, who happened to walk by him shortly after the accident occurred. Respondent did not call Delgado to testify. Respondent's sole witness, Brendan Byrne, who was security supervisor as of February 8, 2018, acknowledged that Petitioner reported the accident to him very shortly after it occurred. His written report reflects that Petitioner reported a low back injury. He did not recall but did not believe that Petitioner also reported a groin injury. Petitioner completed and signed various forms the same morning. One of those forms was an authorization providing Respondent with unfettered access to his medical records. RX A-4. While Petitioner initially declined medical care, based on his belief that the task giving rise to the injury was outside his assigned duties, he did talk with a nurse via Respondent's "hotline," at Byrne's direction, and underwent treatment the same day at Concentra, a facility of Respondent's selection. No documents concerning Petitioner's conversation with the nurse are in evidence. The Arbitrator considers any such documents to be the first treatment records. The Concentra records dated February 8, 2018 confirm Petitioner's claim of a lifting-related event occurring that day. PX 1.

Petitioner filed his Application for Adjustment of Claim on February 23, 2018, only two weeks after the accident. This document clearly describes a lifting-related event of February 8, 2018. Arb Exh 2.

Even if it could be argued that the notice Petitioner provided on the day of the accident was incomplete or deficient in terms of his description of the affected body parts, Respondent received notice of the claimed groin/hernia injury within 45 days of February 8, 2018, as evidenced by its own exhibit, RX D. Respondent's human resources manager, Jennifer Hildebrand, signed RX D on March 9, 2018. In RX D, Petitioner indicated his groin symptoms started at the time of the February 8, 2018 accident he had previously reported.

Did Petitioner establish causal connection?

The Arbitrator finds that Petitioner established causation as to a low back strain that required a course of conservative care through March 8, 2018. In so finding, the Arbitrator relies on Petitioner's testimony, the initial records from Concentra and the records from Illinois Orthopedic Network. PX 1-2. The Arbitrator specifically notes that the doctor who saw Petitioner at Concentra on the date of the accident did not question his presentation. He diagnosed a lumbar strain and prescribed therapy and medication. PX 1.

The Arbitrator further finds that Petitioner failed to establish a causal connection between the February 8, 2018 accident and a groin strain or hernia. Petitioner testified to experiencing left-sided groin as well as back pain at the time of the accident. T. 3/18/19, p. 14-15. At Byrne's direction, he spoke with a "hotline" nurse later the same morning but there are no documents indicating what symptoms he relayed to this individual. He then went to Concentra, a provider of Respondent's selection. The doctor there focused on the back and did not note any groin complaints. PX 1. The first provider to note a complaint of pain in a body part other than the back was Dr. Murtaza, a physician of Petitioner's selection. On February 12, 2018, Dr. Murtaza described Petitioner's groin complaints as right-sided. This description could be inaccurate but he also documented an "obvious bulge in the right side of the testicle," a visible abnormality that Petitioner did not mention during his testimony. Subsequent records only add to the confusion. A therapist at Illinois Orthopedic Network noted right groin pain and a right hernia on February 19, 2018 but left-sided groin complaints on March 7, 2018. On March 16, 2018, Dr. Wiesman described Petitioner as having had a "right groin strain that is resolved." He found no evidence of a hernia on examination. A pain diagram completed by Petitioner on May 3, 2018 (referencing the February 8, 2018 accident) shows circles drawn around the lower right abdomen and groin. RX C1-3. An accident investigation report that also appears to have been completed on May 3, 2018 identifies the following "problem": "Larry [Petitioner] has a hernia. He refuses to get surgery to repair." RX C8. The evidence as a whole supports the conclusion that Petitioner voiced groin complaints and had a visible hernia after the February 8, 2018 accident but the Arbitrator is unable to conclude that the accident was the underlying cause.

Is Petitioner entitled to temporary total disability benefits?

Petitioner claims he was temporarily totally disabled from February 12, 2018 through March 12, 2018. Respondent disputes this claim, based on its various defenses. Arb Exh 1.

The Arbitrator has previously found in Petitioner's favor on the issues of accident and notice. The Arbitrator has also found that Petitioner established causation as to a low back strain that required conservative treatment through March 8, 2018, the date of Petitioner's last back-related office visit. PX 2. The Arbitrator views this condition as unstable until March 8, 2018, the date on which Dr. Chunduri described Petitioner's symptoms as "nearly resolved" and released Petitioner from care. Interstate Scaffolding v. IWCC, 236 Ill.2d 132 (2010).

The Arbitrator recognizes that the physician at Concentra imposed restrictions on February 8, 2018 and that Respondent extended an offer of temporary light duty to Petitioner the same day. The Arbitrator also recognizes that Petitioner declined the offer. The Arbitrator finds it reasonable for Petitioner to have done so, given his personal circumstances and the fact that Respondent was requiring

him to report to light duty at 10 PM on February 9, 2018. RX B. Petitioner credibly testified it was not possible for him to work a night shift since his wife works that shift and they have five minor children.

The Arbitrator finds that Petitioner was temporarily totally disabled from February 12, 2018 (the date Dr. Murtaza took Petitioner off work, PX 2) through March 8, 2018 (the day Dr. Chunduri released Petitioner to full duty with respect to his back), a period of 3 4/7 weeks.

Is Petitioner entitled to reasonable and necessary medical expenses?

Petitioner claims medication expenses in the amount of $3,270.29 from Midwest Specialty Pharmacy along with expenses in the amount of $2,605.20 from Illinois Orthopedic Network. PX 2. Respondent disputes this claim based on its various defenses.

The Arbitrator has previously found in Petitioner's favor on the issues of accident and notice. The Arbitrator has also found causation as to a low back strain. The Arbitrator views Petitioner's one-month course of care at Illinois Orthopedic Network as reasonable, necessary and causally related to the accident. The records from Illinois Orthopedic Network reflect that Petitioner reported improvement of his back symptoms secondary to physical therapy and medication. Petitioner was able to resume full duty within a month or so of the accident. Respondent did not offer any evidence indicating that the treatment was excessive or unreasonable.

The Arbitrator awards Petitioner medication expenses from Midwest Specialty Pharmacy in the amount of $3,270.29 and treatment-related expenses from Illinois Orthopedic Network in the amount of $2,522.77 ($2,605.20 minus $82.43), subject to the fee schedule. Having found that Petitioner failed to establish causation to a hernia, the Arbitrator declines to award the $82.43 in charges relating to Petitioner's hernia-related visit to Dr. Wiesman on March 16, 2018. PX 2.

What is the nature and extent of the injury?

Because the accident occurred after September 1, 2011, the Arbitrator looks to Section 8.1b of the Act for guidance in determining the nature and extent of Petitioner's injury. That section sets forth five factors to be considered in assessing permanency, with no single factor predominating. The Arbitrator views the first factor, any AMA Guides impairment rating, as not relevant since neither party offered such a rating into evidence. The Arbitrator assigns some weight to the second and third factors, Petitioner's occupation and his age at the time of the accident. Petitioner was a houseman who primarily performed cleaning. He was 39 years old as of the accident. The Arbitrator assigns no weight to the fourth factor, future earning capacity. Petitioner acknowledged returning to full duty about a month after the accident. He claims no diminution of salary. As for the fifth and final factor, evidence of disability corroborated by the treating medical records, the Arbitrator notes that no provider ordered lumbar spine radiographic studies. The Arbitrator also notes that, when Dr. Chunduri last saw Petitioner for his back, on March 8, 2018, he described Petitioner's symptoms as nearly resolved and indicated straight leg raising was negative.

The Arbitrator, having considered the foregoing along with Petitioner's credible testimony concerning his lingering back complaints, awards permanency equivalent to 2% loss of use of the person as a whole, representing 10 weeks of benefits under Section 8(d)2 of the Act.

Is Respondent liable for penalties and/or fees?

Initially, the Arbitrator considers whether Respondent is liable for penalties under Section 19(l) of the Act. Such penalties are in the nature of a "late fee." The standard for awarding them is lower than the standard for awarding penalties and fees under Sections 19(k) and 16. McMahan v. Industrial Commission, 183 Ill.2d 499, 514-15 (1998).

The first sentence of Section 19(l) provides as follows: "If the employee has made written demand for payment of benefits under Section 8(a) or Section 8(b), the employer shall have 14 days after receipt of the demand to set forth in writing the reason for the delay" (emphasis added). In the instant case, there is no evidence indicating that Petitioner made a written demand for payment of temporary total disability benefits or specific medical expenses. Petitioner did file a petition on January 7, 2019 (PX 3), referencing his care at Illinois Orthopedic Network and Respondent's failure to pay for same, but he did not mention any claimed period of temporary total disability or tender any medical bills. See Theis v. IWCC, 2017 IL App (1st) 161237WC.

Based on the foregoing, the Arbitrator declines to award Section 19(l) penalties and finds it unnecessary to address Respondent's liability for Section 19(k) penalties and/or Section 16 attorney fees.

STATE OF ILLINOIS)
) SS.
COUNTY OF LAKE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Yolanda Collier,
Petitioner,

vs.

NO: 15WC 37129

Waukegan Housing Authority,
Respondent.

20IWCC0042

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed April 22, 2019, is hereby affirmed and adopted.

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

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

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

DATED: JAN 21 2020
o011520
DDM/jrc
052

D. Douglas McCarthy
Douglas McCarthy

Elizabeth Coppoletti
Elizabeth Coppoletti

Stephen J. Mathis
Stephen Mathis

SOLICCOOS

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

COLLIER, YOLANDA
Employee/Petitioner

Case# **15WC037129**

WAUKEGAN HOUSING AUTHORITY
Employer/Respondent

20IWCC0042

On 4/22/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.39% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1315 DWORKIN AND MACIARIELLO
MARTHA NILES
134 N LASALLE ST SUITE 650
CHICAGO, IL 60602

2389 GILDEA COGHLAN & REGAN LTD
RYAN A REGAN
901 W BURLINGTON AVE SUITE 500
WESTERN SPRINGS, IL 60558

SOINCC0035

S20CC0042

STATE OF ILLINOIS)
)SS.
COUNTY OF LAKE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

YOLANDA COLLIER
Employee/Petitioner

v.

WAUKEGAN HOUSING AUTHORITY
Employer/Respondent

Case # 15 WC 37129

Consolidated cases: _____

20IWCC0042

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **MICHAEL GLAUB**, Arbitrator of the Commission, in the city of **WAUKEGAN**, on **November 27, 2018 and February 19, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **April 3, 2015**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

In the year preceding the injury, Petitioner earned **$64,633.77**; the average weekly wage was **$1,242.96**.

On the date of accident, Petitioner was **51** years of age, ***married*** with **0** dependent children.

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

Respondent ***has*** 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

BENEFITS ARE DENIED AS PETITIONER'S WORK ACTIVITIES WERE NOT SUFFICIENTLY REPETITIVE IN NATURE FOR PETITIONER TO SUSTAIN AN ACCIDENT ARISING OUT OF AND IN THE COURSE OF HER EMPLOYMENT BY RESPONDENT. BENEFITS ARE ALSO DENIED AS PETITIONER'S CONDITION OF ILL-BEING IS NOT CAUSALLY RELATED TO PETITIONER'S WORK ACTIVITIES.

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

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

Signature of Arbitrator

April 19, 2019
Date

APR 22 2019

STATEMENT OF FACTS

Petitioner, Yolanda Collier, was working in her position as Deputy Director for Respondent, the Waukegan Housing Authority, on or about April 3, 2015 when she felt "all of a sudden" a "very strange pain" to her right hand while typing on her computer (T. pp. 11-12, 42) Petitioner noticed that she was unable to type or grasp a pen to write for minutes. (T. pp. 42-43) She admitted that April 3, 2015 was not the first day she felt pain, instead stating that the first day she felt pain was in March 2015. (T. pp. 57-58) Under cross-examination , Petitioner admitted that she had "issues" with her right hand that pre-dated March 2015 and that the "issues" stemmed from two separate incidents, one of which included a slip in her kitchen. (T. p. 59) Petitioner had worked for Respondent for 9 years and 7 months prior to the date of accident and she had worked as the Deputy Director for approximately 2 years prior to the date of accident. (T. pp. 11, 80) Petitioner testified that her job consisted of administering the Section 8 housing program, creating documents including memos, letters and job descriptions, as well as performing and overseeing inspections. (T. p. 12) Petitioner testified that she would write out correspondence by hand in a notebook and later type the information using a computer, and she testified that she used a keyboard 5 to 6 hours per day. (T. pp. 12-13) Petitioner also testified that she would return to the office in the evenings, she would take work home and she would work on weekends. (T. pp. 13-14) Petitioner noted that she mostly typed at work rather than at home. (T. p. 14)

Petitioner would pull files from a standing, rolling shelf system and used her right hand in a circular motion to move the shelving. (T. pp. 16-17) Petitioner would take the files from storage to her office and review the paperwork while taking notes. (T. p. 18, 27) Petitioner would then type her notes into the computer. (T. p. 19, 27) The memos and internal

correspondence Petitioner typed were never longer than one page and were submitted through email. (T. pp. 19-20) Petitioner testified that her duties included dealing with approximately 50 emails from various entities per day as well as participating in approximately 20 phone calls per day. (T. p. 20) Petitioner would type information from the phone messages and phone calls if she could update information by email or she would write a note for herself to perform a task later. (T. p. 21)

Petitioner testified that she reviewed the Housing Authority's job descriptions, taking notes for changes to make to the descriptions. (T. p. 22) She also testified that she created new job descriptions by reviewing prior job descriptions, writing down information for the new descriptions, and typing up the information. (T. p. 22)

Petitioner acted as a hearing officer for the Section 8 program as well as for public housing under her prior supervisor. (T. p. 23) In this position, Petitioner would take notes during the hearing followed by typing the notes as well as a response later in her office. (T. p. 24) Petitioner conducted calculations for Section 8 reviews, and Petitioner testified she was told to complete audits for the Section 8 Management Assessment Program ("C-MAP") in December 2014 or January 2015, when the audit was a job duty of a quality control auditor. (T. pp. 27-30) For the audits, Petitioner would write profiles and review each section in a file to ensure accuracy of the documentation including the financial resources for each Section 8 household. (T. p. 30) There were 1,400 files in Section 8. (T. p. 31)

Petitioner testified that in approximately February or March 2015 she added the supervisor position of Section 8 to her jobs, which included scheduling inspections. (T. pp. 33-24) Petitioner would use the computer to schedule annual inspections as well as to create and schedule annual recertifications for all families of the Section 8 program. (T. p. 34) Petitioner

would also peform some inspections of units and manually input information from the inspection into an inspection booklet. (T. p. 35) Following the inspection, Petitioner would input the information from the inspection she performed into the computer. (T. p. 36)

Petitioner also testified that every month she would have meetings with clients to review their documentation for the Section 8 program recertification, and that Petitioner had to gather paperwork and manually staple papers together. (T. p. 37) The data would then be inputted into the housing data systems. (T. p. 38) Petitioner testified that it took her 30 minutes per inspection to input the data and 60 minutes per client to input data from the annual recertification. (T. pp. 38-39) Petitioner also testified she researched the Housing Urban Development (HUD) website to ensure compliance with regulations. (T. pp. 39-40) Petitioner would type up information if there were new procedures or regulations from HUD. (T. p. 40) Petitioner also testified that she typed information for a new administrative plan and typed reports to the board every month. (T. p. 40)

Petitioner stated that in March and April 2015 she was performing the tasks of the Deputy Director, Quality Control Coordinator and Supervisor of Section 8 Housing. (T. p. 82)

Petitioner testified that as part of her job duties she would have meetings and conferences with landlords and government officials. (T. pp. 76-77) Petitioner also testified that she had a one-hour meeting weekly with staff members. (T. p. 77) Petitioner also had individual meetings with staff members. (T. p. 77)

Petitioner testified that she first informed her staff members in early April 2015 that she had been diagnosed with bilateral carpal tunnel syndrome. (T. pp. 45, 73-74) On the same day, Petitioner testified she next informed the Executive Director, Mr. Charles Chambers, followed by Ms. Celester Rodney, who was with human resources, of her condition. (T. pp. 45-

46) Petitioner testified that she told Mr. Chambers that she had been seen by a neurologist who had informed her she had bilateral carpal tunnel, and she further testified that she informed Mr. Chambers that she contracted bilateral carpal tunnel "from typing and all the reports" she had performed at work. (T. p. 74) Petitioner testified that Mr. Chambers responded by stating that his ex-mother-in-law was a doctor, and that he did not believe Petitioner had carpal tunnel. (T. p. 75)

Petitioner testified that she felt her hands were better since undergoing surgery, but she still had difficulties with her hands including dropping items. (T. pp. 48-49) Petitioner also noted pain and difficulty with washing and drying dishes as well as vacuuming. (T. pp. 49-50) Petitioner also testified that she is unable to drive long distances, nor can she comb or style her hair. (T. pp. 51-52) Petitioner also testified that she is no longer able to play tennis or jump rope. (T. p. 52) Petitioner further testified that she was unable to use the internet and type for more than 15 minutes due to right hand pain and tingling. (T. p.54)

Petitioner was unable to identify the signature on the Application for Adjustment of Claim as her signature, and she did not recall signing the document. (Arb. 2, T. pp. 64-65)

Petitioner acknowledged that an October 30, 2015 HUD deadline was not met and that a deadline extension for November 3, 2015 was also not met. (T. pp. 65-66) Petitioner also was seen by Dr. Arora on November 3, 2015. (T. pp. 71-72) Petitioner admitted she was issued a 3-day suspension on November 4, 2015 which was documented in the Memorandum of the same date. (RX 3, T. pp. 66-68, 71) Petitioner wrote on the memo that she did not agree with the suspension, but that she "will have a response to this write-up within 10 business days." (RX 3, T. pp. 67-68)

Petitioner could not recall who referred her to Dr. Weinzweig. (T. pp. 72-73)

Petitioner stipulated that her neck and low back complaints and treatment were not related. (T. pp. 78-79)

Debra Beshel, Luz Guardado, Damarixa Montoya, Charles Chambers and Celester Rodney testified on behalf of Respondent.

Debra Beshel, currently the Quality Control Coordinator for public housing and Section 8, testified that Petitioner had been her direct supervisor while working for Respondent from 2012 to 2015. (T. pp. 10-11) Ms. Beshel was a Case Manager when working underneath Petitioner. (T. pp. 17, 22) Ms. Beshel testified that she spent 3 to 4 hours per day in Petitioner's presence, and that most of this time was spent in group and individual meetings with Petitioner. (T. pp. 11-13) She noted that there would be at least 4 group meetings every week that would last anywhere from 2 to 6 hours per meeting, and the individual meetings could last from 30 minutes to 2 hours. (T. pp. 20-21, 23-24) Ms. Beshel further testified that Petitioner delegated work activities to her including taking notes for the group meetings. (T. pp. 13-15) She also testified that she did not notice Petitioner typing on the computer when in her presence. (T. p. 15) Ms. Beshel also indicated that she would at times come into work early and at times work late, but Petitioner was not present at the office during these times. (T. pp. 15-16, 24) Ms. Beshel stated that while Petitioner probably did pull her own files from storage, most of the time the staff members were asked to perform this task for Petitioner. (T. pp. 16-17) Ms. Beshel acknowledged that Petitioner made her own notes and that it was possible Petitioner was using computers when Petitioner was not in her presence. (T. p.25)

Ms. Beshel testified that the job duties for the Quality Control Coordinator position includes all of the quality control inspections for the Section 8 Department as well as pulling

reports from the Section 8 Department in order to select file audits. (T. p. 17) When Ms. Beshel became the Quality Control Coordinator in August 2015, there was more work for her to complete than would be typical for the position because the work associated with the position had not been performed. (T. pp. 18-19) In August 2015, Ms. Beshel had to type 15 minutes per day to complete work as a Quality Control Coordinator. (T. pp. 19-21)

Luz Guardado, currently the Director for Housing Choice Voucher, testified that she worked with Petitioner, who was her supervisor, for 4 months beginning in July 2015. (T. pp. 29-30) Ms. Guardado testified that she spent most of her day from 8:00 am to 5:00 pm in Petitioner's presence due to involvement in both group and individual meetings with Petitioner, but Ms. Guardado confirmed that she was not with Petitioner for every minute of the day. (T. pp. 30-31, 39) Ms. Guardado testified that while in Petitioner's presence during a meeting she did not notice Petitioner ever typing on a computer. (T. p. 33) When Ms. Guardado would work after normal work hours, she noticed Petitioner present on no more than one occasion. (T. p. 34) Ms. Guardado could not recall Petitioner picking up files from the file room, but she was asked by Petitioner to pick up files. (T. p.35) Ms. Guardado testified that Petitioner did not perform re-certifications for housing data. (T. p. 35) Ms. Guardado acknowledged that she did not have any personal knowledge as to how much time Petitioner spent typing up notes or minutes when she was not with Petitioner. (T. p. 40)

Damarixa Montoya, currently the Housing Choice Voucher Supervisor, testified that she had been a Re-Certification Specialist from 2003 until about 2015. (T. pp. 41-43) Petitioner was Ms. Montoya's boss for approximately 3 years. (T. p. 43) Ms. Montoya testified that she was in Petitioner's office throughout the day for individual meetings with Petitioner, and she was also in group meetings with Petitioner. (T. pp. 43-45) The group meetings would take place 3 to 4

times per week and last two hours or more for each meeting. (T. pp. 44-45, 53) The individual meetings could last one hour to discuss non-work issues such as their families, and they could last 20 minutes per file with numerous files to discuss at times. (T. p. 45) When in Petitioner's presence, Ms. Montoya did notice Petitioner sometimes typing on a computer for email purposes, but the typing would last seconds. (T. pp. 45-48) She also observed Petitioner making notes on pads of paper. (T. p. 52) Ms. Montoya testified that when she would work after hours or on the weekends, Petitioner was not present. (T. pp. 48-49) Ms. Montaya testified that Petitioner did not perform re-certifications for housing data. Ms. Guardado acknowledged that she did not spend every minute with Petitioner and that she did not have any personal knowledge as to the kind of typing or work Petitioner was performing when she was not with Petitioner. (T. p. 53)

Ms. Montaya testified that Petitioner did inform her that she had carpal tunnel syndrome, but no one else was present when she was so informed, and Ms. Montoya could not recall the date of this discussion. (T. p. 49) Ms. Montoya further testified that Petitioner did not provide any details as to how she contracted carpal tunnel syndrome. (T. p. 50)

Charles J. Chambers, Jr., the Executive Director/Chief Executive Officer for Respondent since 2011, was Petitioner's direct supervisor from 2011 through 2015. (T. pp. 57-58) Mr. Chambers testified that he spent approximately 30 minutes per day in Petitioner's presence. (T. pp. 58, 81-82, 88) He testified that he would be at the office typically from 9:00 am until anywhere from 5:00 to 7:00 pm, and he also testified that at times he worked late as well as worked on weekends, but Petitioner was never present during such times. (T. pp. 59-60) Mr. Chambers testified that Petitioner informed him for the first time in 2011 or 2012 that she does not take work home. (T. pp. 61-64, 85) He acknowledged that he does not have any personal knowledge as to whether Petitioner may have changed her position regarding taking work

home. (T. p. 86) He also agreed that he did not have personal knowledge as to whether Petitioner would be present in the office on weekends or after normal hours when he was not present. (T. pp. 93-94)

Mr. Chambers testified that Petitioner was responsible for completing paperwork for Housing and Urban Development ("HUD") deadlines. (T. p. 64) Mr. Chambers explained that CMAP is a report card on the Section 8 program, and that he has to certify CMAP every March, but HUD can call an audit at any time. (T. p. 66) HUD called an audit in 2015, but Petitioner missed the deadline, and an extension deadline for on or about November 3, 2015 was then scheduled. (T. pp. 66-68) Petitioner failed to prepare and file paperwork necessary to meet the HUD deadline extension, and Petitioner was suspended for three days pending termination. (T. pp. 68-69; RX 3) Mr. Chambers prepared the November 4, 2015 Memorandum detailing the reasoning for Petitioner's suspension. (T. pp. 69-70) Mr. Chambers and the staff then prepared all of the paperwork for the CMAP audit. (T. pp. 99-100)

Mr. Chambers denied that Petitioner informed him in April 2015 that she had bilateral carpal tunnel syndrome, and he testified that he did not become aware that Petitioner had carpal tunnel syndrome until after she had been provided the November 4, 2015 suspension. (T. p. 71) Mr. Chambers also denied ever stating to Petitioner that he could tell that Petitioner does not have bilateral carpal tunnel syndrome as his ex-mother-in law was a doctor, but he did agree that Petitioner knew that his ex-mother-in-law was a doctor from when they worked closely in the past and shared information about each other. (T. pp. 71, 103-105) Since 2013, when an employee has a work injury and informs him of that injury, Mr. Chambers would immediately call in the HR Director, and the employee would write on a piece of paper the injury details. (T. pp. 72-73, 100) Miss Rodney was the person responsible for HR since 2013. (T. pp. 72-73)

Mr. Chambers agreed that one of Petitioner's job duties was to research HUD procedures, but Petitioner would never type up the findings from her research, nor would she need to do so as Petitioner would just follow the procedures. (T. p. 75) Mr. Chambers also agreed that Petitioner was part of the team involved in preparing a new administrative plan, but Petitioner never performed any typing herself related to this project. (T. p. 75) In the meetings he attended relating to the new administrative plan, Mr. Chambers did not see Petitioner taking notes on a pad of paper. (T. p. 90) Mr. Chambers testified that Petitioner was the director over the Section 8 Department, and her job duties included making sure the day-to-day operation ran smoothly, making sure inspections were scheduled for the inspectors and ensuring that they finished their re-certifications. (T. pp. 76-77) Mr. Chambers also highlighted that Petitioner was directly responsible for CMAP, the report card running the Section 8 program, and ensuring that CMAP is ready by March 1st. (T. p. 77) Mr. Chambers testified that Petitioner's use of the keyboard for her job, including emails, amounted to approximately 1 hour per day or a total of 5 hours per week. (T. pp. 78-79)

Mr. Chambers did not recall receiving any regular summaries from Petitioner for any of the meetings she attended. (T. pp. 95-96) Mr. Chambers testified that from January 1, 2015 through Petitioner's suspension on November 4, 2015, Petitioner was not performing all of her work duties, in particular pulling files and pulling the information necessary from the files, as Petitioner would direct the staff to perform that work. (T. p. 98)

Mr. Chambers also testified that the job description found in Respondent's Exhibit 2 was a consistent description of the Deputy Director position. (T. pp. 80-81, 92; Rx. 2)

Miss Celester Rodney, currently the Director of Human Resources since 2015, testified that part of her job duties include preparing paperwork when an employee claims a work injury. (T. pp. 110-111) Miss Rodney testified that in 2015, an employee who alleged a work injury would be taken to Corporate Health Division at Vista East Hospital to examine the injuries and perform drug testing, and then return to complete an incident report as well as documentation for the insurance carrier. (T. p. 112) Miss Rodney testified that Petitioner never came to her to inform her that Petitioner suffered from carpal tunnel syndrome, including in April 2015. (T. p. 113) If Petitioner had notified Miss Rodney of suffering carpal tunnel syndrome from work, Miss Rodney testified that she would have begun the process described above. (T. p. 113) Miss Rodney testified that she first became aware that Petitioner had bilateral carpal tunnel syndrome after Petitioner had been suspended on November 4, 2015 when she came in wearing braces on each arm on her last day of employment. (T. pp. 114-115) Miss Rodney had no personal knowledge whether Petitioner reported her condition to Miss Rodney's predecessor. (T. p. 115)

A March 27, 2014 CT scan of the cervical spine found in Dr. Chhabria's records provide that Petitioner had upper extremity pain and a recent injury while lifting. (PX 1B)

Petitioner was seen at Aurora Health Care on October 27, 2014 providing a history that she fell down steps the day before and wanted the fall noted in her chart, but Petitioner denied any injury at the present time. (RX 5) She was later seen on November 13, 2014 for acute neck pain with radiation to the right upper extremity. (PX 2) It was noted that symptoms began approximately 2 weeks ago after a fall and that she had several similar issues over the past year due to known cervical spondylosis. (PX 2)

On March 13, 2015, Dr. Arora at Aurora Health Care noted a history of right arm weakness and difficulty gripping with the right hand and radiation from the neck/shoulder down which started 3 months prior. (PX 2) Petitioner stated that she worked on a keyboard all day. (PX 2) Dr. Arora assessed Petitioner with possible cervical radiculopathy and ordered an EMG with nerve conduction velocity. (PX 2)

Dr. Shaku Chhabria's medical records provide that Petitioner was seen as a new patient on April 3, 2015 with complaints of a neckache as well as numbness in her right hand. (PX 1A&B) The history indicates Petitioner informed Dr. Chhabria that her arm "feels heavy and dead weight" and it was noted these symptoms were for six months and were a "slow progressive." (PX 1A&B) It was also noted that Petitioner complained of trouble performing her writing and typing activities. (PX 1A&B) The April 3, 2015 EMG report indicated testing revealed bilateral carpal tunnel syndrome as well as cervical radiculitis with C5-6 denervation. (PX 1A&B) Dr. Chhabria diagnosed carpal tunnel syndrome, cervical radiculopathy, neuropathy, and spinal stenosis of the cervical and lumbar regions. (PX 1A&B)

Dr. Arora saw Petitioner on April 5, 2015 with Petitioner complaining of pain bilaterally but worse on the right. (PX 2) Dr. Arora noted that the EMG revealed bilateral carpal tunnel syndrome as well as C5-6 radiculitis. (PX 2) A MRI of the cervical spine was ordered, and Petitioner was to wear carpal tunnel splints. (PX 2)

On November 3, 2015 at 3:15 pm, Petitioner returned to Dr. Arora with complaints of low back pain, arm paresthesias and neck pain. (RX 5) Petitioner indicated that she had not heard from the neurologist, nor had she made an appointment with the neurologist. (RX 5) Dr. Arora indicated that Petitioner attributed some of her symptoms to work, wanted workers' compensation for carpal tunnel and wanted an opinion on the bilateral carpal tunnel

syndrome. (RX 5) Dr. Arora diagnosed Petitioner with bilateral carpal tunnel syndrome as well as spondylosis of the cervical and lumbar regions, and Petitioner was recommended to follow-up with the neurologist. (RX 5)

On November 5, 2015, Dr. Chhabria noted that Petitioner had CTS and a wrist splint. (PX 1A&B) Dr. Chhabria ordered a repeat EMG of the arms, and he ordered Petitioner to avoid repeated use of the arms as well as field work. (PX 1A&B) Dr. Chhabria noted that carpal tunnel syndrome was most likely work related. (PX 1A&B) On November 9, 2015, Dr. Chhabria noted Petitioner works at a computer, data entry and prepared reports, and Petitioner was diagnosed with clinical carpal tunnel syndrome right greater than left although the EMG testing was showing carpal tunnel syndrome left greater than right. (PX 1A&B) The November 9, 2015 EMG report indicates Petitioner provided a history that her symptoms were "worst in the last 1 year" and her numbness and weakness was greater in the right arm versus the left. (PX 1A&B) The EMG findings were consistent with bilateral carpal tunnel syndrome, left greater than right and early C5-6 cervical radiculopathy. (PX 1A&B) Dr. Chhabria noted that Petitioner felt her condition was work related, and Petitioner was going to "talk to her HR." (PX 1A&B)

Petitioner first presented to Dr. Weinzweig on November 18, 2015 with a history of bilateral carpal tunnel syndrome for 2 years. (PX 3) Dr. Weinzweig noted that Petitioner had a typing job for 9 years and that Petitioner had worn splints for 6 months with no improvement. (PX 3) Dr. Weinzweig diagnosed Petitioner with bilateral carpal tunnel syndrome, ordered a left carpal tunnel release to be undertaken initially and placed Petitioner off of work pending surgery. (PX 3)

On December 14, 2015, Petitioner returned to Dr. Arora, wearing splints for bilateral carpal tunnel syndrome. (PX 2) Dr. Arora noted that Petitioner "wants workmans comp for

carpal tunnel," and Dr. Arora noted that Petitioner attributes some of her symptoms to work. (PX 2) Dr. Arora recommended Petitioner follow up with her neurologist. (PX 2)

On January 6, 2017, Dr. Chhabria noted that Petitioner was retired and will not return to work. (PX 1A&B)

Subsequently, on April 12, 2017, Dr. Weinzweig performed a left carpal tunnel release. (PX 3) On June 21, 2017, Dr. Weinzweig noted that Petitioner's right hand was still positive for carpal tunnel syndrome. (PX 3) A release of the right carpal tunnel was planned. (PX 3)

Dr. Weinzweig, a board certified plastic surgeon, testified on May 4, 2018 via deposition. (PX 4) Dr. Weinzweig testified that Petitioner had been working a job largely typing for nine years prior to his first examination of the Petitioner on November 18, 2015, and Petitioner had felt bilateral carpal tunnel symptoms for the two years leading up to this examination. (PX 4, pp. 9, 37-38) Dr. Weinzweig noted that Petitioner had worn splints for 6 months. (PX 4, p. 10) Dr. Weinzweig highlighted that he performed a carpal tunnel release for the left hand on April 12, 2017 and a carpal tunnel release for the right hand on January 3, 2018. (PX 4, pp. 16, 19) Dr. Weinzweig last saw Petitioner on April 18, 2018 at which time he noted both sides had fully resolved and Petitioner was released from care as Petitioner did not require additional treatment. (PX 4, pp. 20, 25) Dr. Weinzweig testified that it was his opinion that Petitioner's bilateral carpal tunnel syndrome was causally related to her repetitive work activities over the nine years of performing such work. (PX 4, p. 23) Dr. Weinzweig admitted that he did not have any information regarding other types of repetitive work Petitioner performed, and he did not have an understanding as to the exact number of hours Petitioner performed typing in her position, although he testified that typing was a "huge part of what she

did on a daily basis," and he was sure that Petitioner's typing accounted for "four hours, six hours, seven hours" of Petitioner's daily work activities. (PX 4, pp. 23-24, 31) Dr. Weinzweig acknowledged that Petitioner may have been referred to him from an attorney's office. (PX 4, p. 30) When asked on cross-examination, Dr. Weinzweig admitted that he did not review a job description, did not know Petitioner's job title, and only knew Petitioner's job duties from that which was provided by Petitioner, namely working in an office for nine years "doing predominantly typing type of activities during the day." (PX 4, p. 31) Dr. Weinzweig did not review records from Chhabria Neurological Services nor from Dr. Arora. (PX 4, p. 33) Dr. Weinzweig acknowledged that carpal tunnel is more prevalent in women in their 40s and 50s, and he noted that Petitioner was obese. (PX 4, pp. 34-35, 40)

Dr. Thomas Francis Gleason, a board certified orthopedic surgeon with Illinois Bone & Joint, performed an Independent Medical Examination on Petitioner on May 10, 2016. (RX 1 pp. 4-6, 9-10) Dr. Gleason noted that his practice includes the treatment of patients involving workers' compensation accidents, and his practice also includes the treatment, including surgery, of carpal tunnel syndrome. (RX 1 pp. 7, 9) Dr. Gleason indicated that 20% of his medical-legal work is at the request of petitioners/plaintiffs. (RX 1, p. 35) Dr. Gleason testified that Petitioner had provided a history to him that on approximately November 1, 2014, having no specific injury, but due to repetitive typing, she started feeling neck pain going down both arms with weakness, numbness, tingling and heaviness of both arms, right greater than left. (RX 1, p. 13) Petitioner told Dr. Gleason that her job required a lot of typing, using a computer mouse and filing as well as sometimes having to lift up to 100 pounds, and she indicated that she did not have any neck or hand injuries or complaints prior to November 1, 2014. (RX 1 pp. 14-15, 38, 41) Dr. Gleason reviewed the Deputy Director job description. (RX 1, pp. 38, 42) Petitioner

was obese. (RX 1, p. 15) Dr. Gleason reviewed records from Dr. Chhabria and Dr. Arora as well as the diagnostic studies including July 30, 2015 MRIs of the lumbar and cervical regions as well as the EMG studies from April 3, 2015 and November 9, 2015 for the bilateral upper extremities. (RX 1, pp. 21-28) Regarding Petitioner's bilateral hands, Dr. Gleason diagnosed Petitioner with bilateral left greater than right carpal tunnel syndrome in the absence of positive objective findings on physical examination. (RX 1, pp. 27-28) Dr. Gleason noted that Petitioner's subjective complaints did outweigh objective findings and there was give way weakness in both hands when testing the hand muscles which could suggest magnification and/or exaggeration. (RX 1, pp. 28-29, 41) Dr. Gleason testified that Petitioner's bilateral hand conditions were not causally related to her work activities, and he further testified that Petitioner's neck and low back conditions were also not causally related to her work activities. (RX 1, p. 29) Dr. Gleason felt that as of May 10, 2016, Petitioner could be considered at MMI with respect to any work activities for Respondent, and he further opined that the treatment Petitioner had undergone was not causally related to her work activities, nor would the bilateral carpal tunnel releases and post-surgical therapy be causally related to Petitioner's work activities. (RX 1, pp. 29-30) Dr. Gleason testified that Petitioner did not require any work restrictions when he examined her on May 10, 2016, and Petitioner did not require any work restrictions prior to his examination that would be related to Petitioner's work activities. (RX 1, p. 31) Dr. Gleason noted that carpal tunnel is more common in women, and more common in women in their 50s than women who are younger. (RX 1, p. 31) Dr. Gleason highlighted that a tight carpal tunnel "can be idiopathic, something that somebody was born with or had a predisposition to." (RX 1, pp. 31-32)

Petitioner claims that there exists $11,440.99 in outstanding medical bills for treatment rendered by Dr. Weinzweig and $5,950.00 outstanding for treatment rendered by Dr. Chhabria. (PX 5) A Blue Cross Blue Shield itemization indicates that total benefits of $4,389.27 were provided to resolve $36,876.02 in charges from April 3, 2015 through April 18, 2018. (RX 4)

The November 4, 2015 Internal Memorandum that was prepared by Mr. Chambers and executed by Petitioner provides that Petitioner was suspended without pay for three days effective November 4, 2015. (RX 3) The three day suspension would start Thursday, November 5, 2015 and end Monday, November 9, 2015. (RX 3) The document detailed that Petitioner had been expected to have documentation ready for an October 30, 2015 HUD audit, but Petitioner failed to meet this deadline and called in sick on October 30, 2015. (RX 3) The Memorandum further detailed that Petitioner met with Mr. Chambers on November 2, 2015 and she admitted to having lost the documentation necessary for the audit. (RX 3) On the HUD extension deadline date of November 3, 2015, as of 1:00 pm Petitioner still had not completed the information necessary for the audit. (RX3) Petitioner ultimately did not complete the report, nor did she advise Mr. Chambers why she had left the office; however, the document indicated that a staff member had indicated that Petitioner claimed she had an emergency when leaving. (RX 3) Petitioner did execute the document on November 4, 2015 and handwrote the following: "I do not agree with this suspension but I will have a response to this write up within 10 business days." (RX 3)

CONCLUSIONS OF LAW

Legal Standard

It is axiomatic that to recover workers' compensation benefits, Petitioner has the burden of proving every element of her case by a preponderance or greater weight of the credible evidence. Arbuckle v. Industrial Commission, 32 Ill.2d 581 (1965) and Hannibal v. Industrial Commission, 38 Ill.2d 473 (1967).

The question of whether a claimant's work activities are sufficiently repetitive must be decided on a case-by-case basis on the particular facts presented in each case, and it is the function of the Commission to judge the credibility of the witnesses, determine the weight to be given to their testimony and to draw reasonable inferences from that testimony. Williams v. Industrial Commission, 244 Ill.App.3d 204, 614 N.E.2d 177, 185 Ill.Dec. 43 (Ill. App. 1st, 1993) citing Berry v. Industrial Commission, 459 N.E.2d 963 (1984) The notice element of a prima facie case involving a repetitive trauma injury first entails a determination as to the manifestation date of the injury. In Peoria County Belwood Nursing Home v. Industrial Commission, 115 Ill.2d 524, 505 N.E.2d 1026, 106 Ill.Dec. 235 (1987), the date of an accidental injury in a repetitive trauma case was found to be the date on which the injury manifests itself. The injury manifests itself on the date when both the fact of the injury and the causal relationship of the injury to the claimant's employment would become plainly apparent to a reasonable person. (Peoria County Belwood, 505 N.E.2d at 1029) In Durand v. Industrial Commission, 224 Ill. 2d 53, 862 N.E.2d 918, 308 Ill.Dec. 715 (2006), the Illinois Supreme Court held that manifestation of a repetitive trauma injury occurs when the fact of injury and causation has become plainly apparent to a reasonable person. The standard for determining the manifestation

date in a repetitive trauma case is flexible and fact-specific and is guided by considerations of fairness. Durand, 862 N.E.2d at 928.

C. In support of the Arbitrator's decision on whether an accident occurred that arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator concludes as follows:

As this case involves repetitive trauma rather than a specific event, the Arbitrator must weigh whether the job activities performed by Petitioner within her employment by Respondent were, in fact, repetitive in nature, and if so, whether those job activities arose out of and in the course of Petitioner's employment.

The Arbitrator concludes that the totality of the evidence presented by both parties does not support that Petitioner performed any work activity in a repetitive fashion so as to be sufficient to meet her burden of proof that she suffered an accident that arose out of and in the course of Petitioner's employment by Respondent.

Discrepancies in Work Activities:

Petitioner testified that her job activities included answering emails, performing and overseeing inspections, taking phone calls, participating in various meetings and creating documents, including memos, letters and job descriptions. Petitioner testified that she would handwrite correspondence in a notebook and then type the correspondence using a computer, and that she used a keyboard 5 to 6 hours per day.

Ms. Beshel testified that she spent 3 to 4 hours per day in Petitioner's presence, mostly in group and individual meetings, but she never noticed Petitioner typing during these periods. Ms. Guardado testified that she spent most of her day in Petitioner's presence due to involvement in both group and individual meetings, but Ms. Guardado never noticed Petitioner typing on a computer when involved in the meetings. Ms. Montoya also testified to spending significant

time with Petitioner in both group and individual meetings. Ms. Montoya testified that she did sometimes observe Petitioner typing on a computer for email purposes, but the typing would only last seconds. Ms. Montoya and Ms. Beshel both agreed that Petitioner would handwrite notes.

Ms. Beshel testified that she took over as Quality Control Coordinator in August 2015. Despite Ms. Beshel testifying that there existed more work for her to complete than typical when she took over because work associated with the position had not been performed, the amount of typing the job required in August 2015 amounted to 15 minutes per day. Mr. Chambers testified that Petitioner's use of the keyboard for her job, including emails, amounted to approximately 1 hour per day for a total of approximately 5 hours per week.

Petitioner also testified that her job activities included pulling files from a storage room. Ms. Beshel testified that while Petitioner probably did pull her own files from storage, most of the time staff members were asked to perform this task for Petitioner. This was echoed by Mr. Chambers who testified that Petitioner was not performing all of her work duties as, in particular, Petitioner was not pulling files and pulling information necessary from the files as she would direct the staff to perform that work. Ms. Guardado testified that she could not recall Petitioner picking up files from the file room, but Petitioner did request Ms. Guardado to pick up files.

Petitioner also testified that every month she would have meetings with clients to review their documentation for the Section 8 program re-certification, and that Petitioner had to gather paperwork and manually staple papers together. The data would then be inputted into the housing data systems. Petitioner testified that it took her 60 minutes per client to input data from the annual recertification, and that she had 100 clients per month. Ms. Montoya, a Re-

Certification Specialist from 2003 until about 2015 and current Director for Housing Choice Voucher Supervisor, testified that Petitioner did not perform re-certifications for housing data. Ms. Guardado also testified that Petitioner did not perform the re-certifications.

Petitioner testified that she would return to the office in the evenings and work on the weekends, and that she mostly typed at work rather than at home. By contrast, Respondent's witnesses, Debra Beshel, Damarixa Montoya and Charles Chambers, testified that they never saw Petitioner present in the office working when they were in the office after normal business hours. Luz Guardado also testified that she only saw Petitioner on one occasion in the office after normal business hours.

Prior Incidents And Complaints:

Petitioner initially testified that she felt a strange pain "all of a sudden" to her right hand while typing on her computer on April 3, 2015, but later testified under cross-examination that she had right hand complaints that pre-dated March 2015 and that the complaints began from two prior incidents, one being a slip in her kitchen. Petitioner acknowledged that the fall incident could have occurred in the fall of 2014 and the records from Aurora Health Care, dated October 27, 2014, indicate that Petitioner provided a history that she fell down steps the day before and wanted the fall noted in her chart. By November 13, 2014, the records from Aurora Health Care highlight that Petitioner was complaining of neck pain with radiation to the right upper extremity following a fall 2 weeks prior.

The March 13, 2015 record from Aurora Health Care indicates Petitioner provided a history of right arm weakness and difficulty gripping with the right hand as well as radiation for the neck down that had started 3 months prior.

The history provided in Dr. Chhabria's records indicate that Petitioner provided on April 3, 2015 that she had felt that her arm "feels heavy and dead weight" and that these symptoms had lasted for 6 months and were a "slow progressive."

Dr. Weinzweig testified that when he first saw Petitioner on November 18, 2015, Petitioner informed him that she had felt bilateral carpal tunnel symptoms for 2 years prior to his examination. Dr. Weinzweig opined that Petitioner's bilateral carpal tunnel syndrome was causally related to her repetitive work activities over the nine years of performing such work, but he admitted that he did not have knowledge of any work activities Petitioner performed repetitively other than he believed Petitioner typed on the computer keyboard for a period of "four hours, six hours, seven hours" each and every day she worked.

Dr. Gleason testified that Petitioner informed him that on approximately November 1, 2014, having no specific injury, but due to repetitive typing, she started feeling neck pain going down both arms with weakness, numbness, tingling and heaviness of both arms, right greater than left. Petitioner informed Dr. Gleason that her job required a lot of typing, using a computer mouse and filing as well as lifting at times up to 100 pounds.

The Arbitrator finds that Petitioner's testimony regarding when she began experiencing hand complaints (April 2015) and how they started (pain all of a sudden) appear inconsistent with the statements she made to Drs. Gleason and Weinzweig, as well as the histories provided in Dr. Chhabria and Aurora Health Care's records.

The Arbitrator finds that Petitioner's testimony regarding the amount of typing she performed per day for Respondent (5 to 6 hours) inconsistent with her actual job duties and not supported by the testimony provided by staff members who worked underneath Petitioner as well as Petitioner's direct supervisor. Respondent's witnesses, namely, Ms. Beshel, Ms. Montoya and

Ms. Guardado, spent significant time in Petitioner's presence, both in group as well as individual settings, and they each testified to Petitioner's lack of typing while in her presence. Furthermore, Mr. Chambers, Petitioner's direct supervisor who had knowledge of Petitioner's job duties, testified that Petitioner's use of the keyboard for her job would amount to only 1 hour per day. Although Petitioner claimed that she would return to the office after hours and she would work on the weekends, except for one occurrence, Ms. Beshel, Ms. Montoya, Ms. Guardado and Mr. Chambers testified that they never saw Petitioner in the office when they were present outside of normal business hours.

Therefore, the Arbitrator concludes that Petitioner's work activities were not sufficiently repetitive in nature and thus Petitioner did not sustain an accident that arose out of and in the course of her employment by Respondent.

E. In support of the Arbitrator's decision as to whether timely notice of the accident was given to Respondent the Arbitrator concludes as follows:

Based on the Arbitrator's Rulings on the issue of Accident and Causal Relation, this issue is moot.

F. In support of the Arbitrator's decision whether Petitioner's condition of ill-being is causally related to the injury, the Arbitrator concludes as follows:

The Arbitrator concludes that Petitioner's bilateral carpal tunnel syndrome is not causally related to her work activities.

Dr. Weinzweig testified that when he first saw Petitioner on November 18, 2015, Petitioner informed him that she had felt bilateral carpal tunnel symptoms for 2 years prior to his examination. Dr. Weinzweig opined that Petitioner's bilateral carpal tunnel syndrome was causally related to her repetitive work activities over the nine years of performing such work, but he admitted that he did not have knowledge of any work activities Petitioner performed

repetitively other than he believed Petitioner typed on the computer keyboard for a period of "four hours, six hours, seven hours" each and every day she worked.

Dr. Weinzweig testified it was his opinion that Petitioner's bilateral carpal tunnel syndrome was causally related to her repetitive work activities over nine years of performing such work; however, Dr. Weinzweig admitted that he did not have any information regarding other types of repetitive work Petitioner performed, and he did not have an understanding as to the exact number of hours Petitioner performed typing in her position, although he believed typing was a "huge part of what she did on a daily basis" and that typing accounted for "four hours, six hours, seven hours" of Petitioner's daily work activities. Dr. Weinzweig also admitted that he did not review a job description, did not know Petitioner's job title and his only understanding of Petitioner's job duties came from what Petitioner told him, namely working in an office for nine years "doing predominantly typing type of activities during the day." Dr. Weinzweig also never reviewed records from Dr. Arora or Chhabria Neurological Services.

Dr. Gleason testified that Petitioner informed him that on approximately November 1, 2014, having no specific injury, but due to repetitive typing, she started feeling neck pain going down both arms with weakness, numbness, tingling and heaviness of both arms, right greater than left.

Dr. Gleason secured a similar history from Petitioner to what she provided Dr. Weinzweig, namely that her job required a lot of typing, using a computer mouse and filing as well as sometimes having to lift up to 100 pounds. Dr. Gleason however had reviewed the Deputy Director job description as well as reviewed records and diagnostic scans from Dr. Arora and Chhabria Neurological Services. With an understanding as to Petitioner's job duties, Dr. Gleason testified that Petitioner's bilateral hand conditions were not causally related to her work

activities. He also noted that carpal tunnel is more common in women as well as women in their 50s than women who are younger. Dr. Gleason also explained that a tight carpal tunnel "can be idiopathic, something that somebody was born with or had a predisposition to."

As noted above under Section C, Petitioner's work activities did not arise to a level that would be considered sufficiently repetitive in nature in order to sustain an accident that arose out of and in the course of Petitioner's employment by Respondent. The Arbitrator also finds Dr. Gleason had more knowledge of Petitioner's work activities than Dr. Weinzweig as Dr. Weinzweig admitted that he did not have a knowledge of Petitioner's work activities that could be considered repetitive other than believing that Petitioner's computer keyboarding accounted for anywhere between 4 to 7 hours of her typical day. Dr. Weinzweig never reviewed Petitioner's job description and he never reviewed the records from Dr. Arora and Dr. Chhabria. In contrast, Dr. Gleason had examined the medical records and diagnostic scans, and he also reviewed Petitioner's job description. Dr. Gleason also noted that Petitioner was in a class (women over 50) in which carpal tunnel is more common, and he testified that a tight carpal tunnel can be idiopathic.

J. In support of the Arbitrator's decision regarding 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 concludes as follows:

While the Arbitrator finds that the medical services Petitioner underwent to resolve her bilateral carpal tunnel syndrome were reasonable and necessary, the Arbitrator concludes that Respondent is not liable for the medical services based upon the Arbitrator's decisions regarding accident, and causal causation.

K. In support of the Arbitrator's decision regarding whether Petitioner is entitled to, and is Respondent liable for, TTD benefits, the Arbitrator concludes as follows:

As the Arbitrator finds Petitioner did not suffer a compensable work injury under the Act, the Arbitrator concludes Respondent is not liable for TTD benefits.

L. In support of the Arbitrator's decision regarding the nature and extent of the injury, the Arbitrator concludes as follows?

As the Arbitrator finds Petitioner did not suffer a compensable work injury under the Act, Petitioner is not entitled to, nor is Respondent liable for, permanency benefits.

SA0030:103

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

RAYMOND SIMENTAL,

Petitioner,

20IWCC0043

vs.

NO: 17 WC 3537

CASSENS TRANSPORT,

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 all issues, and being advised of the facts and law, reverses the Decision of the Arbitrator and finds that Petitioner's current condition of ill-being is causally related to the work accident he sustained on January 12, 2017. 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).

I. Findings of Fact

Petitioner was employed as a car hauler for Respondent. His job duties included loading vehicles onto a semi-truck also called a "car hauler," driving the car hauler truck, and delivering the vehicles. While loading vehicles onto the car hauler truck, Petitioner had to put straps over them and ratchet them down using a tie-down bar. To do so, he had to climb onto the different levels of the car hauler truck. Petitioner performed the loading process at the BSF railyard in Elmwood and then reversed the process to unload the vehicles at dealerships after delivering them.

On January 12, 2017, Petitioner attempted to load a Toyota Tundra onto the car hauler truck at the Elmwood railyard. While driving the vehicle in reverse, Petitioner hung out the door window with his ribs and elbow outside of the vehicle. Petitioner described his position as being

stretched out and standing in the driver's seat with his tip-toes on the accelerator and his head backwards to see as he backed up. As Petitioner proceeded to load the Toyota Tundra, it slid on ice, causing its back wheels to fall off the car hauler truck and slam two feet down onto the ground. Petitioner testified that he felt pain in his left rib cage, low back, and hips after the accident.

Petitioner first sought treatment with Dr. Jonathan Claud for left rib, back, and chest pain on January 17, 2017. Dr. Claud noted no pertinent past medical history. Thoracic and lumbar X-rays were obtained and showed moderate spondylosis with no acute fractures or traumatic malalignments. Dr. Claud diagnosed Petitioner with cardiovascular and musculoskeletal trauma, acute midline low back pain without sciatica, lumbar and thoracic osteoarthritis, and chest wall pain. Shortly thereafter, on January 23, 2017, Petitioner presented for a fitness for duty evaluation that placed his restrictions at no climbing nor lifting over 30 pounds. However, a subsequent fitness for duty evaluation on January 27, 2017 found him to be entirely unfit for duty.

Petitioner next saw Dr. Jennifer Kassir of the DuPage Medical Group on February 1, 2017 and complained of left midback pain and low back pain radiating into the left hip. Dr. Kassir's diagnoses included acute left-sided low back pain without sciatica, acute midback pain, left-sided rib pain, and lower extremity weakness. She noted that Petitioner's X-rays were unremarkable and referred him to physiatry.

Petitioner thereafter began seeing Dr. Martin Fetzer on February 8, 2017. Dr. Fetzer found that Petitioner displayed negative Waddell's signs and an Oswestry disability score of 48%. He read Petitioner's thoracic X-rays to show mild T1-T12 dextroconvex scoliosis and flattening of the thoracic kyphosis with mild to moderate degeneration. He also indicated that the lumbar X-rays showed normal lordosis, mild reduction in disc space at L4 to S1, and Grade 1 retrolisthesis at L4 on L5. Dr. Fetzer's diagnoses included low back and left lower limb pain, Grade 1 spondylolisthesis, and acute left-sided low back pain with sciatica.

On March 6, 2017, Petitioner began physical therapy and reported that his left leg and foot had been falling asleep for a few weeks. While participating in physical therapy, Petitioner continued to follow up with Dr. Fetzer. On March 23, 2017, Dr. Fetzer advised Petitioner to continue normal activities as tolerated and avoid any form of bedrest. He explained that recent guidelines encouraged physical activity for the improvement of functionality and overall pain.

On April 14, 2017, a lumbar MRI revealed a congenitally small bony spinal canal at L1-L5 along with spondylitic and degenerative disc changes resulting in mild central canal and bilateral foraminal stenosis at L4-L5. When Dr. Fetzer reviewed the MRI on April 21, 2017, he observed mild facet arthrosis with an L5-S1 annular fissure. Petitioner also displayed an antalgic gait at this treatment visit. Dr. Fetzer restricted Petitioner to no lifting greater than ten pounds with minimal bending and twisting. He later increased Petitioner's lifting restriction to 20 pounds on July 19, 2017.

Petitioner thereafter underwent an L5-S1 epidural steroid injection on November 17, 2017. When he returned to Dr. Fetzer on December 11, 2017, Petitioner's symptoms had persisted, and he had an Oswestry disability score of 58%. Petitioner received a second L5-S1 epidural steroid injection on December 28, 2017. On January 22, 2018, he reported feeling 70% better, and Dr.

Fetzer lowered his Oswestry disability score to 46%. A third lumbar epidural steroid injection was administered on February 9, 2018. Dr. Fetzer indicated that although these injections provided some improvement, Petitioner's symptoms continued to limit him. Petitioner thereafter underwent lumbar medial branch blocks at L3 to L5 on March 9, 2018.

When he returned to Dr. Fetzer on March 26, 2018, Petitioner's diagnoses included an L5-S1 annular fissure with mild foraminal stenosis and facet arthrosis, Grade 1 spondylolisthesis, lumbosacral spondylosis without myelopathy, and chronic bilateral low back pain with left-sided sciatica. Dr. Fetzer continued Petitioner's light duty restrictions and recommended repeat diagnostic L3 to L5 medial branch blocks. On April 16, 2018 and June 4, 2018, Dr. Fetzer maintained Petitioner's light duty restrictions and began ordering work conditioning. In his final June 4, 2018 work status note, Petitioner's restrictions included no lifting more than 20 pounds with minimal bending and stooping.

The parties deposed Dr. Fetzer on September 28, 2017. Dr. Fetzer testified that he disagreed with any opinion suggesting that Petitioner had no objective pathology, because of the presence of the L5-S1 annular fissure on his MRI images. He opined that Petitioner's annular tear was causally related to his work accident and noted that an annular tear was a more acute pathology within a disc. Dr. Fetzer further testified that because Petitioner did not have any prior symptoms, it was reasonable to conclude that the work event had caused the injury. He also saw no evidence of psychological or secondary gain throughout his treatment of Petitioner and did not find any Waddell's signs at the February 8, 2017 examination.

At Respondent's request, Petitioner also presented for a §12 examination with Dr. Martin P. Lanoff on May 31, 2017. Respondent's Exhibit 12 shows surveillance video of Petitioner being taken to and from this §12 examination by an Uber driver. Dr. Lanoff opined that Petitioner had no diagnosis whatsoever, and instead, he had only subjective complaints that were out of proportion to the objective findings with a maximally nonorganic presentation. Dr. Lanoff believed that Petitioner's current condition and treatment were not related to his work accident. He opined that Petitioner had mild degenerative changes that were normal for his age and there was no objective reason for Petitioner to have continued pain complaints or functional limitations. Dr. Lanoff further indicated that Petitioner had exhibited all five Waddell's findings and no significant radicular pathology.

When deposed on June 21, 2017, Dr. Lanoff testified consistent with his §12 report. He further testified that although he had observed the L5-S1 annular tear on Petitioner's MRI, it was a normal, asymptomatic part of the degenerative process within a disc. Dr. Lanoff clarified that he did not find any physical malady in Petitioner other than psychosocially-based pain behaviors. He acknowledged no objective findings of an injury on Petitioner's examinations or diagnostic images. Dr. Lanoff further testified that although Petitioner had degenerative changes and a high-intensity zone or annular tear, those findings did not hurt and were not objective pathology. He also conceded that there were small protrusions at L4 to S1 and disc bulges at L2 to L5 on Petitioner's films. Nevertheless, Dr. Lanoff testified that although Petitioner's MRI was not pristine, it was normal for his age and had nothing to do with his symptoms.

Due to a scheduling issue, Dr. Lanoff's deposition was bifurcated and resumed on October

19, 2017. At that time, Dr. Lanoff indicated that his opinions had not changed since his prior deposition. He again testified that Petitioner's annular tear, disc protrusions, and degenerative changes had nothing to do with his symptoms. Dr. Lanoff further testified that the L5-S1 retrolisthesis shown on Petitioner's MRI was degenerative and not a pain-causing condition.

This matter proceeded to a §19(b) hearing on March 12, 2019. At that time, Petitioner had not worked anywhere since January 2017, and the work conditioning recommended by Dr. Fetzer had not yet been authorized. Petitioner testified that he continued to have low back, hip, and left leg pain with left leg numbness. He noted ongoing functional limitations with climbing stairs, walking, camping, motorcycling, and participating in car enthusiast activities. Respondent's Exhibit 12 included surveillance videos documenting Petitioner's actions on May 30 and 31, 2017, October 13, 2017, and June 4, 2018.

At the time of the hearing, Petitioner also had a pending penalties petition that alleged, in part, that Respondent was frivolous and vexatious for refusing to send Petitioner's temporary total disability checks directly to his home. Petitioner's attorney represented that he personally had to go to Petitioner's place of employment to pick up the checks. In a prior May 22, 2017 letter, Petitioner's attorney had requested that the checks be sent to Petitioner's home and stated that Petitioner was unable to drive for more than ten to 15 minutes at a time due to his lumbar condition.

Tom Zitt, Respondent's terminal manager, testified that Petitioner was not the only individual who came to the terminal to pick up his temporary total disability checks, and instead, this pick-up procedure had been part of Respondent's policy for 25 years. Mr. Zitt testified that Respondent wanted employees to come to the terminal to pick up their checks, because Respondent could find out about their current conditions, get updates, and let them know if anything was changing within the company.

According to Respondent's Exhibit 6, which was Google directions from Petitioner's residence to Respondent's terminal, the distance between the two locations was 11.4 miles and would take a driver approximately 22 to 24 minutes to travel. Petitioner testified that he picked up his checks once every month and could drive the 11 miles from his home to the terminal to get the checks. Respondent's Exhibit 3 was a log kept by Respondent that showed when Petitioner's temporary total disability checks were picked up.

Petitioner further testified that on May 26, 2017, he drove himself to Respondent's terminal and met his attorney there, so he could observe the procedure for getting the checks. Petitioner testified that when he arrived at the terminal, his attorney was already coming out of Respondent's building with the checks. Petitioner then drove himself to the bank without his attorney. Respondent's Exhibit 5 contained surveillance photographs of Petitioner's vehicle entering and leaving the terminal on May 26, 2017.

In the Decision of the Arbitrator issued on May 1, 2019, the Arbitrator found that Petitioner's current condition was not causally related to the January 12, 2017 accident. Instead, the Arbitrator found that Petitioner had reached maximum medical improvement for his injuries as of May 31, 2017, and as such, both medical expenses and temporary total disability benefits were awarded only up to May 31, 2017. Petitioner's request for penalties and fees was also denied.

20IWCC0043

II. Conclusions of Law

Causal Connection

Following a careful review of the entire record, the Commission reverses the Decision of the Arbitrator and finds that the current condition of Petitioner's lumbar spine is causally related to his January 12, 2017 work accident. In doing so, the Commission relies upon Dr. Fetzer's causal opinions and finds them to be more persuasive than the opinions offered by Dr. Lanoff.

Dr. Lanoff's opinion that Petitioner had no physical malady or objective findings is disproved by Petitioner's MRI and radiographic studies, which showed the presence of an L5-S1 annular fissure, moderate spondylosis, Grade 1 retrolisthesis, reduction in disc space at L4 to S1, mild facet arthrosis, and degenerative changes resulting in mild central canal and bilateral foraminal stenosis. Dr. Lanoff even conceded that there were small protrusions at L4 to S1 and disc bulges at L2 to L5 in Petitioner's films. Given these radiographic findings, the Commission is not persuaded by Dr. Lanoff's contention that there was no objective pathology. Additionally, although Dr. Lanoff suggested that medical literature supported his stance that annular tears were asymptomatic and degenerative, none of the referenced medical studies were included in his deposition transcript. As such, the Commission was unable to evaluate these studies.

In further support of Dr. Fetzer's causal opinions, the Commission places great weight on the fact that Petitioner had no pre-accident lumbar problems. Petitioner began to complain of low back pain immediately after his accident, and there were no other preceding or intervening accidents in which to attribute his symptoms. Even if Petitioner's annular tear was a degenerative condition as Dr. Lanoff had opined, the Commission finds that the work accident would still have aggravated that condition, as Petitioner only became symptomatic after his accident. When considering if an accident aggravated a preexisting condition, the Commission may infer that: "if a claimant is in a certain condition, an accident occurs, and following the accident, the claimant's condition has deteriorated, it is plainly inferable that the intervening accident caused the deterioration." *Schroeder v. Comm'n*, 2017 IL App (4th) 160192WC. As such, even if the annular tear was a degenerative condition and not an acute injury, it is inferable that the work accident aggravated that previously asymptomatic condition.

Finally, the Commission is persuaded by Dr. Fetzer's observation that Petitioner exhibited no evidence of psychological or secondary gain throughout his treatment. Dr. Fetzer found no Waddell's signs at Petitioner's February 8, 2017 examination. Although Dr. Lanoff found Petitioner had positive Waddell's signs and a maximally nonorganic presentation at the §12 examination, the Commission finds Dr. Fetzer's opinion to be more reliable, because Dr. Fetzer saw Petitioner numerous times throughout the course of his treatment and never doubted the authenticity of Petitioner's pain complaints.

The Commission thus relies on Dr. Fetzer's opinions and reverses the Decision of the Arbitrator accordingly to find that Petitioner's current condition is causally related to his January 12, 2017 accident.

Temporary Total Disability

In further reliance on Dr. Fetzer's opinions, the Commission finds that Petitioner proved his entitlement to temporary total disability benefits from June 16, 2017 to July 17, 2017 and from September 7, 2017 to the March 12, 2019 hearing date, as requested on Arbitrator's Exhibit 1.

Petitioner testified that he had not worked anywhere since January of 2017 and was kept on work restrictions throughout his entire course of treatment. The treatment records corroborate that Petitioner was on light duty restrictions in June of 2017, which is the beginning of the temporary total disability period that Petitioner claimed. Petitioner was never subsequently returned to full duty work by Dr. Fetzer.

The Commission further notes that the surveillance videos included in Respondent's Exhibit 12 fail to show Petitioner operating outside of his light duty restrictions. Specifically, the surveillance videos do not appear to show Petitioner lifting any heavy objects over 20 pounds, nor excessively bending or stooping. Moreover, even with these light duty restrictions in place, Dr. Fetzer had counseled Petitioner to continue his normal activities as tolerated, because recent medical guidelines promoted continued physical activity for the improvement of functionality and pain. As such, the surveillance videos do not prove that Petitioner was blatantly operating outside of his light duty capabilities or medical restrictions.

Thus, the Commission awards Petitioner temporary total disability benefits as claimed on Arbitrator's Exhibit 1 and gives Respondent a credit for any amounts previously paid.

Medical Treatment and Prospective Care

Upon finding Petitioner's current condition to be causally related to the work accident, the Commission further awards all reasonable and necessary medical expenses through the March 12, 2019 hearing date and the prospective medical care as recommended by Dr. Fetzer. In his treatment notes from April 16, 2018 and June 4, 2018, Dr. Fetzer ordered work conditioning for Petitioner. He also recommended repeat diagnostic L3 to L5 medial branch blocks, which had not yet been performed as of the hearing date. In further reliance on Dr. Fetzer's opinions, the Commission awards the recommended prospective medical treatment.

Petition for Penalties and Fees

After a careful review of the entire record, the Commission affirms the Arbitrator's denial of Petitioner's petition for penalties and fees. Although the Commission finds Dr. Fetzer's opinions to be more persuasive, Dr. Lanoff nevertheless provided Respondent with reasonable medical justification to base its denial of benefits upon. Respondent did not act unreasonable nor vexatious by acting on Dr. Lanoff's medical recommendations.

The Commission also finds that it was not unreasonable nor vexatious for Respondent to require Petitioner to pick up his temporary total disability checks at Respondent's office. Mr. Zitt testified that Petitioner was not the only person who had to come to the terminal to pick up the checks, as it had been part of Respondent's policy for 25 years. As such, Respondent was not

20IWCC0043

singling out Petitioner nor requiring him to do anything different than what it had required from its other employees.

Additionally, there were never any driving restrictions placed on Petitioner by a medical professional. Instead, Petitioner testified that he was capable of driving the 11 miles from his home to Respondent's terminal to pick up his checks. The surveillance videos in Respondent's Exhibit 12 also show Petitioner driving on numerous occasions. As such, the record does not prove that Petitioner's medical condition prevented him from driving to pick up his temporary total disability checks at the terminal in accordance with Respondent's longstanding policy.

For these reasons, the Commission affirms the denial of Petitioner's petition for penalties and fees. The Decision of the Arbitrator is otherwise reversed as stated above.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator dated May 1, 2019, is hereby reversed as stated herein.

IT IS FOUND that Petitioner's current condition of ill-being regarding his lumbar spine is causally related to his January 12, 2017 accident.

IT IS FURTHER ORDERED that Respondent is liable for all reasonable and necessary medical treatment from January 12, 2017 through March 12, 2019, pursuant to the medical fee schedule, as provided in §8(a) and §8.2 of the Illinois Workers' Compensation Act.

IT IS FURTHER ORDERED that Respondent is liable for prospective medical care for Petitioner's causally related low back condition as recommended by Dr. Fetzer, including but not limited to, work conditioning and repeat diagnostic L3 to L5 medial branch blocks.

IT IS FURTHER ORDERED that Respondent shall pay temporary total disability benefits to Petitioner in the sum of $840.11 per week for 83 3/7 weeks, commencing June 16, 2017 through July 17, 2017 and September 7, 2017 through March 12, 2019, as provided in §8(b) of the Act.

IT IS FURTHER ORDERED that Petitioner's petition for penalties and fees is hereby denied.

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

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

20IWCC0043

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $70,000.00. 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: JAN 21 2020

Barbara N. Flores

Marc Parker

DLS/met
O- 11/21/19
46

DISSENTING IN PART, CONCURRING IN PART

I respectfully dissent from the Decision of the majority and would have affirmed and adopted the Decision of the Arbitrator in its entirety. Petitioner's treating doctor and the §12 examiner offered conflicting medical opinions regarding whether Petitioner's current condition of ill-being was causally related to his January 12, 2017 work accident. Following a careful review of the entire record, I would have found that Dr. Martin Lanoff, the §12 examiner, provided the more persuasive opinion.

At the §12 examination on May 31, 2017, Dr. Lanoff found that Petitioner displayed a maximally nonorganic presentation with all five positive Waddell's signs present. Dr. Lanoff found no anatomic or physiologic explanation for Petitioner's pain complaints and suggested that possible monetary or secondary gain issues were involved. Dr. Lanoff provided several detailed medical reasons to support his position that Petitioner demonstrated nonorganic pain behaviors.

First, Dr. Lanoff noted that Petitioner presented differently at his §12 examination than he did at his earlier February 8, 2017 examination with Dr. Fetzer. At the February 8, 2017 examination, Petitioner had full, pain-free range of motion in his lumbar spine, hips, knees, and ankles. Dr. Lanoff explained that although patients generally stayed the same or got better over time, Petitioner claimed to be getting worse in terms of pain and range of motion.

Second, Dr. Lanoff could only perform a very limited hip examination secondary to Petitioner's complaints of pain with any motion. However, Dr. Lanoff indicated that such complaints were inconsistent with true lumbar pathology. Dr. Lanoff further reported that Petitioner had declined to perform the Trendelenburg test on his right side due to his left-sided motor weakness; however, this complaint was also the opposite of what one would expect from someone with true motor weakness.

Third, Dr. Lanoff concluded that Petitioner's claim of numbness in his entire extremity was a nonorganic finding that was not radicular. He explained that this numbness complaint failed to

make sense, because it covered four to five different nerve areas, which was not something seen in individuals with actual nerve problems.

Fourth, Dr. Lanoff explained that if Petitioner had profound neurogenic weakness to the extent he claimed, there would be atrophy, fasciculations, or some twitching of the muscles. However, Petitioner did not exhibit these findings, and there was no evidence of atrophy or physical limitations in his lower extremities.

Fifth, Dr. Lanoff emphasized that the radiographic studies failed to show any nerve compression, and Petitioner demonstrated no frank impingement.

Lastly, Dr. Lanoff reported that Petitioner's complaints of leg symptoms began approximately five weeks after the accident. Petitioner also had numbness that came on quickly and lasted only for a short period of time with no leg pain. Dr. Lanoff did not believe that these complaints signified radicular pathology.

These thorough medical explanations provided by Dr. Lanoff reinforce his position that Petitioner's subjective complaints were out of proportion to the objective findings. Dr. Fetzer failed to provide such detailed objective evidence in support of his competing causal opinion. Dr. Lanoff also sited to medical literature to show that annular tears were not acute injuries, whereas Dr. Fetzer offered no supporting medical studies to bolster his opposing stance that annular tears were symptomatic and acute.

In further support of Dr. Lanoff's opinions, it is significant that Petitioner had normal range of his motion at his initial post-accident treatment visits on January 17, 2017 and February 8, 2017. Dr. Kassir also called Petitioner's lumbar and thoracic X-rays unremarkable on February 1, 2017, and Petitioner displayed a non-antalgic gait as of February 8, 2017.

The above supporting medical evidence all indicates that Dr. Lanoff provided the more persuasive opinion. Petitioner had no physical malady at the time of the §12 examination other than psychologically-based pain behaviors. As such, the Arbitrator's finding that Petitioner's current condition was not causally related to the work accident should be affirmed. Nevertheless, I concur with the majority's denial of penalties and fees, as Dr. Lanoff provided Respondent with a persuasive medical opinion that justified its denial of benefits after May 31, 2017. Respondent was not unreasonable nor vexatious by acting on Dr. Lanoff's recommendations.

Deborah L. Simpson

DLS/met
46

STATE OF ILLINOIS)
) SS.
COUNTY OF McHENRY)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ERIC HARRIS,

Petitioner,

20IWCC0044

vs.

NO: 11 WC 17615

FUJI FOOD PRODUCTS LTD.,

Respondent.

DECISION AND OPINION ON REVIEW

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

Findings of Fact

On April 19, 2011, Petitioner was involved in a stipulated work-related motor vehicle accident ("MVA"). His van was struck on the driver's side by a truck. Petitioner testified that the van was pretty severely damaged and his "body got thrown pretty hard to the passenger side of the vehicle and then bounced back." He also testified he hit the back and side of his head on a metal plate that seals off the refrigerated section of the van. No pictures of the vehicles involved in the collision were presented into evidence. On cross examination, Petitioner acknowledged prior convictions for selling marijuana and cocaine.

The paramedics' report indicated that the ambulance responded to the MVA in which a dump truck struck a van on the driver's side at 5-10 MPH. Petitioner was out and walking after the MVA, was alert and oriented, and his pupils were reactive. He complained of left shoulder, neck, and arm pain. He denied loss of consciousness, he was wearing a seatbelt, and the airbag did not deploy. He scored 15/15 on the Glasgow Coma Scale, was placed in a cervical collar, secured on a board, and transported to Hospital.

Petitioner arrived at the Emergency Department complaining of left neck/shoulder/arm pain. The chief complaint was the shoulder pain extending to the elbow. The posterior neck pain was described as slight. He denied loss of consciousness or other acute symptoms. A head CT showed no intracranial bleeding and was normal except for evidence of mastoiditis (infection of bone behind the ear) and right otitis media (middle ear infection), thoracic and cervical CTs showed no acute injuries, and elbow x-rays were normal. Acute contusion of the left shoulder/upper arm, acute low back strain, and chronic bilateral otitis media, and possible early mastoiditis were diagnosed. He was prescribed Motrin, Vicodin, Flexeril, and Augmentin and released home.

Petitioner was later admitted to hospital on April 21, 2011, and April 26, 2011, ostensibly for the diagnoses of high blood pressure and diabetes, and renal failure, respectively. After he was released, he came under the care of Dr. Rathi, a neurologist. She treated Petitioner from May 11, 2011 through March 5, 2015, prescribing opioid pain medication and administering numerous occipital injections throughout that period. Despite her prolonged treatment, Dr. Rathi released him to work and declared him at maximum medical improvement as of June 6, 2011.

Petitioner testified that currently he works as a driver for Amazon, where he earns more money. He notices stiffness in his neck and becomes uncomfortable after driving for long periods. He still has migraine headaches for which he takes Frova, Treximet, and uses a TENS unit. He is "not 100% like [he] was before." He has to stretch his neck every morning and throughout the day, and taking medication has become part of his routine. He gets migraine flare-ups four to five times a month. He occasionally gets other headaches as well. They are in the area in which he hit his head. His shoulder was fine.

Dr. Rathi testified by deposition in March of 2015 Petitioner was referred to her for evaluation of "chronic headaches related to an MVA while at work." He also reported associated symptoms of lightheadedness, blurry vision, and "mixing things up." Dr. Rathi's examination was essentially normal, though Petitioner exhibited some stiffness in his cervical spine, occipital tenderness, and muscle spasm. Dr. Rathi diagnosed post-concussion syndrome, tension headaches, cervicalgia, migraines, and previous history of diabetes and hypertension. She administered trigger point/nerve block injections for treatment of the headaches, and she prescribed medication.

Dr. Rathi explained that post-concussion syndrome does not necessarily require a loss of consciousness. It includes headaches, insomnia, irritability, word-finding difficulty, memory problems, and "nonspecific intermittent complaints that are essentially ruled out by the type of lesion in the brain, so his MRI/CT was negative." Post-concussion syndrome is "primarily a clinical diagnosis based on history. The neuro exam was essentially normal."

On her last examination on March 5, 2015, Petitioner reported headaches, migraines, neck/shoulder stiffness, occipital/trigger point tenderness, and muscle spasm. Dr. Rathi recommended continuing prior treatment. Dr. Rathi's current diagnoses were "post-concussion syndrome, which encompasses headache cervicalgia, migraines, depression, and anxiety, and fibromyalgia." She explained that fibromyalgia "is more of a chronic musculoskeletal disorder encompassing diffuse pain, again a diagnosis of exclusion." She could not say that the fibromyalgia was "related to the post-concussive syndrome," but she believed "it's more related to the accident." "Any traumatic injury can set it off or infection, stress, unknown causes." She agreed that Petitioner had complaints regarding various parts of his body that were unrelated to the accident. Petitioner's subjective complaints were consistent with her objective findings.

Dr. Rathi opined that Petitioner's current conditions of ill-being were caused or aggravated by the MVA; there was no other explanation for his symptoms. Post-concussion syndrome could be caused by a whiplash effect by the T-bone impact, even though he was wearing a seat belt. This can cause a concussion, "chronic headaches, and subsequent complaints that he exhibited." The duration of post-concussion symptoms is "quite variable." In a minor insult, patients are usually are at maximum medical improvement within six to 12 months. Sometimes symptoms can last years. She expected to treat Petitioner prospectively for a long period of time; "it's already gone on for about four years."

Dr. Kessler testified by deposition on December 12, 2017. She performed a Section 12 medical examination on Petitioner on June 8, 2017. Petitioner reported driving a work van when a semi full of stone, going downhill, ran a light and struck his van on the driver's side. He was wearing a seat belt but was jarred around and his head struck a metal piece on a board right behind the driver's seat, "then went forward and back again."

In reviewing Petitioner's medical records, Dr. Kessler noted inconsistencies with what Petitioner reported to her. Contrary to his report to her, immediately after the MVA, paramedics found him to be alert with no confusion or memory impairments. He was found normal with a 15/15 Glasgow Coma Scale. She also noted that three weeks after the MVA, he first reported daily headaches that he reported began two days after the accident. He also reported memory/confusion problems, lightheadedness, and blurred vision for the first time. He also now reported he was not sure whether he lost consciousness while previously he denied it.

Dr. Kessler opined that Petitioner could not have suffered a concussion absent loss of consciousness, altered level of consciousness, memory impairment, "or other brain-related neurological dysfunction at the time of the accident. The initial medical records indicate that he

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had none of these at the time of the accident and, therefore, he did not have a concussion." She also noted that symptoms associated with concussion are worse initially and will improve and resolve with days or weeks. Petitioner's report of delayed onset and worsening symptoms is not consistent with a diagnosis of concussion or post-concussion syndrome. She also noted some discrepancies in the urinalysis.

Dr. Kessler opined that Petitioner's symptoms had no neurophysiological basis and Dr. Rathi incorrectly diagnosed post-concussion syndrome because Petitioner did not have a concussion. She continued "by the time [Petitioner] was seen by Dr. Rathi, any of the symptoms that he had had from the accident had already resolved." She also questioned Dr. Rathi's diagnosis of fibromyalgia. "There is no evidence of fibromyalgia, fibromyalgia does not result from trauma," or post-concussion syndrome. Finally, she questioned Dr. Rathi's treatment. The injections she administered were not medically indicated. Such injections are used to treat occipital neuralgia, which Petitioner did not have. In addition, she noted that Dr. Rathi prescribed opioids when Petitioner was working, functioning in his ADLs, and without a narcotic contract to ensure that he did not get such prescriptions from other providers.

Dr. Kessler performed a physical and neurological examination. Contrary to his reports, Petitioner showed no memory or cognitive deficits, he had full cervical range of motion, and he reported tenderness to light touch in the occipital region which is non-physiological. Dr. Kessler opined that Petitioner sustained left-shoulder/arm contusions and a neck muscle strain in the MVA and sustained nothing that would result in long-lasting or permanent symptoms. He had no concussion or any brain injury. The accident could not have caused his hypertension. He was symptoms-free and at maximum medical improvement within two weeks of the MVA regarding any injury sustained in the accident. He needed no treatment or restrictions.

Dr. Levin testified by deposition in a third party civil action which was submitted into the record here. She performed a Section 12 medical examination on Petitioner on February 13, 2014, reviewed medical records, and issued a report. Petitioner reported he was in an MVA, but he could not recall how fast the vehicles were going. He reported continuing headaches and memory problems. He did not have vision problems, balance problems, numbness, or dizziness. Her neurological examination of Petitioner was completely normal.

Dr. Levin opined that Petitioner suffered a minor concussion in the MVA with no bruising/bleeding in the brain. His injuries were soft-tissue in nature. The ambulance report showed no neurological findings and the only abnormality noted was high blood pressure. The Emergency Department records showed no loss of consciousness and no neurological symptoms. A CT, which is routinely done for patients suffering any trauma, was normal, which means there was no bruising, bleeding, or major trauma to the brain. The diagnoses in the Emergency Department were left shoulder contusion, low back strain, an chronic ear infection. Dr. Levin opined that Petitioner would have been back to normal baseline neurologically within several months of the accident.

At Dr. Levin's examination, Petitioner reported headaches, stiff neck, low back pain, head pain, memory loss, and ringing in his ears. Dr. Levin opined that those symptoms were not related to the MVA. She attributed his symptomology to secondary gain and drug-seeking behavior. Regarding drug-seeking behavior, Dr. Levin referred to the Illinois Prescription Monitoring Program which only goes back to 2013. It shows Petitioner was receiving Hydrocodone "from different providers throughout the time." Dr. Levin opined that the medication and the dosage of such medication were not appropriate for the injuries Petitioner sustained. She also noted that urinalyses were positive for cocaine and marijuana, which would not have been prescribed.

Dr. Levin also noted that the injections Petitioner received were not medically indicated. They are performed to treat occipital neuralgia (irritation of the occipital nerve), which Petitioner did not have. She thought the proper treatment would include anti-inflammatories and short period of rest. Petitioner would have recovered from any injuries "by certain with a few months." Dr. Levin opined that Petitioner did not sustain any permanent neurological condition as a result of the MVA, he needed no additional treatment, and should have been able to RTW within a few months of the accident.

On cross examination, Dr. Levin testified that she believed Petitioner had some underlying symptoms for several weeks or months after the accident but he was exaggerating his symptoms. She agreed that Dr. Rathi's primary focus in her treatment was headaches. There are no objective tests to show headaches. She reiterated her opinion that Petitioner had a mild concussion even though the imaging was negative.

Dr. Levin thought Petitioner had a minor collision in which he suffered no direct head trauma, no loss of consciousness, and no intracranial bleeding/bruising. She agreed that one can suffer a concussion without striking one's head. Symptoms of post-concussion syndrome include headaches, dizziness, and vision issues. These symptoms can last for a few weeks to up to six months.

Dr. Levin noted that in his questionnaire, Petitioner indicted that he was driving at 10 to 15 MPH and the other driver was going 20-30 MPH. But on discussion he indicated he did not know how fast either vehicle was going. Petitioner mentioned that the driver's side window was "blown out or shattered." While symptoms can wax and wane, they could not completely resolve and reoccur. Dr. Levin disagreed that the injections benefited Petitioner despite his subjective reports of improvement after injections.

On redirect examination, Dr. Levin opined that the initial Emergency Department visit and follow up with a neurologist for at most a few months thereafter, would have been appropriate. Based on the Emergency Department records, if Petitioner had been referred to her she probably would have seem him in two weeks to see how he was doing, see him again after between two and four months, and perhaps see him once a month for six months thereafter.

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Conclusions of Law

The Arbitrator found that Petitioner proved he suffered only a left-shoulder contusion and neck strain in the MVA. He also found specifically that Petitioner did not prove he sustained other injuries including post-concussion syndrome, renal failure, or tension/occipital/migraine headaches in the MVA. He noted that Petitioner's CTs were all normal, there was no objective evidence of brain injury, all of this neurological testing was normal, and he was never diagnosed with any brain injury prior to his first visit with Dr. Rathi. He also noted that Dr. Rathi based her diagnosis only on Petitioner's subjective complaints. The Arbitrator stressed that Dr. Rathi's statements that Petitioner was compliant with his prescription medication were contrary to his urinalyses, in which he only tested positive for opiates once despite his continuing prescriptions. The Arbitrator also noted that even though Petitioner was not arguing fibromyalgia was related to the accident, Dr. Rathi routinely opined that there was such a relationship even though fibromyalgia is an "inherently idiopathic" condition. Finally, the Arbitrator cited Petitioner's prior marijuana/cocaine convictions in questioning his credibility.

The Commission generally agrees with the Arbitrator's reasoning and conclusions. While generally prior convictions for selling drugs may not be relevant to attack a witness' credibility, it could be relevant here because his urinalysis showed that he tested positive for opiates only in the last test. The past convictions could be probative to suggest why Petitioner did not test positive despite his continuing prescriptions. While the Commission again generally agrees with the Arbitrator's denial of compensation for various alleged ailments that Petitioner reported and attributed to the MVA, the Commission finds that Petitioner suffered a concussion, though likely a minor concussion, in the MVA. We do so based on the opinion of Dr. Levin, a neurologist retained by a defendant in a third party civil action. Nevertheless, the Commission agrees with the Arbitrator, Dr. Kessler, and Dr. Levin that the Petitioner did not prove that he suffered ongoing post-concussion syndrome or symptoms because of the concussion. In this regard the Commission agrees with the Arbitrator that the opinions of Dr. Kessler and Dr. Levin are persuasive, while the opinions of Dr. Rathi were not. We note that Dr. Rathi based her opinions solely on Petitioner's subjective complaints noting that the MVA was the only explanation for his symptoms. We do not find that reasoning persuasive.

Because we find that Petitioner sustained a concussion in his work-related MVA we deem it appropriate to award some benefits that the Arbitrator denied. We award medical and temporary total disability benefits through June 17, 2011, the date in which Dr. Rathi initially declared him at maximum medical improvement and released him to work. We also award Petitioner an additional permanent partial disability award of loss of 3% of the person-as-a-whole because of his concussion.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $352.26 per week for a period of 4&4/7 weeks, that being the period of temporary total incapacity for work under §8(b).

ANEXOS

20IWCC0044

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay medical expenses incurred through June 17, 2011 under §8(a) of the Act, subject to the applicable medical fee schedule in §8.2.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner an additional $317.03 for 15 weeks, for a total of 30 weeks, because the injuries sustained resulted in the total loss of the use of 6% of the person-as-a-whole under §8(d)2 representing loss of 3% loss for the shoulder contusion/neck strain and 3% loss for the concussion.

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: JAN 21 2020

Deborah L. Simpson

Barbara N. Flores

Marc Parker

DLS/dw
O-12/19/19
46

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

20 IWCC0044

HARRIS, ERIC
Employee/Petitioner

Case# **11WC017615**

FUJI FOOD PRODUCTS INC
Employer/Respondent

On 10/1/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.32% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1987 RUBIN LAW GROUP LYD
CATHERINE K DOAN
20 S CLARK ST SUITE 1810
CHICAGO, IL 60603

0507 RUSIN & MACIOROWSKI LTD
DERRICK J N LLOYD
10 S RIVERSIDE PLZ SUITE 1925
CHICAGO, IL 60606

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STATE OF ILLINOIS)
)SS.
COUNTY OF McHenry)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Eric Harris
Employee/Petitioner

v.

Fuji Food Products, Inc.
Employer/Respondent

Case # 11 WC 17615

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 **Arbitrator Glaub**, Arbitrator of the Commission, in the city of **Woodstock**, on **July 12, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] What temporary benefits are in dispute?
   [ ] TPD [ ] Maintenance [x] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [x] Is Respondent due any credit?
O. [x] Other **Is Respondent entitled to a credit for medical paid in the amount of $71,482.47?**

FINDINGS

On **April 19, 2011**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**27,476.28**; the average weekly wage was $**528.39**.

On the date of accident, Petitioner was **28** 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 $**1614.48** for TTD, $ for TPD, $ for maintenance, and $**71,482.47** for other benefits, for a total credit of $**73,096.95**.

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

ORDER

The Arbitrator finds that petitioner's left shoulder contusion and cervical strain were causally related to the accident. The Arbitrator finds that petitioner reached MMI as of May 3, 2011.

Petitioner is not entitled to temporary total disability as a result of the accident. Respondent shall be given a credit of $1,614.48 for temporary total disability benefits that have been paid.

Respondent is liable for reasonable, necessary, and causally related medical services up to May 3, 2011, when Petitioner reached maximum medical improvement. Respondent is entitled to a credit for medical bills previously paid by Respondent in the amount of $73,096.95.

The Arbitrator awards petitioner 15 weeks of permanent partial disability benefits at a rate of $317.03 representing 3% loss of use of the man as a whole.

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

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

Michael A. Alaimo

Signature of Arbitrator

9/27/18
Date

OCT 1 - 2018

ADOPTIONS

Eric Harris v Fuji Food Products, Inc.
11 WC 17615

STATEMENT OF FACTS

This case was tried on July 12, 2018 involving an accident date of April 19, 2011 and alleged injuries to petitioner's head, cervical spine, and left shoulder.

Petitioner testified on direct examination that he worked for the respondent as a driver and salesman for two and a half years prior to the accident. (Tr. 8) He testified that his job duties consisted of loading and unloading a refrigerated van, driving orders to different locations, and occasionally setting up displays. (Tr. 9) He testified that the heaviest object he would have to lift weighed 50 pounds and that he delivered between 12-14 orders per day. (Tr. 10) He testified that prior to April 19, 2011, he did not have any issues performing these job duties. (Tr. 11)

Petitioner testified that on April 19, 2011, he was involved in a motor vehicle accident while making deliveries for the respondent. (Tr. 13) He testified that he was in the northwest suburbs delivering to the south suburbs when he was hit by a semi-truck while he was turning onto a street. (Tr. 13) He testified that he hit his head on the back rear of the cab as well as on the door. (Tr. 14) He testified he immediately had shoulder pain, head pain, and back pain. (Tr. 14) He also testified to stiffness and an inability to get comfortable. (Tr. 14)

Petitioner testified that he then called an ambulance which arrived shortly thereafter. (Tr. 35) The paramedic report from Algonquin/Lake in the Hills Fire Department dated April 19, 2011 indicates that petitioner's chief complaints were left arm pain, chest pain, and neck pain. (Px1) No mention of head pain was noted. (Px1) Further, the report states that petitioner denied any loss of consciousness. (Px1)

Petitioner was then taken to Sherman Hospital. (Tr. 15) At that time, petitioner's chief complaints were of left shoulder pain extending into the elbow along with slight posterior neck pain and a left posterior back pain. (Px2) He denied a loss of consciousness. (Px2) Petitioner's neurologic symptoms were noted to be negative. (Px2) Petitioner underwent a CT scan of his brain which was noted to be normal. (Px2) Petitioner was discharged the same day with diagnoses of a contusion to the left shoulder and upper arm,

an acute low back strain, and chronic bilateral otitis media with possible early right mastoiditis. (Px2) Petitioner was discharged home and was not given any work restrictions. (Px2)

Petitioner testified that he did not return to work on April 20, 2011 as it was a scheduled day off. (Tr. 42)

Petitioner attempted to return to work on April 21, 2011. (Tr. 42) However, respondent advised petitioner that they would not allow him to return to work until he was cleared by his primary care physician. (Tr. 42)

Petitioner thereafter was seen by Dr. Khursheed Ahmed, a primary care physician, on April 21, 2011. (Px3) At that time, petitioner was found to have extremely elevated blood pressure and he was admitted to Alexian Brothers Medical Center. (Px3) At admission it was noted that petitioner's blood pressure was as high as 220/145 with triglycerides of 1,360 and cholesterol of 221. (Px3) In addition, he had blood sugar of 301 and 287. (Px3) Petitioner also complained of a headache during this visit resulting in a second CT scan of his brain which was once again normal. (Px3) Petitioner was referred to Dr. Paul Epstein, an endocrinologist, and Dr. Venoodhar Reddy, a cardiologist. (Px3) It was noted that petitioner's family history was strongly positive for hypertension on petitioner's father's side. (Px3) Petitioner was ultimately diagnosed with uncontrolled high blood pressure, diabetes mellitus, dyslipidemia with very high triglycerides and very low HDL, obesity, and a recent motor vehicle accident with left shoulder and left sided chest pain. (Px3) Once petitioner's blood pressure was controlled, he was discharged. (Px3) His discharge took place on April 25, 2011. Petitioner was given prescriptions for Flexural, Cyclobenzaprine, Lisinopril, Lovaza, Simvastatin, Dyazide, Protonix, Metformin, and Niaspan. (Px3) No work restrictions were given. (Px3)

Petitioner testified that he returned to work on April 26, 2011. (Tr. 46) He testified that he was not feeling right. (Tr. 18) He stated he had a severe headache and began to see bright lights and felt dizzy. (Tr. 18) He testified that he suffered no new trauma or work-related accident prior to the onset of these symptoms on April 26, 2011. (Tr. 47) He believes that a coworker thereafter called the paramedics. (Tr. 18)

Petitioner was taken by the Bensenville Fire Protection District to Alexian Brothers Medical Center on April 26, 2011. (Px4) At admission, petitioner was complaining of occipital headaches, blurred vision, and diplopia. (Px3) He was again seen by Dr. Krasheed Ahmed who did blood work that revealed worsening renal function. (Px3) A CT of the brain was performed that showed no definite evidence of any acute intercranial changes. (Px3) In addition, an ultrasound of petitioner's kidneys was performed that showed an increase in cortical echogenicity in the right kidney. (Px3) This was noted to possibly represent a right renal parenchymal disease. (Px3) An MRI of the brain and kidneys were recommended, however, petitioner was unable to fit in the MRI machine as he weighed 325 pounds at 5"10 tall. (Px3) A CT scan of petitioner's abdomen was performed that showed fatty infiltration of the liver. Petitioner was diagnosed with labile hypertension, diabetes mellitus, hypertriglyceridemia, obstructive sleep apnea, and morbid obesity. (Px3) Petitioner was discharged on April 28, 2011. No work restrictions were given at discharge. (Px3) He was given prescriptions for Flexural, Lovaza, Zocor, Portonix, Glucophage, Niaspan, and aspirin. (Px3)

Petitioner testified that he then returned to work the next day. (Tr. 48) Petitioner filed his Application for Adjustment on May 5, 2011. (Ax5)

Petitioner then began treating with Dr. Sapna Rathi, a neurologist, at the referral of Dr. Ahmed. (Px6) Petitioner was referred for an evaluation of chronic headaches related to the motor vehicle accident on April 19, 2011. (Px6) Petitioner reported having headaches daily beginning 1-2 days after the accident. (Px6) He advised that they were occipital headaches radiating into his temporal/frontal regions bilaterally that were worsened with eating or talking on the phone. (Px6) He advised that he awoke every day with a headache and that he had not gone back to work due to continued headaches, light headedness, and blurry vision. (Px6) In addition, he complained of occasional memory problems such as "mixing things up" and difficulty findings his words. (Px6) On physical examination, petitioner was 5"11 and 315 pounds. (Px6) He had decreased range of motion in the cervical spine and had bilateral occipital tenderness. (Px6) He had some muscle spasms in the cervical, thoracic, and paraspinal regions bilaterally on palpation. (Px6) Neurologic examination revealed that the cranial nerves 2-7 were grossly intact with sharp discs. (Px6)

Motor examination showed normal muscle tone, bulk, and strength at 5/5 in the bilateral upper and lower extremities. (Px6) Petitioner had normal gait and was able to ambulate on his heels. (Px6) Dr. Rathi diagnosed petitioner as suffering from post-concussion syndrome, tension headaches, cervicalgia, and migraines. (Px6) Petitioner was advised to continue taking his current medications. (Px6) In addition, Dr. Rathi performed a bilateral occipital nerve block and trapezius muscle trigger point and fascia. (Px6) Dr. Rathi prescribed Flexeril, Naprosyn, Treximet, and Lidoderm. (Px6)

Petitioner testified that after receiving these injections, he noticed almost immediate relief from the pain. (Tr. 21) He advised that the pain was previously burning and deep located in the back of his head. (Tr. 21) He stated that the burning sensation and pain instantaneously left. (Tr. 21)

Also during this May 11, 2011 visit, a urinalysis was performed by Dr. Rathi. (Rx8) This urinalysis was negative for opiate pain medication, but positive for marijuana and anti-depressants. (Rx8)

Petitioner returned to Dr. Rathi on May 25, 2011 for a follow up examination. (Px6) He advised Dr. Rathi that he was doing better since his previous visit. (Px6) He stated that his tension and occipital headaches were improving, but that his migraine headaches were getting more intense. (Px6) He complained of neck pain and spasms as well as occasional stiffness. (Px6) Dr. Rathi recommended that petitioner continue taking his medications as prescribed. (Px6)

Petitioner testified that he continued to take these medications as recommended by both Dr. Rathi and Dr. Ahmed. (Tr. 22) He testified, however, that he had some issues with his blood pressure medication. (Tr. 23)

On June 5, 2011, petitioner was once again taken to the Alexian Brothers Medical Center. (Px3) Petitioner advised the emergency room staff that he had passed out three times that day. (Px3) Two of those episodes were accompanied with brief losses of consciousness while the third episode was more prolonged. (Px3) Petitioner advised that he had hit his head when he had fallen and also broke a glass table. He complained that he had been throwing up recently as well as having feelings of dizziness and light headedness over the past week. (Px3) During an initial work up, it was noted that petitioner was suffering acute renal failure. Further, his blood pressure was significantly low. (Px3) Petitioner was

diagnosed with syncope/near syncope at the home related to hypotension likely due to dehydration, nausea, and vomiting. (Px3) He was also diagnosed with acute renal failure related to the hypotension in addition to his ace inhibitor, non-steroidal anti-inflammatory drugs, dehydration, nausea, and vomiting. (Px3) A CT scan of his brain was once again performed that was normal. (Px3) It was noted that he had lost 50 pounds in the last six weeks deliberately. (Px3) He was discharged on June 7, 2011. (Px3)

Petitioner returned to see Dr. Rathi on June 15, 2011. (Px6) At that time, petitioner was 5"11 and 280 pounds. (Px6) Petitioner advised Dr. Rathi he was in the hospital the week before for renal failure due to medication and dehydration. (Px6) He advised that his headaches were returning, but had been better following the last set of injections. (Px6) He also stated that his migraines were flaring up. (Px6) He complained of poor memory, concentration, mixing things up a lot, and snapping at his family. (Px6) Dr. Rathi recommended petitioner continue his current medication. (Px6) She performed bilateral occipital nerve blocks and trapezius muscle trigger points and fascia injections. Petitioner was to continue working without restrictions. (Px6)

Petitioner returned to see Dr. Rathi on July 20, 2011. (Px6) He stated he was doing better since his previous visits having some improvement with his headaches and post-concussion syndrome symptoms. (Px6) He stated that his headache intensity and frequency was improving and he was no longer as tense or stressed as before. (Px6) He believed that his pain medication and injections were helping and he wanted to continue the same. (Px6) He did, however, continue to complain of frontal headaches especially with driving as well as neck pain and stiffness with some headaches. (Px6) Dr. Rathi recommended petitioner continue with his current medications and prescribed a refill for the same. (Px6) In addition, Dr. Rathi performed occipital nerve blocks and trapezius muscle trigger point and fascia injections. (Px6)

Dr. Rathi also performed a urinalysis on petitioner on July 20, 2011. (Rx8) Once again, this urinalysis proved positive for cocaine and marijuana. (Rx8)

Petitioner returned to see Dr. Rathi on August 31, 2011, as well as October 19, 2011. (Px6) During these visits, petitioner complained of some worsening pain in his wrists and head. (Px6) He advised that the injections were helping. (Px6) Dr. Rathi continued to recommend that petitioner take his prescriptions

as directed. (Px6) Dr. Rathi performed occipital nerve blocks and trapezius muscle trigger point and fascia injections. (Px6)

On October 19, 2011, another urinalysis was performed. (Rx8) The markings were unclear as to whether or not petitioner again tested positive for cocaine. (Rx8)

Petitioner returned to see Dr. Rathi on November 22, 2011. (Px6) He advised that he was doing worse with respect to his migraine symptoms. (Px6) He also stated that his symptoms were flaring up while riding an exercise bicycle and while driving. (Px6) He complained of memory problems. (Px6) He felt roughly 50% back to baseline and denied any other acute changes. (Px6) His prescriptions were refilled. (Px6)

Petitioner returned on January 9, 2012 to see Dr. Rathi. (Px6) At that time, petitioner's weight was down to 230 pounds. (Px6) He complained that he was doing worse than his previous visit with respect to his headaches. (Px6) However, he advised that he was no longer feeling any lower back pain. (Px6) Petitioner was once again advised to continue with his medication as directed. (Px6) Dr. Rathi performed occipital nerve blocks and trapezius muscle trigger point and fascia injections. (Px6)

A urinalysis was performed on January 9, 2012 by Dr. Rathi which was positive for cocaine. (Rx8)

Petitioner presented to Dr. Rathi on January 31, 2012. (Px6) Petitioner continued to complain of neck pain and headaches that he stated were worse since his previous visit. (Px6) As a result, Dr. Rathi performed occipital nerve injections along with trapezius muscle trigger point and fascia injections. (Px6) Likewise, she added Norco, an opioid pain medication to petitioner's active prescriptions. (Px6)

Petitioner returned to see Dr. Rathi on March 6, 2012. (Px6) At that time, petitioner had a significant change since his last visit. (Px6) He stated he was doing well and believed that his headaches, neck, and shoulder pain were all controlled with the medication and injections he was receiving. (Px6) He advised that he was going to be returning to work on April 1, 2012. (Px6) He advised that his symptoms were roughly 50% back to baseline and continued to complain of daily tension headaches and improving migraines. (Px6) His physical examination continued to reveal that his cranial nerves 2-7 were grossly intact with sharp discs. (Px6) He had normal muscle tone and full strength in his bilateral upper and lower

extremities. (Px6) Dr. Rathi continued to recommend that petitioner continue his course of medication including his Norco. (Px6)

Dr. Rathi also performed a urinalysis on March 6, 2012 that was negative for opioid pain medications despite petitioner's active prescription for Norco at that time. (Rx8)

Petitioner saw Dr. Rathi on April 4, 2012 and April 25, 2012. (Px6) On both occasions, he was given occipital nerve blocks and trapezius muscle trigger point and fascia injections. (Px6) In addition, Dr. Rathi continued to recommend continued use of Norco. (Px6)

Petitioner returned to see Dr. Rathi on August 22, 2012 stating that he was 95% better. (Px6) Petitioner advised that he had not used any opioid pain medications the previous two months. (Px6) It was noted that his weight was down to 225 pounds. (Px6) Petitioner was given bilateral occipital nerve blocks and trapezius muscle trigger point and fascia injections. (Px6) Refills were given for his medications and he was found to have reached maximum medical improvement by Dr. Rathi. (Px6)

Thereafter, petitioner did not treat for over seven months. (Px6) He then returned to see Dr. Rathi on April 9, 2013. (Px6) At that time, he advised that he was doing worse with increased neck pain and headaches as well as insomnia. (Px6) He complained of neck stiffness and spasms as well as tension and migraine headaches. (Px6) He also complained of memory problems and poor concentration along with word difficulty. (Px6) His neurologic examination was normal and on physical exam, he was 225 pounds with decreased range of motion in the cervical spine. (Px6) Dr. Rathi prescribed Treximet and Norco. (Px6) In addition, petitioner requested injections which were then performed by Dr. Rathi including bilateral occipital nerve blocks, trapezius muscle trigger point, and fascia injections. (Px6)

On July 23, 2013, petitioner presented to Stroger Hospital due to treatment for a shingles rash. (Rx5) At that time, petitioner denied any headaches or dizziness. Petitioner was given codeine, another opioid pain medication. (Rx5)

Petitioner returned to see Dr. Rathi on September 11, 2013 and was prescribed Cumavel Dosepro, Elavil, and Norco. (Px6) In addition, petitioner requested occipital nerve blocks and trapezius muscle trigger point and fascia injections. (Px6) Dr. Rathi performed the same. (Px6)

Despite receiving opioid prescriptions from both Dr. Rathi as well as at Stroger Hospital, a urinalysis was performed on September 11, 2013 that was again negative for opioid pain medication. (Rx8)

Petitioner returned to see Dr. Rathi on October 16, 2013 complaining of increased headaches as well as neck and shoulder pain. (Px6) Petitioner was once again prescribed Norco, a Z Pack, and Amlodipine. (Px6) In addition, he underwent occipital nerve blocks and trapezius muscle trigger point and fascia injections. (Px6)

He then returned to Dr. Rathi on November 20, 2013 continuing to complain of shoulder pain, headaches, and migraines. (Px6) He also described increased anxiety and irritability as well as mood swings and memory difficulty. (Px6) Once again, he was given a prescription for Norco and underwent occipital block injections as well as trigger point injections. (Px6) He was given prescriptions for Cymbalta, Treximet, Xanax, and Norco. (Px6)

Dr. Rathi performed a urinalysis on November 20, 2013 that was negative for opioids but positive for anti-depressants. (Rx8)

Petitioner returned to see Dr. Rathi on both December 11, 2013 and February 19, 2014. (Px6) He received occipital nerve blocks and trigger point injections during these visits. (Px6) Likewise, he was given prescriptions for Norco during both visits. (Px6)

Petitioner had a urinalysis performed on February 19, 2014 that was negative for opiates. (Rx8)

On February 13, 2014, petitioner was seen at respondents request by Dr. Karen Levin, a board certified neurologist. (Rx7)

Petitioner returned to see Dr. Rathi on April 23, 2014 wherein he again received trigger point injections as well as occipital nerve blocks and received a prescription for Norco. (Px6) A urinalysis performed that same day was again negative for opioid pain medications. (Rx8)

Petitioner then returned to see Dr. Rathi on June 4, 2014 wherein he was again prescribed Norco and given trigger point and occipital nerve block injections. (Px6)

Petitioner returned to see Dr. Rathi on July 25, 2014. (Px6) On that date, he described worsening symptoms. (Px6) He advised that he exercising and stretching throughout the day "took away a little bit

of the tension." (Px6) He believed that his symptoms were bad and that he had no significant change to his headaches, insomnia, anxiety, memory difficulty, or chronic pain. (Px6) His physical examination revealed slightly decreased strength in the upper and lower extremities at 5-/5. (Px6) Otherwise, his physical and neurological examinations were unchanged from all previous visits. (Px6) Dr. Rathi once again prescribed Namenda, Exelon, Xanax, and Norco. Petitioner was given occipital nerve blocks as well as trigger point injections. (Px6)

A urinalysis was performed that was positive for opioid pain medications. (Rx8) This is the only urinalysis taken by petitioner that was positive for opioid pain medications despite ongoing and consistent prescriptions for opioid pain medications by Dr. Rathi. (Rx8)

Petitioner was seen by Dr. Rathi on July 21, 2015 and March 4, 2015. (Px6) During both of these visits, petitioner was prescribed Norco and given occipital nerve blocks and trigger point injections. (Px6)

Petitioner testified that he has not returned to see Dr. Rathi since March 4, 2015. (Tr.70) He testified that he stopped seeing Dr. Rathi because he moved to Arizona. (Tr. 70) He testified that Dr. Rathi gave him a year's worth of prescriptions including his Norco in order to tide him over following his move. (Tr. 31)

Dr. Sapna Rathi testified by the way of evidence deposition on March 12, 2015 and March 26, 2015. (Px8 at 1) Dr. Rathi testified that she first saw petitioner on May 11, 2011 after a referral from Dr. Ahmed following a motor vehicle accident on April 19, 2011. (Px8 at 11) She advised that at that time petitioner complained of lightheadedness, headaches, blurry vision, memory problems, mixing things up, and other associated symptoms. (Px8 at 12) She testified that Petitioner's positive findings on physical examination were some stiffness in the cervical spine, occipital tenderness, and muscle spasms. (Px8 at 12)She believed that petitioner was suffering from post-concussion syndrome, tension headaches, cervicalgia,, and migraines, along with a previous history of diabetes and benign hypertension. (Px8 at 12)

Dr. Rathi testified that post-concussion syndrome primarily results from a concussion or head injury, which may or may not involve a loss of consciousness. (Px8 at 13) She stated that associated symptoms include headaches, insomnia, irritability, difficulty finding words, memory problems, as well as other sorts

of nonspecific intermittent complaints. (Px8 at 13) She advised that post-concussion syndrome is a clinical diagnosis based solely on the history. (Px8 at14) She noted that petitioner's neurologic exam was essentially normal and that she based her diagnosis on the history and the timeframe, along with the lack of any other significant findings. (Px8 at 14) The primary complaints associated with this diagnosis for petitioner were his headaches and insomnia. (Px8 at 14)

Dr. Rathi stated that the injections she performed were trigger point injections and occipital nerve blocks. (Px8 at 15) She advised that the same were used to control muscle spasms in the occipital nerve to help relieve the chronic headaches. (Px8 at 15) She advised that the occipital region is the region in the back of the head just above the nuchal line and lateral to the erector muscles in the neck. (Px8 at 15) She advised that these injections provide only symptomatic pain relief that was not permanent. (Px8 at 15)

Dr. Rathi advised that she continued to see petitioner monthly after this initial visit in order to provide treatment to control the headaches, spasms, stiffness, and pain. (Px8 at 15) She advised that during this period of time petitioner had good days and bad days, which is consistent with her diagnosis. (Px8 at 17) She advised that petitioner was being prescribed NSAIDs, muscle relaxants, and narcotic pain medications. (Px8 at 17) She advised that she periodically performed a urinalysis to make sure that petitioner was taking his medication and not selling them. (Px8 at 17-18) Urinalysis is also used to make sure that patients are not using illicit medications. (Px8 at 18) She advised that based upon these urinalysis, petitioner was generally in compliance with her expectations. (Px8 at 18)

Dr. Rathi testified that she believed that petitioner had reached maximum medical improvement during his visit of August 22, 2012 since his symptoms had essentially plateaued. (Px8 at 19) She believed that petitioner was as good as he was going to get. Dr. Rathi advised that she continued to recommend treatment, including nerve blocks, trigger point injections, medications, and additional therapies. She also advised petitioner to continue to follow up with her as needed. (Px8 at 19)

Dr. Rathi testified that she resumed regular treatment of petitioner beginning in April of 2013 due to a resurfacing of his symptoms. (Px8 at 19) She advised that in March of 2013 petitioner had a flare-up of his condition which was to be expected. (Px8 at 20) She advised that post-concussion syndrome and

headaches can flare up due to weather changes, stress, work, hormones, accidents, trauma, and a variety of other factors. (Px8 at 20)

Dr. Rathi advised that she continued to see petitioner monthly through December of 2013, and then intermittently through 2014 with two visits in 2015. (Px8 at 21) She stated that petitioner's symptoms stayed consistent during that period of time. (Px8 at 21) She advised she continued to perform injections and prescribe opiate pain medications. (Px8 at 21-22)

Dr. Rathi then testified that she last saw petitioner on March 4, 2015. (Px8 at 22) At that time, petitioner was continuing to complain of headaches, neck pain, shoulder pain and migraines. (Px8 at 22-23) She stated that the physical exam findings were very similar to his initial presentation. (Px8 at 22-23) He did have some increased stiffness in his neck and back. (Px8 at 21-22) She continued to diagnose post-concussion syndrome, tension headaches, cervicalgia, migraines, hypertension, diabetes, depression, anxiety, myositis, and carpal tunnel syndrome. (Px8 at 22) She recommended that petitioner continue taking anti-inflammatories, as well as Namenda for his memory and cognition. (Px8 at 23) Likewise, she prescribed him Cymbalta for his depression and anxiety, along with Xanax. (Px8 at 23) Finally, she prescribed him Norco for his pain management. (Px8 at 23) She also gave him a last round of occipital nerve blocks and trigger point injections and advised that petitioner should continue to exercise and take his medication. (Px8 at 23)

Dr. Rathi believed that petitioner's current diagnosis is post-concussion syndrome that encompasses petitioner's diagnoses of headaches, cervicalgia, migraines, depression, anxiety, and fibromyalgia. (Px8 at 25) She advised that fibromyalgia is a chronic musculoskeletal disorder encompassing diffuse pain. (Px8 at 25) She advised that the objective findings encompassing fibromyalgia would be muscle spasms, stiffness, and trigger point. (Px8 at 25) She advised this diagnosis of fibromyalgia was based upon petitioner's history and physical examination, his complaints, and the lack of other associated findings. (Px8 at 26)

Dr. Rathi testified that she believed that petitioner's current condition was caused as a result of the work-related accident on April 19, 2011. (Px8 at 27) This opinion was based upon petitioner's lack of

complaints prior to the accident and complaints afterwards. (Px8 at 27) Dr. Rathi believed that petitioner's current condition was going to be long-term and chronic. (Px8 at 27) She believed that petitioner was going to continue to require the injections and opiate pain medications every month to four to six times a year. (Px8 at 30)

During cross examination, Dr. Rathi admitted that while her characterizations of headaches are usually based upon a headache diary filled out by her patients, there were no indications in her records that she ever reviewed a headache journal from petitioner. (Px8 at 47)

Dr. Rathi admitted that petitioner went from 315 pounds at his initial evaluation to 280 pounds three weeks later. (Px8 at 50) She testified that it is not normal to see that type of weight loss in such a short period of time. (Px8 at 50) She admitted that by November of 2011 petitioner had lost approximately 80 pounds, according to her own records. (Px8 at 51) She admitted that such weight loss is not necessarily healthy. (Px8 at 51) She admitted that this weight loss was extreme. (Px8 at51) She admitted that it is possible for rapid weight loss to cause kidney problems. (Px8 at 52) She admitted that during this period of rapid weight loss petitioner complained of significant pain with general activities, including work and enjoyment of life. (Px8 at53) She admitted that dehydration can cause headaches, irritability, fatigue, lightheadedness, and mood disturbances. (Px8 at 54)

Dr. Rathi admitted that she released petitioner to work on June 17, 2011, but that her prior notes did not comment on petitioner's work status. (Px8 at 57)

She admitted the first time petitioner documented any memory problems was on March 6, 2012, one year after the accident. (Px8 at 61) She admitted that she did not do any actual testing regarding petitioner's memory complaints. (Px8 at 61-64)

She admitted that petitioner filled out a pain questionnaire on August 22, 2012, indicating that petitioner had 0/10 pain and that he had not used pain medications for two months. (Px8 at 65-66) Petitioner indicated that he felt "back to normal" on that date. (Px8 at 66) She admitted that she still recommended injections and medications on that date. (Px8 at 67)

She admitted that petitioner had approximately a nine-month period following this August 22, 2012 visit where his post-concussion syndrome symptoms had mostly resolved. (Px8 at 68)

Dr. Rathi admitted that the first documented reference to anxiety was in October of 2013. (Px8 at 72) She also admitted that her records did not reflect petitioner's complaints of poor concentration or word recall for many months following the accident. (Px8 at 72) She admitted petitioner's first complaints of anxiety took place almost two years after the accident. (Px8 at72) Dr. Rathi admitted that it was possible that petitioner's anxiety and depression could have been related to a condition separate from the post-concussion syndrome. (Px8 at 74-75)

She admitted that the first time petitioner complained of trouble driving at night and photophobia was three years after the accident. (Px8 at 80)

Dr. Rathi admitted that fibromyalgia is not typically related to post-concussion syndrome. (Px8 at She stated that she could not say that petitioner's fibromyalgia was in fact related to post-concussion syndrome. She admitted that petitioner's back pain that he was complaining of in November of 2014 could not be reasonably expected to be related to the accident four years later.

She testified that diabetes can be associated with symptoms of lightheadedness, urinary frequency, fatigue, dizziness, and fainting spells. (Px8 at 99-100) Dr. Rathi admitted she never tested petitioner for dehydration. (Px8 at Dr. Rathi admitted that fibromyalgia can be diagnosed without an underlying known cause as it is idiopathic, meaning no known cause, and could be genetic for all people know. (Px8 at 120) She admitted that irritable bowel syndrome, headaches, irritability, and insomnia can all be related to the fibromyalgia. (Px8 at 121-123)

Dr. Rathi admitted that petitioner was refilling his prescriptions for opiate pain medications on a monthly basis every four to six weeks. (Px8 at125)

She also admitted that people can experience memory issues without any underlying condition. (Px8 at 126) Dr. Rathi admitted there is no way to differentiate between a fibromyalgia headache and the headaches petitioner described that were not migraines. (Px8 at 133-134) She admitted that people with fibromyalgia can have what is caused "fibro fog." (Px8 at 134) She stated that fibro fog is a feeling like

you do not have a clear head, which can be associated with memory difficulty and word recall problems. (Px8 at134) Likewise, it is associated with difficulty with numbers. (Px8 at 134)

On May 12, 2015, respondent's independent medical examiner, Dr. Karen Levin, testified by way of evidence deposition in petitioner's third-party civil claim. (Rx7 at 1) She testified that she examined petitioner for the purpose of an independent medical examination on February 13, 2014. (Rx7 at 11) She testified that in anticipation for the same, she reviewed records from Algonquin Fire Department, Sherman Hospital, Alexian Brothers Medical Center, Dr. Reddy, Dr. Epstein, Dr. Rathi, Dr. Chappidi, reports of CT scans, as well as a Illinois Prescription Monitoring Program search. (Rx7 at14)

She testified that the Illinois Prescription Monitoring Search has certain medications being tracked on this program. (Rx7 at 14-15) She stated these medications are the kind that can be abused and addictive. (Rx7 at 15)

Dr. Levin testified that during this examination she obtained a history of the accident from petitioner. (Rx7 at 16-17) Petitioner told Dr. Levin that he was involved in a motor vehicle accident, but could not recall how fast the cars were going at the time of the collision. (Rx7 at16-17) Petitioner stated he could not recall what happened, but believes he called the police as well as the paramedics. (Rx7 at 16-17) He advised that he saw another doctor the next day, but was taken to the hospital due to high blood pressure. (Rx7 at 16-17) Petitioner stated that since that day he was getting migraines quite often and had the third hospital stay shortly thereafter. (Rx7 at16-17) Petitioner stated he was continuing to have headaches as well as memory problems, along with vision problems, numbness problems, balance problems, and dizziness that he did not have prior to the accident. (Rx7 at 16-17)

Dr. Levin testified that she performed a physical examination and a neurological examination of petitioner. (Rx7 at 17) She typically looks at blood pressure, pulse and weight, as well as on the nervous system and different parts of the nervous system. (Rx7 at 17) She advised the petitioner's blood pressure was extremely high at 160/110 and that petitioner at this point weighed 320 pounds. (Rx7 at 17) She noted that petitioner was oriented to time and place and that the cranial nerves were all normal. (Rx7 at 18) She noted that petitioner had a normal motor exam test and had completely normal sensation. (Rx7 at 18) She

noted that petitioner had a normal gait and equal reflexes. (Rx7 at 18) Therefore, the only abnormality was petitioner's extremely high blood pressure. (Rx7 at 19)

Dr. Levin believed that petitioner suffered some mild injuries as a result of the motor vehicle accident. (Rx7 at 21) She noted that petitioner suffered no major intracranial injuries including bleeding or bruising of the brain. (Rx7 at 21) She stated he might have had a minor concussion. (Rx7 at 21) The basis for her opinion was the mechanism of injury, the way these injuries interact, and her 25 years of experience. (Rx7 at 21) With respect to the mechanism of injury, she believed that petitioner was involved in a low to medium speed car accident. (Rx7 at 21) She believed this was a minor accident. (Rx7 at 21-22) She, therefore, believed that petitioner's injuries were soft tissue in nature meaning no major problems to the bones, brain or any organ. (Rx7 at 22)

Dr. Levin stated that petitioner's initial physical examination and neurologic examination taken at Sherman Hospital were completely normal other than petitioner's high blood pressure. (Rx7 at 23-24) Further, she noted that there were no neurologic symptoms noted during this initial stay at Sherman Hospital. (Rx7 at 25-26) She stated this was very significant as was the statement that petitioner denied any loss of consciousness. (Rx7 at25-26) She noted that petitioner underwent a CT scan. (Rx7 at26) She testified that taking CT brain scans is routine for any type of trauma. (Rx7 at 27) She noted that the CT scan performed on the date of the accident was unremarkable and normal. (Rx7 at27-28) She advised that petitioner likely suffered a contusion to the left shoulder and back which would be expected to resolve in a week or two. (Rx7 at 29-30)

Dr. Levin opined that petitioner's symptoms of headaches, stiff neck, low back pain, head pain, ringing in the ears, and memory loss were not related to the auto accident of April 19, 2011 based upon the way that people with these types of injuries respond and her 25 years of experience. (Rx7 at 39)

It was her belief that petitioner was stating that he had these symptoms due to secondary gain. (Rx7 at39-40) She noted that petitioner had ongoing litigation as well as the fact that he was getting quite a bit of narcotic pain medication, indicating drug-seeking behavior. (Rx7 at 40) Dr. Levin noted that the Illinois Prescription Monitoring Program search for petitioner showed that petitioner was receiving significant

quantities of hydrocodone. (Rx7 at 41-43) Dr. Levin stated that these quantities of narcotic pain medications would not be appropriate for the type of injuries petitioner received as a result of the accident on April 19, 2011. (Rx7 at 43-44) She stated that petitioner should not have been receiving narcotic pain medication two years after the accident. (Rx7 at 44) She did not believe that these prescriptions were reasonable and necessary. (Rx7 at 44) She stated that if petitioner was her patient, she would absolutely not prescribe any of these medications. (Rx7 at 44)

Dr. Levin then reviewed the multiple urinalyses that were taken by Dr. Rathi during her treatment of petitioner. (Rx7 at 45) Dr. Levin stated that a urinalysis is a drug screening wherein a patient pees into a cup which is then tested for a list of drugs. (Rx7 at 45) She noted that petitioner had several drug tests that were positive for marijuana and cocaine. (Rx7 at 46) She stated it was therefore reliable to assume that petitioner was using marijuana and cocaine in conjunction with his other prescribed medications. (Rx7 at 47)

Dr. Levin reported that she did not believe that the injections performed by Dr. Rathi were reasonable or necessary. (Rx7 at48) She noted that these injections are used to treat occipital neuralgia which petitioner did not have. (Rx7 at 48) She advised that occipital neuralgia is an irritation of the occipital nerve in the back of the head. (Rx7 at 49) She noted that petitioner was never diagnosed with occipital neuralgia. (Rx7 at48-49) When asked why petitioner was prescribed injections, Dr. Levin stated that she did not know. (Rx7 at 49) She did not believe that these injections were reasonable or necessary. (Rx7 at 48-49)

Dr. Levin testified that the only treatment the petitioner would have required would have been anti-inflammatories, a short period of rest after which he likely would have been normal within several weeks. (Rx7 at 49-50)

Dr. Levin testified that petitioner's diagnosis of hypertension and diabetes was not related to the accident. (Rx7 at 2-53) She noted that petitioner's blood pressure was extremely high right from the first time the paramedic saw it and then it continued when he was seen in Dr. Levin's office for the independent medical examination. (Rx7 at 52-53) She advised that these types of injuries do not cause high blood

pressure. (Rx7 at 53) She advised that diabetes is high blood sugar. (Rx7 at 52-53) She stated that it cannot be caused by trauma or a car accident. (Rx7 at 53)

Dr. Levin testified that petitioner did not suffer any permanent neurologic injuries as a result of the accident. (Rx7 at 53) She advised the petitioner should have been able to return to work at full duty without restriction likely several weeks after the accident. (Rx7 at 54) She testified that petitioner has drug-seeking behaviors and ongoing litigation and therefore has secondary gain in this case. (Rx7 at 64-65) She, therefore, believed that petitioner was embellishing his current symptomologies due to this secondary gain. (Rx7 at 64-65)

On cross examination, Dr. Levin testified that petitioner likely had a mild concussion as a result of the accident despite the normal findings at the hospital immediately following the accident. (Rx7 at 66) She also admitted that one can have a concussion without actually striking their head. (Rx7 at 70) She admitted that post-concussion syndrome can include headaches, dizziness, vision issues, and that it can last for a few weeks to six months. (Rx7 at 70-71) She stated that six months, however, would be pushing it. (Rx7 at71) She stated that if these symptoms last after six months that is when she would start looking at what else is going on. (Rx7 at71) She stated that she has never had a patient with symptoms of post-concussion syndrome lasting beyond six months without secondary gain issues. (Rx7 at71)

Dr. Levin stated that an individual with post-concussion syndrome such as headaches can have waxing and waning of symptoms; however, they do not completely resolve and then come back. (Rx7 at

Dr. Levin testified when an individual is suffering from occipital neuralgia, three to five occipital nerve injections should cure it. (Rx7 at78)

Petitioner was then seen at respondent's request by Dr. Elizabeth Kessler, a board certified neurologist with forty years of experience, on June 8, 2017 for the purposes of a second independent medical examination. Dr. Kessler testified by way of evidence deposition on December 12, 2017. (Rx6 at 1)

Dr. Kessler testified that in anticipation of her June 8, 2017 independent medical examination she reviewed medical records of petitioner's treatment from Algonquin Fire Protection District, Sherman

Hospital, Alexian Brothers Medical Center, and Dr. Rathi. (Rx6 at 16-17) In addition, she reviewed Dr. Karen Levin's February 13, 2014 independent medical examination report. (Rx6 at 17)

With respect to these medical records, Dr. Kessler noted petitioner had a normal CT scan as well as normal neurologic evaluation and a 15/15 Glasgow coma scale upon initial presentation at Sherman Hospital. (Rx6 at17-18) Further, she noted petitioner's initial treatment included a denial of the loss of consciousness or any memory problems. (Rx6 at 18) Dr. Kessler testified that the Glasgow coma scale is used to determine whether or not there is any brain or neurologic issues. (Rx6 at 18) A score of 15/15 indicated that petitioner did not suffer any neurologic injuries or brain injuries at that time. (Rx6 at 18) She stated, therefore, that this initial treatment record at Sherman was helpful in determining whether or not petitioner had any brain or neurologic injuries. (Rx6 at18)

Dr. Kessler testified that based upon her review of all of petitioner's medical records, it did not appear as though petitioner suffered any neurologic injuries or brain injuries as a result of the April 2011 accident. (Rx6 at20-21) Further, she noted that petitioner did not suffer a concussion as there was no evidence of the signs or symptoms of a concussion at the time of this initial visit. (Rx6 at 20-21)

Dr, Kessler testified that the medical records documenting petitioner's initial treatment were inconsistent with the history provided by petitioner at the time of his independent medical examination. (Rx6 at18-19) When petitioner presented to Dr. Kessler, he described having a loss of consciousness as well as a hazy memory which petitioner specifically denied in the records of the Algonquin Fire Protection District, Alexian Brothers Medical Center, and Advocate Sherman Hospital. (Rx6 at 19)

Dr. Kessler testified that the first time petitioner described the onset of headaches with occipital pain radiating into his temporal/front region bilaterally was during his first visit with Dr. Rathi on May 11, 2011. (Rx6 at19) At that time, petitioner was taking both Naprosyn and Tylenol. (Rx6 at22) Dr. Kessler noted that this was an odd combination as both Naprosyn and Tylenol would lead to a medication overuse headache. (Rx6 at 22) She stated that as of the date of this first visit with Dr. Rathi, petitioner's symptoms should have resolved. (Rx6 at 25-27) Dr. Kessler testified that even had petitioner had a concussion, those symptoms would have resolved by this visit as well. (Rx6 at25-27) She noted petitioner's comments made

to Dr. Rathi during this initial visit were inconsistent with his previous treatment records as he was unsure whether or not he lost consciousness at the time of the accident. (Rx6 at25-27) She noted that at the time of Dr. Rathi's examination, petitioner had muscle spasms in the cervical and thoracic spines bilaterally and that the same could not have been caused by the accident as any such injuries would have resolved by the time of this initial evaluation by Dr. Rathi. (Rx6 at 25-27)

Dr. Kessler testified that while Dr. Rathi diagnosed petitioner with post-concussion syndrome, there was no medical support noted for the diagnosis of concussion or post concussion syndrome. (Rx6 at24-25)

Dr. Kessler noted that petitioner received multiple bilateral occipital nerve blocks and trapezius trigger point injections that were not necessitated by the accident. (Rx6 at 27-29) Dr. Kessler testified that the only reason why a doctor would perform an occipital nerve block is if the individual was suffering from occipital neuralgia. (Rx6 at 27-29) She stated that there was no evidence that petitioner was suffering from the same. (Rx6 at 27-29) Dr. Kessler testified that when an individual suffers from occipital neuralgia, the capping of the occipital nerve in the back of the head results in an electric shooting pain in the back of the head, known as a positive Tinel's. (Rx6 at 27-29) This test was never performed on petitioner. (Rx6 at 27-29)

Dr. Kessler testified that petitioner's complaints of worsening symptoms months and years after the alleged accident is inconsistent with the actual way in which post-concussion syndrome as well as sprains and strains present themselves diagnostically. (Rx6 at 37-38)

Dr. Kelssler testified that use of marijuana and cocaine could cause several of petitioner's symptoms including insomnia, memory difficulties, headaches, irritability, changes in mood and depression. (Rx6 at 84-85)

Dr. Kessler testified that petitioner was also complaining of constant 6/10 pain in his neck and shoulders that was allegedly worsened with repeated turning of his head. (Rx6 at 34-35) Dr. Kessler stated that if these symptoms were accurate there was no way it could be related to the alleged accident as any sprain or strain of the shoulder or neck would have resolved within weeks of the alleged accident date. (Rx6 at 34-35)

Dr. Kessler testified that based upon her review of the medical records, diagnostic studies, and her examination of petitioner, she believed petitioner sustained a sprain/strain of the neck and shoulder contusion as a result of the accident. (Rx6 at 37-38) She specifically testified that petitioner did not suffer from a concussion, did not suffer post-concussion syndrome, did not suffer from fibromyalgia, and did not suffer from migraines. (Rx6 at 37-38)

Dr. Kessler testified that in order to be diagnosed with a concussion, a patient needs either a loss of consciousness, an altered level of consciousness, memory impairment before or after the accident, or some other evidence of brain dysfunction. (Rx6 at 58) She stated that at least one of these four symptoms must occur at the time of the event. (Rx6 at 58) Dr. Kessler stated that none of these were present or documented in petitioner's medical records on the date of the accident. (Rx6 at 58) She noted that subsequent reports were not consistent with a concussion or petitioner's complaints of these symptoms weeks and months afterwards are not consistent with a diagnosis of a concussion. (Rx6 at 58)

Dr. Kessler stated that post-concussion syndrome is not in and of itself an actual syndrome. (Rx6 at 59) She noted that it is not a worsening of a brain condition. Rather, it is a mere continuation of symptoms. (Rx6 at 59) She stated that this condition would last at most two to three weeks. She stated that post-concussion syndrome is not permanent and can last anywhere from days to three months. (Rx6 at 59)

Dr. Kessler stated that in order to be diagnosed with fibromyalgia, one would need to have tenderness in very specific points of the body in addition to the unexplainable subjective complaints of pain. (Rx6 at 41, 60) Dr. Kessler noted that there was no physical examination documented by Dr. Rathi that would support a diagnosis of fibromyalgia. (Rx6 at 41, 60) Further, the diagnosis of fibromyalgia could not have been caused by the alleged accident date. (Rx6 at 41, 60) Dr. Kessler noted that Dr. Rathi had testified that fibromyalgia is a part of post-concussion syndrome. (Rx6 at 41, 60) Dr. Kessler stated that there is no diagnostic test needed in order to diagnose fibromyalgia, rather it is a chronic pain located in various locations. (Rx6 at 41, 60) She noted there are comorbidities of IBS and migraines, but in order to diagnose fibromyalgia a patient needs tenderness over very specific points in the body most of which are joints. (Rx6

at 41,60) She testified there are no findings consistent in Dr. Rathi's medical records to suggest that petitioner was suffering from fibromyalgia. (Rx6 at 42, 60)

Dr. Kessler stated that petitioner's complaints of migraines were likely not migraines at all. (Rx6 at 70-72) She testified that migraines have a very specific pattern that need to be followed in order for a diagnosis of migraine to be made. (Rx6 at 70-72) This pattern includes certain stimuli resulting in an increasing pain. (Rx6 at 70-72) Among the stimuli would be lights, sounds, and movement. (Rx6 at 70-72) Therefore, petitioner's description of these migraines was inconsistent with the diagnosis of migraines. (Rx6 at 70-72)

She noted that petitioner's diagnosis of hypertension and diabetes were in no way related to the alleged accident date. (Rx6 at 45-47) Dr. Kessler specifically noted that petitioner's visits to Alexian Brothers Medical Center on April 21 2011, April 25, 2011, and June 5, 2011 were purely related to petitioner's personal and pre-existing hypertension and diabetic condition. (Rx6 at 45-47) She testified that the renal failure and loss of consciousness was a result of petitioner's hypertension medication which was a personal condition. (Rx6 at 45-47)

Dr. Kessler believed that petitioner had reached maximum medical improvement for his cervical strain and should have been able to return to work as soon as one week after the accident. (Rx6 at 42-44) She stated that petitioner did not currently require any work restrictions as a result of the accident and that he did not require any additional treatment, surgical or otherwise. (Rx6 at 42-44) She did not believe that any of the treatment after the first ER visit and two outpatient visits would have been reasonable, necessary, or causally related to the April 2011 accident date. (Rx6 at 42-44)

Dr. Kessler admitted that petitioner was given opioid prescriptions despite having no medical indications for the same. (Rx6 at 82) She admitted that it was not unusual in 2011 for physicians to prescribe opioid pain medications, but that even back in 2011 it was well known that hydrocodone was not effective against headaches. (Rx6 at 86-87)

Dr. Kessler testified that the side effects of hydrocodone can include nausea, memory impairment and sleepiness. (Rx6 at 65-66) She noted that petitioner was also prescribed cyclobenzaprine, a muscle

relaxant. (Rx6 at 66) She stated that the same was not needed as the petitioner was not known to have any significant muscle spasms. (Rx6 at 66) She stated that the side effects of cyclobenzaprine can include dizziness and nausea. (Rx6 at 66)

At trial, Petitioner testified that after he returned to work from the accident on June 17, 2011, he continued to deal with headaches while going about his job. (Tr. 25) He noticed after long periods of driving or driving through the day he would have frequent headaches that would become more aggravated. (Tr. 25-26) He also complained of occasional muscle stiffness and pain, but he worked through it. (Tr. 26) The stiffness would be from the base of the shoulders into the base of his head. (Tr. 26) He testified that after his return to work for the respondent before he was terminated, he was able to work the same hours, made the same amount of money and performed the same job duties. (Tr. 48)

He testified that he continued to work for respondent until August 10, 2011 when he was fired from Fuji Foods due to attendance issues. (Tr. 53) He stated that thereafter, he began working for Aquatics, Inc. as well as several bars including Cobra Lounge and Evil Olive. (Tr.53-55) He advised that position at Evil Olive and Cobra Lounge was security and bar back. (Tr. 53-55)

Petitioner testified that his work for Aquatics, Inc. and the bars required him to lift greater than 50 pounds. (Tr. 50) He stated that Cobra Lounge is a music venue that regularly had loud music. (Tr. 59-60) He testified that the loud music and lights did not bother him while working. (Tr. 90) He testified that he never worked at a bar at the same time that he worked for respondent because his hours with the respondent would begin at 2:30 in the morning while the bar closed at 2 in the morning. (Tr. 55-56) He stated that additional job duties at the bar included carrying beer cases, stocking the bar and taking out trash. (Tr. 57-59) He also advised that as security, he had to physically restrain individuals and remove them from the premises. (Tr. 57-59)

Petitioner testified that he currently lives in Arizona. (Tr. 8) He has two jobs, working as a driver for Amazon and part time for a construction company. (Tr. 49) He admitted that for both of these positions, he regularly has to lift greater than 50 pounds. (Tr. 50) He stated that he is able to perform both these jobs without any issues (Tr. 88-90)

Petitioner testified that he continues to occasionally get headaches, but not as often as he used to. (Tr. 32-34) He stated he currently is not 100% like he was before the accident and often times has to do stretches for his neck in order to get comfortable. (Tr. 32-34) He complained of occasional migraine flare-ups that last a couple of days four to five times a month, but not as much as it used to. (Tr. 34)

On cross examination, petitioner admitted that he submitted multiple urinalysis with Dr. Rathi. (Tr. 60-70) He testified that he never received the results of the urinalysis. (Tr. 70) He testified that he has smoked marijuana in the past and has a felony conviction for selling the same. (Tr. 62, 75) In addition, he testified that he has never taken cocaine. (Tr. 62) Two of petitioner's urinalysis were positive for cocaine. (Rx8) He admitted that he has possessed cocaine in the past for distribution purposes. (Tr. 64)

Petitioner admitted that he received prescriptions for Norco throughout the vast majority of his treatment with Dr. Rathi. (Tr. 65-68) He stated that when he received prescriptions for Norco, he filled the same regularly as prescribed. (Tr. 68) He stated he did not know whether he tested positive or negative for opioid pain medications during the multiple urinalysis performed by Dr. Rathi. (Tr. 60-70)

Petitioner admitted that at one point after the April 19, 2011 accident he weighed as much as 315 pounds and was down to 238 pounds by November 22, 2011. (Tr. 76) He stated his weight loss was due to diet as well as exercise at the gym every day. (Tr. 76) He stated that he rode a bike 40 miles every day. (Tr. 76-77) He stated he continues to bike, but not as much. (Tr. 77) In addition, he performs weight lifting activities. (Tr. 77-81) He stated he did 45 minutes of lifting followed by 20 minutes of cardio. (Tr. 77) He stated that he weight lifted three times a week. (Tr. 80) He stated that he lifted over 100 pounds for pec exercises, 45 to 50 pounds for shoulder exercises, 80 to 90 pounds for back exercises and resistance machines for his trapezius. (Tr. 77-81)

In addition, he testified that following his move to Arizona he began to participate in cross fit. (Tr. 80-81) He described cross fit as a high intensity workout wherein he performed olympic lifting, power lifting, aerobics and gymnastics and a variety of other different exercises for a 40 minute period. He stated that the idea is to keep a high heart rate in order to burn more calories.(Tr. 80-81)

He testified that when he worked out, he felt good. He stated that he started working out immediately after he got out of the hospital for his last hospital stay because he decided he did not want to have to go back to the hospital. (Tr. 91)

He testified that currently his left shoulder is fine with no complaints. He stated that his lower back is fine with no complaints. (Tr. 82) He admitted that he has not seen any orthopedic surgeons for any of the injuries in this case. (Tr. 82)

Petitioner testified that at the time of his June 5, 2011 hospital stay, it was his understanding that the complications were caused by an Ace inhibitor. (Tr. 82-83) He stated he did not recall whether or not his doctors or pharmacists told him not to drink any alcohol while on these medications. (Tr. 83) He stated he believed the bottle stated that alcohol may intensify such symptoms. He stated he did not recall whether or not he drank alcohol the night before. (Tr. 83)

Petitioner also testified that he performs his construction job without any issues. (Tr. 88-89) Further, he testified that when he was working for Evil Olive and Cobra Lounge, he did not have any issues. (Tr. 88-89) He testified that he never had any issues listening to the loud music at the concert venue. (Tr. 90)

CONCLUSIONS OF LAW

In support of the Arbitrator's decision relating to (F) Is Petitioner's current condition of ill-being causally related to the injury?

Based on the testimony of Petitioner and the objective medical evidence, the Arbitrator finds Petitioner's neck strain and left shoulder contusion are causally related to the accident of April 19, 2011.

The Arbitrator notes that Petitioner contends he currently suffers from post-concussion syndrome, tension headaches, migraines, occipital headaches, and renal problems as a result of the work-related accident of April 19, 2011. However, the Arbitrator does not find these medical conditions to be causally related to his April 19, 2011 injuries.

Immediately after the accident, Petitioner was taken by the Algonquin Fire Protection District to Sherman Hospital. While en route, EMTs performed preliminary neurologic testing finding that petitioner

was awake and alert and suffered no loss of consciousness. (Px1) Petitioner had no headache complaints but rather complained of low back pain, left shoulder pain, and neck pain.

Upon arriving at Sherman Hospital, Petitioner once again denied a loss of consciousness or any other neurologic symptoms. (Px2) Additional neurologic testing and a CT of petitioner's brain were both performed, and were normal. (Px2) Further, while petitioner testified to striking his head twice during the collision, there were no abrasions, tenderness, or bruising to petitioner's head or scalp during physical examination at Sherman Hospital. (Px2)

The Arbitrator notes that between the date of accident and Petitioner's first visit with Dr. Rathi on May 11, 2011, Petitioner underwent three separate CT scans of his brain, all of which were normal. Further, at no point was petitioner diagnosed with a concussion or any other brain injury in between the accident and petitioner's first visit with Dr. Rathi. Upon transferring his care to Dr. Rathi, petitioner continued to have normal neurologic findings.

The Arbitrator therefore finds that the objective medical evidence presented at trial is consistent with the opinions of Respondent's independent medical examination physician, Dr. Elizabeth Kessler, a neurologist with over forty years of experience. During her deposition, Dr. Kessler testified consistently and credibly. Dr. Kessler testified that in order to diagnose a concussion, a patient needs a loss of consciousness, an altered level of consciousness, memory impairment before or after the accident, or some other evidence of brain dysfunction. She stated that at least one of these four symptoms must occur at the time of the event.

The medical records from Algonquin Fire Protection District, Sherman Hospital, and Alexian Brothers Medical Center are devoid of any such findings. Dr. Kessler credibly opined that one cannot diagnose a traumatic brain injury without symptoms, objective findings, or an MRI or CT scan showing a traumatic brain injury. She noted that in this case petitioner's initial care did not reveal any signs or symptoms of a traumatic brain injury. Further, Petitioner has never had any objective findings of a traumatic brain injury or any abnormal brain imaging.

Alternatively, Dr. Rathi's diagnosis of post-concussion syndrome is based solely on petitioner's subjective complaints. During her deposition, Dr. Rathi admitted that petitioner's physical and neurologic examinations were consistent throughout her course of care. Further, she admitted that petitioner's neurologic examinations were routinely normal. Rather, Dr. Rathi testified that her diagnosis of post-concussion syndrome and aggravation of fibromyalgia were based upon petitioner's subjective complaints of headaches, migraines, dizziness, impaired memory, confusion, insomnia, irritability, and word finding-difficulty. The Arbitrator notes that Dr. Rathi admitted that many of these complaints can also be caused by dehydration, diabetes, and fibromyalgia. Likewise, many of these complaints could have been caused by the medications Petitioner was taking for his personal conditions of hypertension and diabetes.

None of petitioner's subjective complaints were supported by objective findings noted in Dr. Rathi's medical records. While Dr. Rathi testified that headaches can be diagnosed with use of a "headache journal," she did not know whether or not one was ever filled out by petitioner. Dr. Rathi also testified that there are tests that can be performed to determine memory impairment. No such tests were ever performed on petitioner.

The Arbitrator therefore finds the opinions of Dr. Kessler to be highly persuasive and the opinions of Dr. Levin to be persuasive. However, the Arbitrator does not find the opinions to Dr. Rathi to be persuasive.

In finding the same, the Arbitrator notes certain specifics of the medical care provided by Dr. Rathi. During the course of her treatment of Petitioner, Dr. Rathi routinely commented that petitioner was compliant with his prescriptions. This was clearly contrary to the facts. Dr. Rathi's own treatment records document that petitioner repeatedly tested negative for the opioid pain medications she was prescribing. Likewise, Petitioner tested positive for illicit and illegal substances on multiple occasions.

Further, Dr. Rathi testified at length about the methods and tests that could have been used to diagnose and verify petitioner's subjective complaints of headaches and memory problems. Despite this testimony, Dr. Rathi did not perform any of these tests.

Finally, while Petitioner is not making a claim that his diagnosis of fibromyalgia is related to the April 19, 2011 accident, it cannot be ignored that Dr. Rathi routinely causally related the same during her deposition. Not only does the Arbitrator note that fibromyalgia is an inherently idiopathic condition but that it also does not result from trauma. Likewise, the standard for diagnosing fibromyalgia was not met by Dr. Rathi.

As Dr. Rathi's diagnosis rests solely on petitioner's subjective complaints, it is also important to assess petitioner's credibility. After reviewing the medical records and listening to petitioner's testimony, the Arbitrator does not find petitioner to be credible.

As Respondent's other IME, Dr. Karen Levin, explained, "patients who suffer from post-concussion syndrome do not experience symptoms lasting longer than six months unless there is some sort of secondary gain." This secondary gain can include pending litigation or drug seeking behavior. In this case, both motivations are present.

Dr. Rathi's medical records document that petitioner was routinely prescribed narcotic pain medication. Petitioner testified that whenever he obtained such prescriptions, he would fill the same at whatever pharmacy was closest to him at the time. Respondent offered into evidence the prescription records from some of these pharmacies showing that petitioner regularly filled his prescriptions for Norco.

Dr. Rathi's medical records and Petitioner's testimony also document routine and regular drug testing. Dr. Rathi explained that such drug tests were performed in order to determine whether or not Petitioner was compliant with his prescriptions as well as to keep an eye out for potential abuses. Over the course of petitioner's treatment with Dr. Rathi, he was drug tested fourteen times. (Rx8) Thirteen of those fourteen drug tests were negative for opioids. (Rx8) In fact, petitioner tested positive for illegal and illicit substances more often than he tested positive for his prescribed opioid pain medications. (Rx8) The Arbitrator cannot understand why any medical professional would continue prescribing opioid medication for a patient who continues to test negative for opioids in the urine test that the medical professional was prescribing. It appears to the Arbitrator that Dr. Rathi was ignoring the urine testing results she had

prescribed at best. This factor plays a large factor in the Arbitrator's conclusions regarding the lack of credibility he gives to the testimony and conclusions of Dr. Rathi.

In light of the glaring discrepancy between petitioner's prescriptions and drug tests, it is impossible for the Arbitrator to ignore Petitioner's own testimony. During trial, Petitioner admitted to selling cocaine, selling marijuana, and being a convicted felon. (Tr. 64, 75-76) Due to these issues, the Arbitrator does not find petitioner to be credible.

As Dr. Rathi's diagnosis rest primarily on the subjective complaints of petitioner and as petitioner is not credible, the Arbitrator find that petitioner did not suffer from post-concussion syndrome, tension headaches, migraines, or occipital headaches as a result of the work-related accident of April 19, 2011.

The Arbitrator further finds that Petitioner's June 5, 2011 hospital stay and corresponding diagnosis of renal failure were not caused by the April 19, 2011 accident. Petitioner's renal failure was found to be multifactorial by his treating physicians. They found the same to be related to hypotension in conjunction with his Ace Inhibitor, his use of Aspirin, and dehydration. The Arbitrator notes that petitioner's Ace inhibitor was prescribed to treat his personal condition of hypertension, unrelated to the April 19, 2011 accident. Likewise, no doctor has attributed Petitioner's dehydration on June 5, 2011 to the April 19, 2011 accident. Rather, petitioner testified that he had already begun a significant work out regime close in time to this hospital stay. Further his medical records document he had recently lost 50 pounds over a three week period of time. Therefore, Petitioner's argument rests solely with the NSAID, Aspirin, alleging Petitioner was taking the same due to the April 19, 2011 accident. The Arbitrator find insufficient evidence that petitioner was taking aspirin at that time to treat the injuries related to the April 19, 2011 accident. Further, the Arbitrator does not find sufficient nexus between over the counter pain medications and petitioner's renal failure on this date.

The Arbitrator does find, however, that Petitioner suffered from a left shoulder contusion and a neck muscle strain as a result of the April 19, 2011 accident. Immediately following the accident, Petitioner made complaints of left shoulder pain and neck pain as documented by the records of Algonquin Fire Protection District and Sherman Hospital.

Petitioner's left shoulder pain was short lived. Subsequent visits to Alexian Brothers Medical Center on April 21, 2011 and April 26, 2011 contain no mention of shoulder pain or issues. Further, during trial, Petitioner admitted to having no pain or issues with respect to his shoulders.

Consistent with Dr. Kessler's opinions and the medical records from Sherman Hospital and Algonquin Fire Protection District, the Arbitrator finds that Petitioner also suffered a neck strain. While the Arbitrator notes petitioner testified to continued neck pain and tightness, for the reasons stated above, the Arbitrator does not find petitioner to be credible. The Arbitrator therefore agrees with Dr. Kessler that petitioner reached maximum medical improvement for his neck strain two weeks following the April 19, 2011 accident.

Based on all of the above, the Arbitrator finds the petitioner's left shoulder and cervical conditions are causally related to his April 19, 2011 accident and that the petitioner failed to prove any other medical conditions are causally related to the April 19, 2011 accident.

(I) Were 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

Consistent with the Arbitrator's findings above, the Arbitrator gives great weight to the opinions of Dr. Kessler with respect to the reasonableness and necessity of the medical treatment received by petitioner. Similarly, very little weight is given to the opinions of Dr. Rathi for the same reasons set forth above.

Consistent with the Arbitrator's findings with respect to causation, the only conditions found to be causally related are the left shoulder contusion and neck muscle strain. As such, the Arbitrator finds that the only medical care that has been reasonable, necessary, and causally related to the accident is the care provided by Sherman Hospital and the Algonquin Fire Protection District on April 19, 2011. While the Arbitrator finds that petitioner did not reach maximum medical improvement for these conditions until May 3, 2011, he finds that no other treatment received by petitioner before that date was directed at conditions petitioner sustained as a result of the April 19, 2011 accident.

Petitioner was admitted to Alexian Brothers Medical Center on April 21, 2011. Although petitioner had yet to reach maximum medical improvement for his causally related neck strain, his admittance to Alexian Brother Medical Center at this time was due solely to his elevated blood pressure. Petitioner admitted during cross examination that this elevated blood pressure was the reason he was admitted to the hospital at this time. Further, he admitted that he was not released until after his blood pressure was managed. As Petitioner's hypertension was a personal condition unrelated to the April 19, 2011 accident, the treatment petitioner received at Alexian Brothers Medical Center is similarly unrelated.

Petitioner's subsequent treatment at Alexian Brother Medical Center on April 26, 2011 is similarly unrelated to the April 19, 2011 accident date. At that time, he was admitted primarily due to worsening kidney function. Much of his treatment and his hospital stay was related to this personal and unrelated condition. While petitioner did complain of headaches during this visit, the Arbitrator finds that the same were due to petitioner's personal underlying renal problems. It should be noted that Petitioner himself believes his morbid obesity was the cause of this hospital stay, testifying that he resolved to work out and lose weight after this visit so that he would never have to go back to the hospital again.

Finally, the Arbitrator notes that petitioner received extensive treatment from Dr. Rathi in the form of occipital nerve blocks, trigger point injections and various prescriptions including norco. The Arbitrator finds that all of the treatment rendered by Dr. Rathi was not reasonable, necessary, or causally related to the accident on April 19, 2011 for the reasons set forth above.

Based on the above Arbitrator's findings regarding the reasonableness and necessity of the treatment Petitioner received, the Arbitrator finds that the Respondent is liable for medical bills from April 19, 2011 but not thereafter. The Arbitrator finds that Respondent has paid for all reasonable and necessary treatment related to the April 19, 2011 accident.

(K) What temporary benefits are in dispute? the Arbitrator find the following facts:

Petitioner has also made a claim for 4 4/7 weeks of temporary total disability benefits. The Arbitrator finds, however, that petitioner suffered no lost time as a result of the April 19, 2011 accident.

Upon his discharge from Sherman Hospital on April 19, 2011, petitioner was not provided any work restrictions. While Petitioner did not return to work on April 20, 2011, he admits the same was a scheduled day off. Petitioner then attempted to return to work on April 21, 2011 but was advised that he needed to be medically cleared by his primary care physician before returning. While visiting his primary care physician that day, however, petitioner was admitted to the hospital for his personal condition of extreme hypertension. As explained above, this period petitioner was off work was for a purely personal condition. Petitioner was not given work restrictions upon his discharge from Alexian Brothers Medical Center on April 25, 2011.

Petitioner returned to work on April 26, 2011 but was taken to Alexian Brothers Medical Center shortly thereafter. Petitioner admits no additional trauma or accident occurred while he was at work on April 26, 2011. Upon admittance to Alexian Brothers Medical Center on April 26, 2011, Petitioner was again treated for his hypertension and worsening kidney function. Both of these conditions were personal in nature and unrelated to the work accident on April 19, 2011. Therefore, petitioner's time off of work for this hospital stay was unrelated to the April 19, 2011 accident. Petitioner was not provided with work restrictions upon discharge from Alexian Brothers Medical Center on April 28, 2011.

Thereafter, petitioner returned to work for the Respondent until his fourth hospital stay on June 5, 2011. At that time, petitioner was admitted to Alexian Brothers Medical Center for renal failure. As explained above, petitioner's renal failure was not caused by the April 19, 2011 accident. Therefore, this time off work was not related to the April 19, 2011 accident. Petitioner was discharged the same day without work restrictions. Petitioner thereafter returned to work for Respondent without restrictions. Dr. Rathi's treatment notes contain no notations placing petitioner off of work or providing work restrictions.

Based on all of the above, the Arbitrator findsPetitioner suffered no lost time as a result of the April 19, 2011 accident and as such is not entitled to temporary total disability benefits.

In support of the Arbitrator's decision relating to (L) What is the nature and extent of the injury? the Arbitrator find the following facts:

As this matter involves an accident occurring before September 1, 2011, the five factors set forth by Section 8.1(b) of the Act do not apply.

Petitioner testified that he worked as a delivery driver and salesman for the insured. He advised that the most he would have to lift was fifty pounds. While working for the Respondent, Petitioner was involved in a motor vehicle accident on April 19, 2011. As a result of the April 19, 2011 accident, Petitioner suffered a left shoulder contusion and a neck muscle sprain. He reached maximum medical improvement for these conditions two weeks later on May 3, 2011.

Petitioner testified that following the accident, he continued to perform the same job duties for the Respondent, work the same hours, and earn the same amount of money. He testified that he was able to perform these job duties without issue until his termination in August of 2011.

After his termination from Respondent, Petitioner began working for Aquatics Inc. Petitioner admitted he would sometimes have to lift greater than 50 pounds while working for Aquatics Inc. While under oath, Petitioner denied that he was paid between $115.00 and $96.18 per hour while working for Aquatic Inc. Respondent, however, offered into evidence Petitioner's wage records from Aquatics Inc. showing that petitioner's wage rates were $115.00 and $96.18 per hour. These records further show that petitioner earned an average weekly wage of $581.05 while working for Aquatics, Inc., greater than his pre-accident average weekly wage of $528.39. These wage records not only call petitioner's credibility further into question, they also show that petitioner did not suffer a decrease in earning potential as a result of the injuries sustained on April 19, 2011.

Petitioner testified that he continues to have neck pain and stiffness after long periods of driving for work. However, Petitioner also testified that he currently works in a more physically demanding job than his previous position with Respondent. Despite these higher physical demands, Petitioner testified to "having no problems" while working any of his jobs following his employment with Respondent. Further,

the Arbitrator notes that petitioner became involved in high intensity workouts shortly after his April 26, 2011 hospital stay. He testified to regularly lifting over 100-pound weights three to four times a week and biking 40 miles a day calling petitioner's neck complaints further into question.

Based on all of the above, the Arbitrator therefore finds that Petitioner is entitled to 3% loss of use of the man as a whole for his left shoulder contusion and his cervical strain conditions.

In support of the Arbitrator's decision relating to (N) Is Respondent due any credit?, and (O) Is respondent entitled to a credit for medical paid in the amount of $71,482.47?, the Arbitrator find the following facts:

It is undisputed that Respondent paid petitioner TTD benefits in the amount of $1,614.48 and medical benefits in the amount of $71,482.47. Therefore, Respondent is entitled to a credit against Petitioner for TTD and medical paid in the amount of $73,096.95.

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

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Brad Taflinger,

Petitioner,

vs.

NO: 16 WC 29155

John Deere,

Respondent.

20IWCC0045

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by Respondent and Petitioner herein and notice provided to all parties, the Commission after considering the sole issue of nature and extent of permanent partial disability and being advised of the facts and the 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 notes the Arbitrator awarded Respondent a credit of $6,235.24 for payment of temporary total disability benefits but did not award the corresponding benefits. The Commission finds Petitioner was temporarily totally disabled from September 29, 2014 intermittently to May 26, 2017, a total of 11-3/7 weeks. ArbEX1, Request for Hearing form. The Commission awards temporary total disability benefits for the above period and affirms the Arbitrator's granting of credit to Respondent in the amount of $6,235.24 for temporary total disability benefits paid.

Pursuant to Section 8.1b of the Act, the Commission weighs the following five factors accordingly (*820 ILCS 305/8.1b(b)* (West 2014); *Corn Belt Energy Corp. v. Illinois Workers' Compensation Commission*, 2016 IL App (3d) 150311WC, ¶ 52, 56 N.E.3d 1101):

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Section 8.1b(b)(i) – level of impairment

Dr. Deignan rated Petitioner's impairment at 4% of the left upper extremity. RX3. The Commission finds this factor weighs moderately in favor of a decreased permanence.

Section 8.1b(b)(ii) – occupation of the injured employee

The Arbitrator noted Petitioner was employed as an assembler at the time of his injury. Petitioner was subsequently reassigned to the position of fork truck operator, which is within his permanent restrictions. The Commission finds this factor weighs moderately in favor of an increased permanence.

Section 8.1b(b)(iii) – age of the employee at the time of the injury

Petitioner was 42 years old at the time of his injury. As such, he will live with the effects of his injury for a longer period of time. The Commission finds this factor weighs slightly in favor of an increased permanence.

Section 8.1b(b)(iv) – employee's future earning capacity

The Arbitrator noted Petitioner's future earning capacity is diminished as Petitioner currently earns $19.60 as a fork truck operator (actually $19.51 per hour; RX1). The Arbitrator noted Petitioner earned $22.00 as an assembler at the time of his injury (actually $19.98 at the time of injury and $20.85 per hour currently; RX1). The Commission finds this factor weighs slightly in favor of an increased permanence.

Section 8.1b(b)(v) – evidence of disability corroborated by treating medical records

Petitioner testified that in June 2014, he had been employed with Respondent for four years. T. 12. His job duties included assembling parts for use on a combine such as the air filter, the air cleaner door and a top cover. *Id.* He used tools of a battery gun with a half-inch socket (an impact gun with a battery), a wrench, and a drift pin. T. 13

Petitioner testified on June 25, 2014, he was unable to perform his job due to pain in his left arm and elbow. T. 14-15. He experienced pain around his left elbow. T. 15.

The medical records evidence Petitioner sought treatment at Respondent's Occupational Health facility on August 4, 2014 for complaints of left elbow pain. It was noted Petitioner was attending physical therapy and reported his left elbow felt better with increased range of motion and decreased pain. He was released to work with restrictions of no lifting or pulling over 10 pounds with his left arm. RX2.

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On August 27, 2014, Dr. Cobb evaluated Petitioner who voiced complaints of aching left elbow pain beginning in June 2014. Dr. Cobb assessed left lateral epicondylitis and recommended surgery which was performed on September 22, 2014. PX2; PX3.

On November 17, 2014, Petitioner reported to Dr. Cobb he was performing full duty at work. He was not attending physical therapy or taking prescribed medications. It was noted he was doing very well overall and was to follow-up in six weeks. On December 19, 2014, Petitioner reported he had no pain. He reported performing full duty at work and was tolerating this well. PX2.

Petitioner returned to work in a full duty capacity but not as an assembler. T. 19-20. In April or May 2016, Petitioner returned to work as an assembler. T. 21. Petitioner noticed he did not possess the strength in his hand or arm to perform the job. *Id.* He was having trouble squeezing clamps together, lifting anything heavy and with repetitive work. T. 22.

Petitioner testified he sought additional medical treatment with the Occupational Medicine Department at John Deere from about May to August 2016. T. 22. Occupational Health records, RX2, evidence Petitioner was seen May 19, 2016 and reported weakness of his left upper extremity. It was noted, "EE was assigned to a new job where he reports he is having difficulty." Petitioner denied re-injury. Petitioner was provided restrictions of no lifting, pushing or pulling over eight pounds with the left hand and rarely use his left hand; he was allowed to lift/push/pull up to eight pounds eight times an hour with his left hand. On May 23, 2016, Petitioner presented for follow-up for left forearm and hand weakness. It was noted that this dated back to June 2014. Petitioner reported he only had problems with the assembly job; he had no issues with the previous fork truck job, painting or maintenance positions. It was noted the left forearm and hand weakness had only surfaced since Petitioner returned to assembly line duties. Petitioner attended physical therapy without improvement. RX2.

On October 2016, Dr. Li evaluated Petitioner who complained of increased pain and weakness in the left arm upon working as an assembler. Dr. Li diagnosed recurrent lateral epicondylitis and recommended an MRI which was subsequently performed on October 12, 2016. The MRI evidenced mild tendinosis of the common extensor tendon without tear. PX6. A functional capacity evaluation was performed on May 9, 2017 finding Petitioner capable of performing at a medium level. PX9. On May 18, 2017, Dr. Li released Petitioner within the parameters of the FCE and recommended against Petitioner working with his left elbow extended due to a high risk of reinjure. PX8.

Petitioner testified his current position at Respondent is fork lift driver. T. 25. He currently notices a lack of strength in his left arm or hand. T. 26. Petitioner testified he is unable to perform the job duties of an assembler. *Id.* On a day-to-day basis, his left arm is weak and aches every once in a while. T. 26-27.

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Petitioner underwent a left lateral release procedure performed by Dr. Cobb on September 22, 2014 with a subsequent valid functional capacity evaluation which confirmed Petitioner's ongoing subjective complaints and need for restrictions. The Commission finds this factor weighs significantly in favor of an increased permanence.

Based on the above factors and the record in its entirety, the Commission finds Petitioner sustained permanent disability to the extent of 29.6% loss of use of the left arm pursuant to §8(e)10 of the Act.

The Commission affirms all else.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's July 5, 2019 decision is modified for the reasons stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $532.74 per week for a period of 11-3/7 weeks, representing from September 29, 2014 intermittently to May 26, 2017, that being the period of temporary total incapacity for work pursuant to §8(b) of the Act. The Commission notes Respondent paid $6,235.24 for temporary total disability benefits and is entitled to credit for same.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $479.47 per week for a period of 75 weeks, as provided in §8(e)10 of the Act, for the reason that the injuries sustained caused the permanent loss of use of the left arm to the extent of 29.6%.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $35,900.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JAN 21 2020
LEC/maw
o12/10/19
43

L. Elizabeth Coppoletti

L. Elizabeth Coppoletti

Stephen J. Mathis

Stephen J. Mathis

SOIACC00?2

DISSENT

I respectfully dissent and would affirm and adopt the Arbitrator's well-reasoned decision awarding Petitioner 15% permanent disability of the person as a whole as provided in §8(d)2 of the Act.

D. Douglas McCarthy

3A0030W10S

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

TAFLINGER, BRAD
Employee/Petitioner

Case# **16WC029155**

JOHN DEERE
Employer/Respondent

20IWCC0045

On 7/5/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.04% 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:

5354 STEPHEN P KELLY ATTY AT LAW
MATT BREWER
2710 N KNOXVILLE AVE
PEORIA, IL 61604

2119 CALIFF & HARPER PC
STEVEN NELSON
506 15TH ST SUITE 600
MOLINE, IL 61265

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
NATURE AND EXTENT ONLY

Brad Taflinger
Employee/Petitioner

v.

John Deere
Employer/Respondent

Case # **16** WC **29155**

Consolidated cases: _____

20 IWCC0045

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Paul Seal**, Arbitrator of the Commission, in the city of **Rock Island**, on **May 7, 2019**. By stipulation, the parties agree:

On the date of accident, **6/25/14**, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $**41,554.24**, and the average weekly wage was $**799.12**.

At the time of injury, Petitioner was **42** years of age, ***married*** with **1** dependent children.

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

Respondent shall be given a credit of $**6,235.24** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**6,235.24**.

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

The Respondent shall pay the Petitioner $479.47 for a further period of 75 weeks, because the injuries sustained resulted in permanent partial disability to the extent of **15% loss of use of the Man As A Whole under section 8(d) (2) of the Act.**

FACTS IN CASE

The Petitioner was employed by the Respondent on 6/25/14 as an assembler. The Petitioner's job duties included assembling air cleaners, as well as doors and top covers. Petitioner used numerous tools, including battery guns, wrenches, and drift pins.

The Petitioner testified that on 6/25/14, he began to notice a lot of pain in his left elbow. Petitioner testified that he did not have any strength at that time. The Petitioner provided notice to his employer. The Petitioner was then sent to the Respondent's internal medicine facility.

The Petitioner subsequently began treating with Dr. Tyson Cobb at Orthopedic Specialists, P.C., in Davenport, Iowa. The Petitioner was initially seen by Dr. Cobb on 8/27/14 and presented with left elbow pain. The Petitioner was diagnosed with lateral epicondylitis and surgery was recommended.

On 9/22/14, Dr. Cobb performed a left lateral release procedure. Petitioner was taken off work after surgery. Petitioner followed-up with Dr. Cobb on 9/24/14, 10/1/14, and 10/10/14. The Petitioner was kept off work at this time. The Petitioner continued to note improvements throughout these visits.

On 10/17/14, the Petitioner presented to Dr. Cobb's office and indicated that he felt that he could return to work full duty.

The Petitioner followed-up with Dr. Cobb's office on 11/7/14. The Petitioner's symptoms at that time included having a dull ache, as well as numbness and tingling in his ring and small fingers. The Petitioner was working full duty at this time.

Dr. Cobb placed the Petitioner at maximum medical improvement on 12/19/14. A later follow-up visit with the Petitioner and Dr. Cobb occurred on 3/20/15. The Petitioner was continued to work full duty at that time.

The Petitioner testified that when he returned to work full duty, following his surgery, he was working a lighter job. The Petitioner was no longer an assembler at this time. His position was labeled "light repairer". The Petitioner testified that he did not have to do any of the lifting or utilize the tools he had to as an assembler. From there, the Petitioner was assigned work as a paint/e-code operator. The Petitioner did that position for several months. Later, the Petitioner was again transferred to work as a fork truck driver.

In the spring of 2016, the Petitioner was again re-assigned. At this time, the Petitioner was assigned back as an assembler, which was the original position he had at the time of the accident. The Petitioner testified that his job duties as an assembler at this time were the same as they were in June of 2014. Once the Petitioner began working again as an assembler in the spring of 2016, he began to notice he had no strength in his left arm. The Petitioner's symptoms began to reoccur, and he sought care again at the Respondent's internal medicine facility.

The Petitioner underwent care at the internal medicine facility with the Respondent from April 2016 – May 2016.

An EMG of the left upper extremity performed on 7/27/16 was normal. An MRI was also later ordered and performed on 10/12/16 of the left elbow and revealed mild tendinosis.

The Petitioner also later sought care with Dr. Lawrence Li. Dr. Li saw the Petitioner on 4/3/17 and issued permanent restrictions. These restrictions included no elbow fluxion more than 30 degrees and a 20 lb. weight restriction. There was also discussion regarding ordering of an FCE.

On 5/9/17, the Petitioner did undergo an FCE. This was a valid study and revealed the need for permanent work restrictions as follows: 35 lbs. floor to waist occasionally, 17 lbs. floor to waist frequently, 40 lbs. carrying occasionally, and 20 lbs. carrying frequently.

The Petitioner followed-up with Dr. Li on 5/18/17. Dr. Li released the Petitioner with permanent restrictions per the FCE and instructed the Petitioner to avoid extending his elbow.

Following the Petitioner's release by Dr. Li with permanent restrictions, he was assigned work again as a fork truck operator. The Petitioner testified that he is unable to perform the job duties of an assembler. Petitioner testified that he continues to have symptoms regarding the left elbow, which include weakness, and at times pain.

The Petitioner testified that due to the fact that he is unable to work as an assembler and is now assigned as a fork truck operator, he is making less money. Petitioner testified that he works approximately the same number of hours as a fork truck operator as he did as an assembler, which is 40 hours/week. As an assembler, the Petitioner testified that he was making approximately $22.00/hour. As a fork truck operator, the Petitioner is now making $19.60/hour. As such, the Petitioner does have decreased earnings.

NATURE AND EXTENT OF THE INJURY

With regard to the issue of nature and extent, the Arbitrator notes that 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 makes the following findings listed below.

With regard to Sec. 8.1(b) (i); Petitioner was examined and evaluated by Dr. Christine Deignan who rated his impairment at 4% of the left upper extremity.

With regard to Sec. 8.1(b) (ii); the occupation of the Petitioner, the Arbitrator notes that the Petitioner was employed by the Respondent as an assembler at the time of the injury and has since been reassigned as a fork truck operator. The job as a fork truck operator is not as strenuous as that of an assembler. However, the Petitioner cannot return to work as an assembler with the permanent restrictions issued by Dr. Li.

With regard to Sec. 8.1(b) (iii); the Arbitrator notes that the Petitioner was 42 years old at the time of the injury and has over 20 years left of his work life. The Arbitrator believes it is significant that the Petitioner has an additional 20+ years of work life wherein he will have to deal with his ongoing symptomatology.

With regard to Sec. 8.1(b) (iv); the Petitioner did suffer slight earnings diminution as a result of the work injury. The Petitioner was earning $22.00 as an assembler at the time of the injury and now earns $19.60 as a fork truck operator. The Petitioners future earning capacity is diminished.

With regard to Sec 8.1(b) (v); the Arbitrator notes that the Petitioner underwent a surgery for the diagnoses provided in this case. The Arbitrator notes that the Petitioner underwent a left lateral release procedure performed by Dr. Cobb on 9/22/14. The valid FCE confirms the Petitioners ongoing subjective complaints.

Based on Petitioner's change of job and the fact that he is earning slightly less money as a fork truck operator, the Arbitrator awards Petitioner 15% loss of use of the man as a whole under section 8(d) (2) of the Act.

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

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

Signature of Arbitrator

July 1, 2019
Date

JUL 5 - 2019

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

JOSEPH KARCZEWSKI,

Petitioner,

vs. NO: 16 WC 34864

OTIS ELEVATOR,

Respondent.

20IWCC0046

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

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 the testimony, exhibits, pleadings, and arguments submitted by the parties. The Commission is not bound by the Arbitrator's findings. Our Supreme Court has long held that it is the Commission's province "to assess the credibility of witnesses, resolve conflicts in the evidence, assign weight to be accorded the evidence, and draw reasonable inferences from the evidence." *City of Springfield v. Indus. Comm'n*, 291 Ill. App. 3d 734, 740 (1997) (citing *Kirkwood v. Indus. Comm'n*, 84 Ill. 2d 14, 20 (1981)). Interpretation of medical testimony is particularly within the province of the Commission. *A. O. Smith Corp. v. Indus. Comm'n,* 51 Ill. 2d 533, 536-37 (1972).

The Arbitrator considered the five factors under Section 8.1b of the Act and determined that Petitioner sustained fifteen percent (15%) loss of use of the person as a whole. The Arbitrator

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gave no weight to the first factor [level of impairment] and no weight to the second factor [occupation of the injured employee]; the Arbitrator further assigned greater weight to the third factor [age of the employee at the time of injury], lesser weight to the fourth factor [employee's future earning capacity], and greater weight to the fifth factor [evidence of disability].

Having reviewed and reweighed the evidence, the Commission finds the PPD award to be excessive. The Commission instead finds that Petitioner is entitled to twelve-and-a-half percent (12.5%) loss of use of the person as a whole under Section 8(d)2 of the Act.

The Commission agrees with the Arbitrator's Decision relative to the first and fifth factors under Section 8.1b of the Act, but modifies the Arbitrator's Decision as to the second factor. Following his work-related injury on August 26, 2016, Petitioner was released without restriction. He returned to his regular duties as an elevator repair mechanic with Respondent. However, Petitioner testified that he noticed that his strength in his right shoulder and arm had diminished. He also had difficulty using lever hoists and removing and replacing escalator stairs. Petitioner stated that he was able to lift 40 to 50 pounds overhead with two hands compared to 70 to 100 pounds before the August 2016 injury. Thus, the Commission assigns the second factor moderate weight. The Commission further modifies the Arbitrator's Decision and gives no weight to the third and fourth factors. There is no evidence that Petitioner's age had any effect on the level of permanent partial disability, and there is also no evidence that Petitioner's future earning capacity was affected by his work-related injury.

Based on the totality of all five factors, the Commission modifies and reduces the Arbitrator's PPD award to twelve-and-a-half percent (12.5%) loss of use of the person as a whole under Section 8(d)2 of the Act. The Commission finds that this award corresponds with the evidence in the record and the injuries sustained by Petitioner as a result of the August 26, 2016 work accident.

With respect to the medical bills awarded, the Arbitrator considered each medical bill offered and admitted into evidence by Petitioner. The Commission modifies the Arbitrator's Decision to emphasize that the Act allows employers to take advantage of rates it negotiates with the medical providers. Section 8(a) of the Act states that the employer is required to pay (1) the negotiated rate, if applicable, or (2) the lesser of the health care provider's actual charges, or (3) according to a fee schedule. *820 ILCS 305/8(a)* and *8.2. See also Perez v. Ill. Workers' Comp. Comm'n*, 2018 IL App (2d) 170086WC. The Illinois Administrative Code provides, in pertinent part:

> Under the fee schedule, the employer pays the lesser of the rate set forth in the schedule or the provider's actual charge. If an employer *or* insurance carrier contracts with a provider for the purpose of providing services under the Act, the rate negotiated in the contract shall prevail. (Emphasis added.) 50 Ill. Adm. Code 7110.90(d), amended at 36 Ill. Reg. 17108 (eff. Nov. 20, 2012). *Perez v. Ill. Workers' Comp. Comm'n*, 2018 IL App (2d) 170086WC, ¶ 21.

As such, the Commission finds as follows:

1) As to PX5-6: The Commission affirms the Arbitrator's findings;
2) As to PX7: The Commission modifies the Arbitrator's Decision and finds that the negotiated rate is applicable, and Respondent shall therefore pay the negotiated rate of $39.58 as indicated on PX7;
3) There is no PX8;
4) As to PX9 [Mercyhealth Statement]: The Commission modifies the Arbitrator's Decision for this medical bill as follows:

a) 10/24/2017 MRI arthrogram of the right shoulder: Respondent does not dispute the group carrier's adjustment for this date of service as noted in PX7, but does dispute this charge altogether in PX9 indicating that no MRI report exists in the record. The Commission finds that although no report exists, Dr. Izquierdo specifically referenced the MRI by date and reported its findings; Dr. Izquierdo agreed with the radiologist's findings upon his independent review. *See* PX4. The Commission finds this bill to be reasonable, necessary, and causally related to the August 26, 2016 work injury.

By its Brief, Respondent provides a detailed breakdown for each service rendered on 10/24/2017; the Commission finds that Respondent shall pay the negotiated rate, if applicable, or the lesser of the fee schedule rate or the provider's actual charge.

b) 8/31/2016: Based on PX9 and RX6 [AIG Explanation of Benefits], the Commission finds that nothing further is owed for this date of service as the workers' compensation carrier paid this charge and the provider's statement reflects a zero balance.

c) 9/8/2016: The Commission finds that Respondent shall pay the negotiated rate, if applicable, or the lesser of the fee schedule rate or the provider's actual charge.

d) 10/6/2016: Based on PX9 and RX6, the Commission finds that nothing further is owed for this date of service as the workers' compensation carrier paid this charge and the provider's statement reflects a zero balance.

e) 10/19/16: Unrelated charge; the Commission finds that Respondent is not liable for this charge.

f) 10/27/2016-11/21/2016: The Commission finds that Respondent shall pay the negotiated rate, if applicable, or the lesser of the fee schedule rate or the provider's actual charge.

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g) 11/22/2016: Based on PX9 and RX6, the Commission finds that nothing further is owed for this date of service as the workers' compensation carrier paid these charges and the provider's statement reflects a zero balance.

h) 12/6/2016: The Commission finds that Respondent shall pay the negotiated rate, if applicable, or the lesser of the fee schedule rate or the provider's actual charge.

i) 1/5/2017 and 2/7/2017: No charge for post-op visits; the Commission finds that nothing further is owed for these dates of service.

j) 3/7/2017-10/3/2017: Based on PX9 and RX6, the Commission finds that nothing further is owed for these dates of service as the workers' compensation carrier paid these charges and the provider's statement reflects a zero balance.

k) 11/1/2017-6/14/2018: The Commission finds these charges to be reasonable, necessary, and causally related to the August 26, 2016 work injury. Thus, the Commission finds that Respondent shall pay the negotiated rate, if applicable, or the lesser of the fee schedule rate or the provider's actual charge.

5) As to PX10: The Commission finds that Respondent shall pay the negotiated rate, if applicable, or the lesser of the fee schedule rate or the provider's actual charge.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator, filed April 8, 2019, is hereby modified as stated above, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay all reasonable and necessary medical services pursuant to Sections 8(a) of the Act and 8.2 of the Act, and as provided above.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is entitled to 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 pursuant to Section 8(j) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner temporary total disability benefits of $1,398.23 per week for 46 weeks, commencing November 21, 2016 through October 8, 2017, that being the period of temporary total incapacity for work under Section 8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall be given a credit of $59,324.91 for temporary total disability benefits that have been paid.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $775.18 per week for a period of 62.5 weeks, as provided in Section 8(d)2 of the Act,

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20IWCC0046

for the reason that the injuries sustained caused twelve-and-a-half percent (12.5%) loss of use of the person as a whole.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $53,500.00. 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 the Circuit Court.

DATED: JAN 22 2020

DDM/pm
O: 1-15-20
052

D. Douglas McCarthy

Stephen J. Mathis

L. Elizabeth Coppoletti

SOIHC0078

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

KARCZEWSKI, JOSEPH
Employee/Petitioner

Case# **16WC034864**

OTIS ELEVATOR
Employer/Respondent

20IWCC0046

On 4/8/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.38% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0222 GOLDBERG WEISMAN & CAIRO LTD
KITRA K KILLEN
ONE E WACKER DR SUITE 3800
CHICAGO, IL 60601

0481 MACIOROWSKI SACKMANN & ULRICH
JEREMY SACKMANN
105 W ADAMS ST SUITE 2200
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

Joseph Karczewski
Employee/Petitioner

v.

Otis Elevator
Employer/Respondent

Case # **16** WC **34864**

Consolidated cases: **n/a**

20IWCC0046

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Maria Bocanegra**, Arbitrator of the Commission, in the city of **Chicago**, on **1/17/19 and 2/19/19**. 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. ☒ 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 _____

20IWCC0046

FINDINGS

On **August 26, 2016**, Respondent ***was*** operating under and subject 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 **$109,061.60**; the average weekly wage was **$2,097.34**.

On the date of accident, Petitioner was **50** years of age, ***married*** with **2** dependent children.

Petitioner ***has not*** received all reasonable and necessary medical services.

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

Respondent shall be given a credit of **$59,324.91** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$59,324.91**.

Respondent is entitled to a credit of **$17,823.80** under Section 8(j) of the Act.

ORDER

As to Px5-6, the balance is zero and no further balance is owed by either party. Respondent shall be entitled to credits for group and workers' compensation insurance carrier payments made.

As to Px7, Respondent shall pay the gross outstanding balance of $202.97, subject to the provisions of Section 8(a) and 8.2. Respondent shall be given a credit for medical benefits that have been paid as to Px7 and Respondent shall hold Petitioner harmless form any claims by any provider of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

As to Px9, Respondent shall pay for the gross medical charges for dates of service 10/24/17 through 6/14/18, subject to the provisions of Section 8(a) and 8.2. The Arbitrator has considered Rx5 and finds that Respondent shall be given a credit for medical benefits that have been paid as to Px9 and Respondent shall hold Petitioner harmless form any claims by any provider of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

As to Px10, Respondent shall pay for the gross medical charges of $20,951.25, subject to the provisions of Section 8(a) and 8.2. The Arbitrator has considered Rx5 and finds that Respondent shall be given a credit for medical benefits that have been paid as to Px10 and Respondent shall hold Petitioner harmless form any claims by any provider of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall be given a credit of $17,823.80 for medical benefits that have been paid, and Respondent shall hold Petitioner harmless form any claims by any provided of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

20 IWCC0046

Respondent shall pay Petitioner temporary total disability benefits of $1,398.23/week for 46 weeks, commencing 11/21/16 through 10/08/17, as provided in Section 8(b) of the Act. Respondent shall be given a credit of $59,324.91 for temporary total disability benefits that have been paid.

Respondent shall pay Petitioner permanent partial disability benefits of $775.18/week for 75 weeks, because the injuries sustained caused the 15% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

Signature of Arbitrator

4-5-2019
Date

ICArbDec p. 2

APR 8 - 2019

FINDING OF FACTS

Petitioner testified that he was employed by Respondent on August 26, 2016 and had been employed by Respondent for approximately 15 years at the time. (1/17/19, TR 13). On August 26, 2016, Petitioner worked as an elevator repair mechanic for Respondent and was a long-time member of the International Union of Elevator Constructors Local 2. (01/17/19, TR 13-14). Petitioner described his job as a heavy job with occasional lifting up to 100 pounds. (02/19/19, TR 8). The job requires crawling and carrying items, as well as use of heavy tools. (02/19/19, TR 8)

Petitioner testified that on 08/26/16 at about 11:00 a.m. he had an accident at work doing escalator repair while installing escalator stairs. (01/17/19, TR 14 & 16). Petitioner explained that he was lifting the escalator, twisting it to pop it into the track when he felt a sharp pain in his right shoulder and dropped the step. (01/17/19, TR 14-15). Petitioner estimated that the escalator stair that he had lifted weighed between 40 to 50 pounds (01/17/19, TR 15). Petitioner testified that after the accident happened he noticed severe pain in his right shoulder and he did seek medical attention. (01/17/19, TR 17).

On Monday the 29th of August 2016, Petitioner went to the company medical clinic with his supervisor, Ken McCann. (01/17/19, TR 17-18). At the company clinic, he was administered a protocol drug test and he was examined and x-rays were taken. (01/17/19, TR 17-18). Petitioner sought further medical care with Dr. Tarandy on 08/31/16. (01/17/19, TR 19). At the first visit, Dr. Tarandy examined Petitioner and ordered an MRI arthrogram of the right shoulder, and also provided work restrictions. (01/17/19, TR 19-20). Petitioner testified that he underwent the MRI arthrogram on 09/07/16 and saw Dr. Tarandy in a follow-up appointment on 09/08/16 at which time the doctor administered an injection into the right shoulder. Dr. Tarandy also ordered a course of physical therapy which Petitioner began on 09/26/16 at AthletiCo. Petitioner continued the physical therapy sessions through 10/04/16 and the saw Dr. Tarandy on 10/06/16. At the time of the 10/06/16 visit, Petitioner was complaining about his right hand and Dr. Tarandy ordered an EMG for the right hand. Petitioner clarified for the record that he was not alleging a right-hand injury nor making any claim related to the right hand. Petitioner returned to Dr. Tarandy on 10/27/16 at which time the doctor recommended arthroscopic surgery for the right shoulder. Between the accident date and 10/27/16, Petitioner had been working light duty for Respondent.

On 11/21/16 Petitioner underwent surgery for the right shoulder as well as surgery for the unrelated right carpal tunnel. Petitioner was off work following his 11/21/16 surgery pursuant to doctor's orders. Petitioner had post-operative visits with Dr. Tarandy on 11/22/16 and 12/06/16. Petitioner underwent additional physical therapy from 12/13/16 to 05/08/17. In therapy, Petitioner reported being sorer, pain with increased weights, pain with reaching up. Therapists noted both improvement and worsening of symptoms during this time. Rx7-8.

Petitioner had follow up visits with Dr. Tarandy on 01/05/17, 02/07/17, 03/07/17 and 04/05/17. Petitioner testified that he had been doing well but during his last month of therapy, from early April to early May of 2017, he was tested on his maximum abilities regarding lifting weight with his right-hand overhead. Each time 5 pounds would be added to the weight for him to lift. (01/17/19, TR 24-25). When the weight was increased to about 25 or 30 pounds, he felt a sharp pain in his right shoulder and the therapist had to help him take the weight out of his hand. (01/17/19, TR 25). Petitioner had a visit with Dr. Tarandy on 05/09/17 at which time he explained to the doctor the sharp pain he was feeling in his right shoulder. (01/17/19, TR 26).

Petitioner admitted on cross-examination that he asked Dr. Tarandy, during the 04/06/17 visit, if he could ride his motorcycle and the doctor did clear him to do so. (02/19/19, TR 12-13).

At the 05/09/17 visit, Dr. Tarandy ordered a repeat MRI arthrogram. (01/17/19, TR 26). Petitioner testified that he tried to schedule the MRI arthrogram but due to difficulties he put the test trough his group insurance company, Blue Cross/Blue Shield. (01/17/19, TR 26-30).

Petitioner saw Dr. Tarandy on 10/03/17 and was given a release to return to work with restrictions of no lifting over 5 pounds and no above shoulder level work. (01/17/19, TR 30-31). Petitioner explained that due to financial hardship, he requested that Dr. Tarandy release him to light duty at the October 2017 visit. (02/19/19, TR 36-37). Petitioner returned to restricted duty work on 10/09/17 and returned to Dr. Tarandy on 11/01/17. (01/17/19, TR 30-31) At this visit, Dr. Tarandy referred Petitioner to a surgeon named Dr. Izquierdo for evaluation. (01/17/19, TR 32-33). Petitioner saw Dr. Tarandy again on 01/30/18 after which he returned him to a full duty work. (01/17/19, TR 34-35).

Petitioner had subsequent visits with Dr. Tarandy on 02/27/18, 03/27/18, 05/01/18 and finally on 06/14/18. (01/17/19, TR 35). At the last visit on 06/14/18, Dr. Tarandy recommended that Petitioner undergo the right shoulder surgery that Dr. Izquierdo recommended. (01/17/19, TR 36).

Petitioner testified that from late January 2018 until the day of hearing, he has continued to work full duty for Respondent. He stated he had no right shoulder accident or injuries prior to the 08/26/16 work accident, nor had he had any medical care of treatment for his right shoulder before 08/26/16, and he had not had any new accident on the job regarding his right shoulder. (01/17/19, TR 36-37).

Regarding his current symptoms, Petitioner testified that he has had a loss of strength which he notices doing work activities with heavy lever hoists. Prior to his work accident, he could do 100 cranks on the hoist before taking a break. Nowadays, he gets sore after just 25 cranks. (01/17/19, TR37). Similarly, he notices that he used to remove and replace elevator stairs all day long and up to 75 a day. Nowadays, after 10 to 15 stairs he requires a break. (01/17/19, TR 37-38). Petitioner testified that because he is right hand dominate, almost all his activities on the job are affected by his shoulder condition. (01/17/19, TR 38). Regarding overhead lifting, Petitioner explained that before his accident he was able to lift 75 to 100 pounds overhead, whereas he can only lift 40-50 pounds overhead post-accident. (01/17/19, TR 38). Petitioner explained that since returning to full duty work in January 2018, he now has a helper when his shoulder is hurting, and he no longer lifts 100 pounds. (02/19/19, TR 24).

Petitioner testifies that as of the hearing date he had not had the second shoulder surgery which was recommended by Dr. Tarandy and Dr. Izquierdo . (001/17/19, TR 39).

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

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. Having considered all evidence, the Arbitrator concludes that Petitioner has proven by a preponderance of the evidence that he sustained accidental injuries to his right shoulder as a result of his work accident. Petitioner's credible and unrebutted testimony was that he injured his right shoulder while replacing the escalator stair on 08/26/16. He testified that he lifted the step and twisted it to pop it into the track when he felt a sharp pain in his shoulder and dropped the step. (01/17/19, TR 14-15). Petitioner reported the accident to his supervisor who took Petitioner to the company clinic on 08/26/16. Petitioner's testimony, which is corroborated by his treatment records, establishes that Petitioner was in the course of his employment at the time that he was

injured and was performing an employment related task; namely, that of repairing and installing an elevator stair. For these reasons, the Arbitrator finds in favor of Petitioner on the issue of accident.

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

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. Having considered all evidence, the Arbitrator concludes that Petitioner has proven by a preponderance of the evidence that his current condition of ill-being as to the right shoulder is causally related to his work accident. The Arbitrator considered the testimony of Dr. Tarandy, the treating surgeon, and found his testimony to be clear and credible. Dr. Tarandy opined that the condition of Petitioner's right shoulder is causally related to the work accident on 08/26/16. (PX 3, p.26-27). The doctor based his opinion on the "mechanism of injury, his absence of pain and shoulder problems prior to the date of injury, the MRI findings, the physical exam, the arthroscopic surgical findings support his injury-causing findings that we had in the surgery. (PX 3, pg. 26-27). Regarding the mechanism of injury, Dr. Tarandy testified that upon the first visit, Petitioner provided a specific history of the accident at work and described to the doctor that he was in an awkward position when placing a stair on an escalator and felt something tear or pop in his shoulder, injuring his arm.(PX 3, pg. 29-30). Dr. Tarandy further testified that the finding observed in the arthroscopic surgery performed 11/21/16 are even more reliable than those from the pre-surgery MRI arthrogram. (PX 3, pg. 32). The doctor pointed out that what the radiologist perceived as a sub-labral foramen, was actually noted during surgery to be a partial labral tear. (PX 3, pg. 32).

Dr. Tarandy testified that the medical care and treatment provided to Petitioner was causally related to his work accident and was standard and customary. (PX 3, pg. 31-32). The doctor also opined that the repeat MRI arthrogram he ordered for Petitioner was causally related to the work accident. (PX 3, pg. 33).

Petitioner eventually underwent right shoulder surgery with Dr. Tarandy. Despite some progression, in April 2017, AthletiCo noted Petitioner had increased pain following an increase in weights during therapy sessions. In May 2017, Dr. Tarandy noted Petitioner was not progressing. Eventually, an MRI arthrogram was performed and revealed "high grade bursal sided supraspinatus tear." Petitioner sought a second opinion with Dr. Izquierdo, who recommended "arthroscopic right shoulder debridement rotator cuff repair, biceps tendonitis and revision distal clavicle excision." (PX 4, pg. 2). Both Drs. Tarandy and Izquierdo agreed on the necessity of a revision right shoulder surgery. Dr. Tarandy's January 2018 visit note and his testimony both indicate that he felt the need for both surgeries was the result of this work accident. The Arbitrator agrees. The Arbitrator finds that Petitioner's accident resulted in right shoulder pathology for which surgery was ultimately required. During the course of his post-operative rehabilitation, Petitioner's reinjured his right shoulder and thus, but-for the work accident, Petitioner would not have reinjured his right shoulder during therapy. Thus, Petitioner's resultant pathology and revision surgery is also causally related as a sequela of the original work injury.

The Arbitrator has considered the opinions of Dr. Atluri, however the Arbitrator adopts the treating surgeon records and opinion as he in a better position to opine on the issue of causation. For these reasons the Arbitrator finds that Petitioner's current condition of ill-being, as well as the need for revision surgery, are causally related to the work accident of 08/26/16.

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 incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. Having considered all evidence, the Arbitrator concludes that Petitioner has proven by a preponderance

of the evidence that the medical services provided as it relates to the right shoulder were reasonable and necessary and that Respondent has not yet paid all appropriate charges for same. The Arbitrator finds the testimony and opinions of Dr. Tarandy to be credible and reliable. Dr. Tarandy, testified the medical care and treatment of Petitioner was both reasonable and necessary as well as standard and customary. Respondent offered no evidence to dispute the Petitioner's right shoulder medical care and treatment was not both reasonable and necessary, therefore, the Arbitrator finds in favor of Petitioner on this issue.

The Arbitrator notes that no charges for services rendered for right wrist or carpal tunnel treatment are awarded as Petitioner is not claiming this condition is work related.

Petitioner seeks payment for outstanding balances on bills as noted in Px5-7 and Px9-10. Ax1. Regarding Px5, the balance is zero and confirms payment by AIG and BCBS. See, Rx5. The Arbitrator finds no further payment is owed, that Respondent is entitled to both 8(j) credit under BCBS and credit for AIG payments made.

Regarding Px6, the balance is zero and confirms payment by AIG and BCBS. See, Rx5. The Arbitrator finds no further payment is owed, that Respondent is entitled to both 8(j) credit under BCBS and credit for AIG payments made.

Regarding Px7, the document from Equian concerns both reimbursement to Petitioner's health plan and an outstanding balance of $39.58. It is unclear from the evidence whether this balance is balance billing, a negotiated rate or simply a balance. The Arbitrator finds the appropriate award considers the gross amount with any applicable rate(s) and credits. Thus, Respondent shall pay the gross outstanding balance of $202.97, subject to the provisions of Section 8(a) and 8.2. Respondent shall be given a credit for medical benefits that have been paid as to Px7 and Respondent shall hold Petitioner harmless form any claims by any provider of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Regarding Px9, the Arbitrator finds the charges for date of service of 11/21/16 are for unrelated carpal tunnel and those charges are denied as unrelated. The Arbitrator denies the 6/9/17 as unrelated where this visit concerned right sided low back pain. Px 2:304. The remaining dates of service directly relate to Petitioner's treatment for his work-related right shoulder injury. From 10/24/17 through 6/14/18, the record shows payments by both BCBS and "insurance payment" but no carrier is specified. Further, there are write-offs, adjustments and discounts, which are also not explained. The Arbitrator finds the appropriate award considers the gross amount with any applicable rate(s) and credits. Therefore, Respondent shall pay for the gross medical charges for dates of service 10/24/17 through 6/14/18, subject to the provisions of Section 8(a) and 8.2. The Arbitrator has considered Rx5 and finds that Respondent shall be given a credit for medical benefits that have been paid as to Px9 and Respondent shall hold Petitioner harmless form any claims by any provider of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Regarding Px10, the Arbitrator finds the charges related to the work injury. The gross balance was $20,951.25 and workers compensation insurance payments were made totaling $9,309.12. The Arbitrator is unable to verify whether the coded charges are to fee schedule and/or whether Respondent's payments are to fee schedule. The Arbitrator finds the appropriate award considers the gross amount with any applicable rate(s) and credits. Therefore, Respondent shall pay for the gross medical charges of $20,951.25, subject to the provisions of Section 8(a) and 8.2. The Arbitrator has considered Rx5 and finds that Respondent shall be given a credit for medical benefits that have been paid as to Px10 and Respondent shall hold Petitioner harmless form any claims by any provider of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

ISSUE (K) What temporary benefits are in dispute?

The Arbitrator notes that Petitioner returned to light duty on 10/08/17 and then full duty of after the 01/30/18 visit with Dr. Tarandy. Petitioner testified that even when working light duty, he was paid his regular wages. The Arbitrator awards TTD benefits from 11/21/16-10/08/17, which is 46 weeks. Respondent shall be entitled to a credit of $59,324.91 for TTD benefits paid.

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

The Arbitrator has considered Petitioner's credible testimony of the lingering effects of his right shoulder injury and how it impacts his work as an elevator repair mechanic Petitioner testified to reduce lifting and overhead abilities and now requires a helper at times at work for Respondent. The Arbitrator has further noted and considered Dr. Tarandy's records and specifically notes that the doctor continued to recommend the revision surgery from December 2017 until the final visit on 06/14/18. (PX 2). Consistent with the Act, the Arbitrator considers the following factors:

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

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as an elevator repair mechanic 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. Arbitrator therefore gives *no* weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 50 years old at the time of the accident. Because of Petitioner, the Arbitrator therefore gives *greater* weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes no evidence of a reduced earning capacity. The Arbitrator therefore gives *lesser* weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability is corroborated by the treating medical records, The Arbitrator therefore gives *greater* weight to this factor.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 15% loss of use of person as a whole § 8(d) 2 of the Act.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

PAUL ALVAREZ,

Petitioner,

vs. NO: 12 WC 31615

CITY OF CHICAGO,
DEPARTMENT OF WATER MANAGEMENT,

20IWCC0047

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 benefit rates and permanent partial disability (PPD), 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 PPD award to 15% loss of use of the left arm. The Commission adopts the Arbitrator's analysis of Section 8.1(b) but disagrees with the weight assigned to subsection (v). The Commission gives moderate weight to subsection (v) noting that Petitioner's elbow had recovered well. Dr. Visotsky noted that Petitioner's upper extremity had the capability of performing at a higher level than indicated in the FCE. Dr. Visotsky further noted that the limiting factors noted in the FCE were due to his back condition, and not his left elbow. Because of this, the Commission finds that Petitioner sustained 15% loss of use of the left arm.

The Commission further modifies the PPD rate to the statutory maximum rate of $712.55.

A separate decision has been issued for case 13 WC 16859.

YAOOOOWIOS

20IWCC0047

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $712.55 per week for a period of 37.95 weeks, as provided in §8(e)10 of the Act, for the reason that the injuries sustained caused 15% loss of use of the left arm.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $2,860.00 for medical expenses under §8(a) of the Act.

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

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

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

DATED: JAN 2 2 2020

D. Douglas McCarthy
Douglas McCarthy

Stephen J. Mathis
Stephen Mathis

L. Elizabeth Coppoletti
L. Elizabeth Coppoletti

DDM/tdm
O: 12/18/19
052

SOINCC0043

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ALVAREZ, PAUL
Employee/Petitioner

Case# **12WC031615**

CITY OF CHICAGO DEPT OF WATER MANAGEMENT
Employer/Respondent

20IWCC0047

On 3/20/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.45% 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:

2988 CUDA LAW OFFICES LTD
ANTHONY GATTUSO
6525 W NORTH AVE SUITE 204
OAK PARK, IL 60302

0010 CITY OF CHICAGO DEPT OF LAW
LUCY HUANG
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

Paul Alvarez
Employee/Petitioner

v.

City of Chicago, Dept. of Water Management
Employer/Respondent

Case # **12** WC **31615**

Consolidated cases: **N/A**

20 IWCC0047

An *Application for Adjustment 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 T. Cronin**, Arbitrator of the Commission, in the city of **Chicago**, on **1/16/2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ 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

20IWCC0047

On **7/12/12**, 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 $**70,408.00**; the average weekly wage was $**1,354.00**.

On the date of accident, Petitioner was **41** years of age, ***married*** with **2** dependent children.

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

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

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $**755.12**/week for **63.25** weeks, because the injuries sustained caused a **25%** loss of use of the left arm, pursuant to Section 8(e)10 of the Act.

Pursuant to stipulation (Tr. 4-5), Respondent shall pay, directly to the providers, the outstanding medical bills that total $**2,860.00 ($1,500.00 to Park Ridge Anesthesia and $1,360.00 to NovaCare)**, pursuant to Section 8(a) and subject to Section 8.2 of the Act. Respondent is entitled to a credit if all or part of these outstanding bills has already been paid to these two providers.

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

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

3/18/2019
Date

MAR 20 2019

Paul Alvarez v. City of Chicago, Dept. of Water Mgmt.
12 WC 31615

FINDINGS OF FACT

The Parties stipulated that on July 12, 2012, Paul Alvarez (hereinafter referred to as "Petitioner") sustained an accidental injury to his left arm that arose out of and in the course of his employment by the City of Chicago (hereinafter referred to as "Respondent"). His job title was motor truck driver for the Department of Water Management.

Petitioner identified Arbitrator's 19(b) decision as Px. 10 of Petitioner's exhibits for the consolidated case of 13 WC 16859.

On March 15, 2013, Arbitrator Barbara Flores presided over the 19(b) hearing. She rendered a 19(b) decision on March 26, 2013 in which she found that Petitioner's current condition of ill-being of his left arm was causally related to the July 12, 2012 accident and that Petitioner was entitled to prospective medical care for his left arm. Arbitrator Flores ordered Respondent to authorize and pay for Petitioner's left arm surgery, which Jeffrey Visotsky, M.D., had prescribed. (Px. 10 of Petitioner's exhibits for consolidated case # 13 WC 16859)

On May 30, 2013, Dr. Visotsky performed the following surgery on Petitioner's left arm:

1. Left lateral epicondylar repair and debridement.
2. Left excision of pisiform bone.
3. Left flexor carpi ulnaris tenosynovectomy
4. Left extensor carpi ulnaris tenosynovectomy.
5. Left injection of flexor carpi radialis with Celestone. (Px. 2 of exhibits for case #12 WC 31615)

On June 5, 2013, Petitioner presented to Dr. Visotsky's office in follow-up. He offered the following impression of Petitioner's condition: left lateral epicondylitis, left extensor carpi ulnaris synovitis, and left pisotriquetral arthritis. This surgeon noted that Petitioner was feeling

fairly well following the surgery. He placed Petitioner's left arm in a well-padded long arm cast for protective purposes. (Px. 2 of exhibits for case # 12 WC 31615)

Dr. Visotsky later prescribed occupational therapy for Petitioner's left arm. (Px. 2 of exhibits for case # 12 WC 31615)

On June 27, 2013, Petitioner presented for the Occupational Therapy Initial Evaluation.

On July 30, 2013, Petitioner saw Dr. Visotsky and informed him that the therapy has increased the functionality of his arm and wrist since the surgery. However, Petitioner still had weakness and limited ranges of motion of the left arm. Dr. Visotsky noted that the back injury Petitioner sustained on April 8, 2013 was hampering possible progress in occupational therapy, so he encouraged Petitioner to perform most of the therapy while lying down. (Px. 2 of exhibits for case # 12 WC 31615)

At the next follow-up visit on September 24, 2013, Dr. Visotsky noted that Petitioner had regained flexion and extension in his left elbow. (Px. 2 of exhibits for case # 12 WC 31615)

Petitioner returned to Dr. Visotsky on October 22, 2013. He released Petitioner to return to light-duty work and ordered a functional capacity evaluation ("FCE"). (Px. 2 of exhibits for case # 12 WC 31615)

On February 26, 2016, Petitioner presented at Dr. Visotsky's office for a check-up on the progress of his left arm. (PX 2). Petitioner reported that he was feeling persistent pain in the left wrist and pain over the ECRB origin. Based Petitioner's pain complaints, Dr. Visotsky recommended initiating a conservative treatment program and after that, an FCE. (Px. 2 of exhibits for case # 12 WC 31615)

Petitioner underwent an FCE at NovaCare on March 22, 2016. (Px. 5). On April 19, 2016, Dr. Visotsky reviewed the results of the FCE with Petitioner and opined Petitioner would not be able to return to his job as a motor truck driver. The FCE evaluator found that Petitioner can only work at a light-duty physical demand level. (Px. 5) Dr. Visotsky opined Petitioner's left hand and elbow have recovered well and that Petitioner's limiting factors are not his elbow as he has reached maximum medical potential with respect to his elbow and has had a good

recovery. His limitations are as outlined in the FCE. He is more limited in his lifting due to his back condition. Dr. Visotsky further opined that his upper extremity has the capability of performing at a higher level than indicated in the FCE report. The FCE placed him at light duty with the caveat that this is probably due to his back. At that point in time, his upper extremity taken in isolation would allow him to perform a higher level of lifting if not for his back. He noted that Petitioner is at MMI with respect to his back at that time. (Px. 2 of exhibits for case # 12 WC 31615)

At the permanency hearing before Arbitrator Cronin on January 16, 2019, Petitioner testified that in 2008, he sustained an injury to his left arm. Respondent offered into evidence Rx. 8 of Respondent's exhibits for consolidated case # 13 WC 16859. Respondent stated that the purpose for offering this exhibit is to show that these are the cases that have been pending in front of the Commission. (Tr. 122) Petitioner testified that pursuant to the results of the March 22, 2016 FCE for his left arm injury, he understands that he has light-duty restrictions.

CONCLUSIONS OF LAW

In support of his decision with regard to issue (J) "Were the medical services that were provided to Petitioner reasonable and necessary? Has the Respondent paid all appropriate charges for all reasonable and necessary medical expenses?", the Arbitrator finds as follows:

Petitioner claims that there remains an outstanding balance to Park Ridge Anesthesia and to Nova Care in the amounts of $1,500.00 and $1,360.00, respectively. Respondent agrees that the treatment/charges from Park Ridge Anesthesia and Nova Care was necessary, reasonable and related. Respondent argues that they may have paid the bills and, if not, they should be directed to pay such bills. Respondent submitted into evidence a Payment Listing that documents the payments made on this claim. (Rx. 1 of exhibits for case # 12 WC 31615) It looks as though a payment is due and owing to RCI WRS, INC., for a date of service of March 22, 2016, in the amount of $1,360.00. The Arbitrator does not note a bill in the amount of $1,500.00.

The Arbitrator finds the treatment provided by Park Ridge Anesthesia and Nova Care to be reasonable, necessary and related to the July 12, 2012 accidental injury Petitioner sustained. As such, and based upon the stipulation of the Parties, Respondent shall pay directly to Park Ridge Anesthesia and to Nova Care the amounts of $1,500.00 and $1,360.00, respectively, pursuant to Section 8(a) and subject to Section 8.2 of the Act. Respondent is entitled to a credit for previous payment of these outstanding amounts to these providers.

In support of his decision with regard to issue (L) "What is the nature and extent of the injury?", the Arbitrator finds as follows:

Pursuant to Section 8.1b of the Act, for accidental injuries that occur on or after September 1, 2011, the following criteria are to be used in the determination of permanent partial disability:

(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 finds that neither Petitioner nor Respondent submitted a report setting forth an AMA impairment rating. The Arbitrator finds that an impairment rating is not necessary based on the Appellate Court's holding in *Corn Belt Energy v. Illinois*

Workers' Compensation Commission, 2016 IL App (3d) 150311WC (3d Dist. 2016). The Court held that an AMA Impairment Rating is not required for the Arbitrator to award permanent partial disability benefits. *Id.* Accordingly, the Arbitrator will not consider this factor as it relates to the nature and extent of the injury.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals Petitioner was a motor truck driver for the City of Chicago Department of Water Management. Petitioner testified that as a motor truck driver, he would inspect the truck every day, make sure the materials and tools were properly secured in the back, drive to the locations, and drop off the materials with the work crews. The job also required him to perform lifting. The heaviest item he had to lift was a water pump, which weighed between 75 and 100 pounds. The Arbitrator gives moderate weight to this factor and finds that it would result in an increase in permanency.

With regard to subsection (iii) of §8.1b(b), the age of the employee at the time of the injury, the Arbitrator notes that Petitioner was 41 years old at the time of the accident. The Arbitrator takes judicial notice that, *ceteris paribus*, Petitioner has a longer work life expectancy than a 51-year-old worker or a 61-year-old worker. The Arbitrator gives moderate weight to this factor and finds that it would result in an increase in permanency.

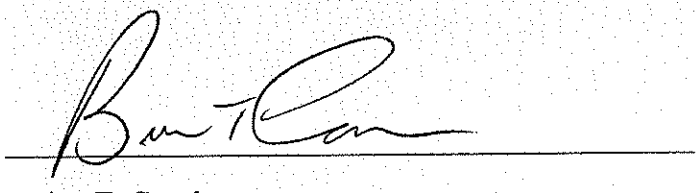
With regard to subsection (iv) of §8.1b(b), the employee's future earning capacity, the Arbitrator notes that in case # 12 WC 31615, there is no evidence that his future earning capacity has been affected as a result of the July 12, 2012 accident. The Arbitrator gives minor weight to this factor and finds that it would result in little, if any, increase in permanency.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes the following:

Petitioner underwent an FCE at NovaCare on March 22, 2016. (Px. 5). On April 19, 2016, Dr. Visotsky reviewed the results of the FCE with Petitioner and opined Petitioner would not be able to return to his job as a motor truck driver. The FCE evaluator found that Petitioner can only work at a light-duty physical demand level. (Px. 5) Dr. Visotsky opined Petitioner's left hand and elbow have recovered well and that Petitioner's limiting factors are not his elbow

as he has reached maximum medical potential with respect to his elbow and has had a good recovery. His limitations are as outlined in the FCE. He is more limited in his lifting due to his back condition. Dr. Visotsky further opined that his upper extremity has the capability of performing at a higher level than indicated in the FCE report. The FCE placed him at light duty with the caveat that this is probably due to his back. At that point in time, his upper extremity taken in isolation would allow him to perform a higher level of lifting if not for his back. The Arbitrator gives major weight to this factor and finds that it would result in an increase in permanency.

Determination of permanent partial disability ("PPD") is not simply a calculation but is an evaluation of the five factors. The Arbitrator has carefully considered all five factors. By applying §8.1b and by considering the relevance and weight of all five factors, the Arbitrator finds that as a result of the July 12, 2012 accident, Petitioner has sustained a permanent loss of use of his left arm to the extent of 25%, pursuant to Section 8(e)10 of the Act.



3-18-2019

Brian T. Cronin

Arbitrator

Date

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

PAUL ALVAREZ,

Petitioner,

vs. NO: 13 WC 16859

CITY OF CHICAGO,
DEPARTMENT OF WATER MANAGEMENT,

20IWCC0048

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 maintenance benefits, duration of temporary total disability (TTD), and permanent partial disability (PPD), and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission agrees with the Arbitrator's ultimate decision that Petitioner is permanently and totally disabled as a result of his April 8, 2013 work-related accident. The Commission, however, finds that Petitioner is permanently and totally disabled under the "odd lot" category.

If an employee's disability is limited and it is not obvious that the employee is unemployable, the employee may nevertheless demonstrate an entitlement to PTD by proving he or she fits within the "odd lot" category. *Westin Hotel v. Industrial Comm'n*, 372 Ill. App. 3d 527, 544, 865 N.E.2d 342, 310 Ill. Dec. 18 (2007). The odd-lot category consists of employees who, "though not altogether incapacitated for work, [are] so handicapped that [they] 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, 547, 419 N.E.2d 1159, 50 Ill. Dec. 710 (1981). An employee generally fulfills the burden of establishing that he or she falls into the odd-lot category in one of

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two ways: (1) by showing a diligent but unsuccessful search for employment or (2) by demonstrating that because of age, training, education, experience, and condition, there are no available jobs for a person in his or her circumstance. *Professional Transportation, Inc. v. Illinois Workers' Compensation Comm'n*, 2012 IL App (3d) 100783WC, ¶ 34, 966 N.E.2d 40, 358 Ill. Dec. 855; *Alano v. Industrial Comm'n*, 282 Ill. App. 3d 531, 534-35, 668 N.E.2d 21, 217 Ill. Dec. 836 (1996). If an employee makes this showing, the burden shifts to the employer to show that some kind of suitable work is available to the employee. *Westin Hotel*, 372 Ill. App. 3d at 544.

Here, the evidence establishes that Petitioner performed a diligent but unsuccessful job search, and that Respondent has failed to show that suitable work is available to the Petitioner.

Petitioner sustained an injury to his lumbar spine on April 8, 2013 resulting in an L5-SI anterior lumbar interbody fusion that was performed on June 17, 2014. Thereafter, Petitioner underwent permanent placement of a spinal cord stimulator on August 21, 2015. Petitioner then underwent an FCE on December 29, 2015 that placed him within the light physical demand level. His prior duties, however, were classified within the medium physical demand level.

Petitioner underwent a vocational rehabilitation evaluation with Susan Entenberg on March 3, 2016. Ms. Entenberg opined that Petitioner was not capable of performing his past work as a truck driver. He was, however, an appropriate candidate for vocational rehabilitation. PX.9.

Respondent then obtained a vocational evaluation from Lisa Helm of Vocamotive on April 12, 2017. Ms. Helm opined that Petitioner lost access to his usual and customary line of occupation as a truck driver. Petitioner, however, remained employable and should be able to locate employment in any position congruent with his previous experiences and physical capabilities. She opined that Petitioner was a viable candidate for vocational rehabilitation. RX.4.

Respondent obtained a labor market survey from Vocamotive on September 25, 2017. Per the survey, Petitioner was "prospectively employable." The majority of the positions identified by the survey required computer proficiency, which Petitioner did not have. Computer training was recommended. RX.4.

The Respondent offered Petitioner vocational rehabilitation; however, it was against his restrictions as he could only drive for 30 minutes. He would have been required to drive in excess of 45 minutes in order to attend vocational rehabilitation.

Petitioner obtained an updated vocational assessment from Susan Entenberg on April 21, 2018. She reviewed Petitioner's job logs and noted that he submitted 1,223 job contacts without success. Ms. Entenberg opined that Petitioner has been performing a diligent job search without the support of professional rehabilitation. Without the necessary services, a stable labor market did not exist. She further stated that, in all likelihood, Petitioner would be unable to secure stable and gainful employment even with professional help. PX.9.

Petitioner testified that he has applied for 1,533 jobs without success.

The Commission finds that Petitioner has fulfilled his burden of establishing a diligent but

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unsuccessful job search. He has applied to over 1,500 jobs without success. Ms. Entenberg reviewed the job logs and noted that Petitioner's independent job search has been diligent. The Commission finds Ms. Entenberg's opinion persuasive.

The Commission finds that the Respondent has failed to satisfy its burden of establishing that suitable work is available to the Petitioner. While the Respondent offered Petitioner vocational rehabilitation, it required Petitioner to drive for more than 30 minutes, which was against his restrictions. Instead of offering Petitioner vocational rehabilitation in compliance with his restrictions, Respondent obtained a labor market survey. The Respondent's labor market survey found Petitioner to be "prospectively employable." The jobs identified in the survey required computer proficiency, which Petitioner did not have. No other vocational rehabilitation was offered to the Petitioner. The Commission is not persuaded by the Respondent's labor market survey. Ms. Entenberg, on the other hand, opined that a stable labor market did not exist. Her opinion is supported by the fact that Petitioner remains unemployed after applying for over 1,500 jobs. The Respondent has failed to satisfy its burden of establishing that some kind of suitable employment is available to the Petitioner. Therefore, the Commission finds that Petitioner is permanently and totally disabled under the "odd lot" category.

A separate decision has been issued for case 12 WC 31615.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 20, 2019, 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 $902.67 per week for a period of 138-4/7 weeks, (May 15, 2013 through January 9, 2016) 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 902.67 per week for a period of 73-1/7 weeks, (January 10, 2016 through June 4, 2017), as Petitioner had reached MMI and was entitled to maintenance benefits, in accordance with Section 8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $1,274.15 for medical expenses under §8(a) of the Act, and subject to the medical fee schedule.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $902.67 per week for life, commencing June 5, 2017, as provided in Section 8(f) of the Act, because the injury caused the permanent and total disability of the Petitioner.

IT IS FURTHER ORDERED BY THE COMMISSION that commencing on the second July 15th after the entry of this award, the Petitioner may become eligible for cost-of-living adjustments, paid by the Rate Adjustment Fund, as provided in Section 8(g) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner

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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.

D. Douglas McCarthy

Douglas McCarthy

DATED: JAN 22 2020

DDM/tdm
O: 12/18/19
052

Stephen J. Mathis

Stephen Mathis

L. Elizabeth Coppoletti

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ALVAREZ, PAUL
Employee/Petitioner

Case# **13WC016859**

12WC031615

CITY OF CHICAGO DEPT OF WATER MANAGEMENT
Employer/Respondent

20IWCC0048

On 3/20/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.45% 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:

2988 CUDA LAW OFFICES LTD
ANTHONY GATTUSO
6525 W NORTH AVE SUITE 204
OAK PARK, IL 60302

0010 CITY OF CHICAGO DEPT OF LAW
LUCY HUANG
30 N LASALLE ST SUITE 800
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

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ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Paul Alvarez
Employee/Petitioner

v.

City of Chicago, Dept of Water Management
Employer/Respondent

Case # **13** WC **16859**

Consolidated cases: **12 WC 31615**

20IWCC0048

An *Application for Adjustment 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 T. Cronin**, Arbitrator of the Commission, in the city of **Chicago**, on **1/16/19**. 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. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [ ] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [ ] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

FINDINGS

On **4/8/13**, 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 $**70,408.00**; the average weekly wage was $**1,354.00**.

On the date of accident, Petitioner was **42** years of age, ***single*** with **2** dependent children.

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

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

Respondent shall be given a credit of $**124,960.86** for TTD, $**0.00** for TPD, and $**161,258.76** for maintenance/PTD benefits, for a total credit of $**286,219.62**.

ORDER

Respondent shall pay outstanding medical bills that total $**1,274.15**, pursuant to Section 8(a) and subject to Section 8.2 of the Act.

Respondent shall pay Petitioner $**902.67**/week from **5/15/2013** through **1/9/2016**, which represents a period of **138-4/7** weeks, because Petitioner was temporarily totally disabled during that period, in accordance with Section 8(b) of the Act.

Respondent shall pay Petitioner $**902.67**/week from **1/10/2016** through **6/4/2017**, which represents a period of **73-1/7** weeks, as because Petitioner had reached MMI and was entitled to maintenance benefits, in accordance with Section 8(a) of the Act.

Respondent shall pay Petitioner permanent and total disability benefits of $**902.67**/week for life, commencing on **6/5/2017**, as provided in Section 8(f) of the Act.

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

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

Signature of Arbitrator

3/19/2019
Date

MAR 20 2019

Paul Alverez v. City of Chicago
13 WC 16859

FINDINGS OF FACTS

The Parties stipulated that on April 8, 2013, Paul Alverez (hereinafter referred to as "Petitioner") sustained an injury in the course and scope of his employment with the City of Chicago (hereinafter referred to as "Respondent"). His job title was motor truck driver for the Department of Water Management. On April 8, 2013, Petitioner was driving in his truck, struck a large dip in the street with such force that it caused him to become ejected from his seat and to strike his head on the ceiling of the truck cab. (TX 26) Petitioner testified that this accident jarred his back, which caused him to feel immediate pain in his lower back. (TX 27) Petitioner notified his supervisor about the accident. (TX 28)

Petitioner testified that he tried to treat his back injury with self-care during the month of April; however, he continued to experience ongoing pain. (TX 28)

On May 24, 2013, Petitioner sought medical treatment for his back injury at MercyWorks. Dr. Tschangi Mehrpuyan examined Petitioner and diagnosed him with lumbar strain with radiculopathy. The doctor administered an injection of Toradol. (PX 1) Petitioner was taken off work until May 21, 2013, which was his next follow-up visit.

On May 21, 2013, Petitioner attended a follow-up visit with Dr. Mehrpuyan. The doctor ordered an MRI of the lumbar spine and kept Petitioner off work. (PX 1)

Petitioner underwent an MRI on May 29, 2013, which revealed a large central and right protrusion at L5-S1 with marked neural foraminal narrowing at that same level. (PX 1) The MRI also showed effacement and edema of the S1 nerve root on the right side. (PX 1)

On June 3, 2013, Petitioner attended his last visit to Dr. Mehrpuyan. The doctor discussed the results of the MRI and referred Petitioner to a spine specialist, Dr. Alexander Ghanayem. Petitioner continued to be off work. (PX 1)

On August 3, 2013, Petitioner was seen by Dr. Alexander Ghanayem. (PX 4) The doctor recommended a course of physical therapy and several epidural steroid injections.

On September 5, 2013, Petitioner followed up with Dr. Ghanayem and reported that he continued to experience back pain. The doctor ordered more physical therapy and referred Petitioner to Dr. Troy Buck for the epidural injections (PX 4).

On September 10, 2013, Petitioner underwent a lumbar epidural injection (PX 4). Petitioner followed up with Dr. Ghanayem on September 19, 2013. At that visit, the doctor recommended a lumbar discectomy at L5-S1, and Petitioner indicated that he wanted to proceed with the recommended surgery.

On December 10, 2013, Petitioner presented to Dr. Ghanayem with complaints of severe pain in the middle of his lumbar spine. The doctor ordered another MRI of the lumbar spine. (PX 4) MR images were taken on January 22, 2014, which showed the same L5-S1 disc protrusion with a mild disc desiccation, an additional loss of 50% of disc height, a right paracentral annular tear and a mild diffuse disc bulge with rightward predominance. (PX 4)

Petitioner visited Dr. Ghanayem on January 30, 2014, February 24, 2014, and June 9, 2014. Petitioner continued to report back pain and was kept off work for that time period. (PX 4) Dr. Ghanayem changed the surgical plan after Petitioner's January 30, 2014 office visit. Dr. Ghanayem recommended an anterior lumbar interbody fusion at L5-S1 in order to restore disc height and open the foramen. (PX 4)

On May 8, 2014, Petitioner attended a Section 12 examination with Dr. Jesse Butler at the request of Respondent. On examination, the doctor observed that Petitioner had a normal gait. He had 5/5 strength in the lower extremities. Examination of the spine revealed reduced ranges of motion, tenderness, and negative straight leg raising. The neurological examination was normal: there were no motor, sensory, or reflex deficits. Dr. Butler diagnosed Petitioner with a lumbar disc herniation at L5-S1 on the right with degenerative disc disease. The doctor reviewed the MRI reports and stated that he agreed with Dr. Ghanayem's recommendation for a spinal fusion. Dr. Butler further stated that Petitioner would reach maximum medical improvement seven months after the surgery. (RX. 5)

On June 17, 2014, Petitioner underwent the fusion surgery, which was performed by Dr. Ghanayem (PX 4). A prosthetic device was implanted into the spine to help stabilize the loss in disc height and an anterior plate was used to keep all the hardware in place. (PX 4)

Following the surgery, Petitioner attended his first post-operative visit on July 14, 2014. Petitioner was instructed to begin a walking program and to follow up in a month (PX 4).

On August 25, 2014, Petitioner was advised to begin physical therapy. Petitioner continued to complain of pain and numbness that radiated into his left leg (PX 4). Due to these complaints, Dr. Ghanayem ordered another MRI of the lumbar spine on September 4, 2013. (PX 4). The MR images revealed the status post anterior lumbar fusion at L5-S1 level with near anatomic alignment of the lumbar spine; no evidence of disc herniation, spinal stenosis or foraminal compromise, but a minimal bulge of the disc at L5-S1. (PX 4)

Petitioner underwent physical therapy from August 26, 2014 to December 1, 2014 (PX 4). On November 3, 2014, Petitioner informed Dr. Ghanayem that he had not felt any pain relief from the last course of physical therapy. The doctor ordered additional physical therapy (PX 4).

On December 1, 2014, Petitioner followed up with Dr. Ghanayem with complaints of ongoing pain. The doctor ordered an x-ray of the lumbar spine and referred Petitioner to Dr. Larry Frank for pain management (PX 4).

Petitioner saw Dr. Frank on December 12, 2014. On December 23, 2014, the doctor administered an epidural steroid injection to his lumbar spine at L3-L4 and L4-L5 (PX 7).

On January 22, 2015, Petitioner underwent a medial branch nerve block. Petitioner reported that he did not feel any type of lasting relief and followed up with Dr. Frank on January 29, 2015 (PX 7). Another injection was ordered and was administered on February 26, 2015.

Due to Petitioner's ongoing complaints of pain, Dr. Frank recommended that Petitioner follow up with Dr. Ghanayem (PX 7).

On March 30, 2015, Petitioner presented to Dr. Ghanayem. The doctor recommended that Petitioner explore the possibility of a dorsal column stimulator. Dr. Ghanayem referred Petitioner to Dr. Troy Buck for further pain management treatment (PX. 4)

On May 1, 2015, Petitioner attended a consultation with Dr. Troy Buck. The doctor discussed the inner workings of a spinal cord stimulator.

On May 20, 2015, Petitioner was deemed a candidate for the spinal cord stimulator. Dr. Buck ordered a mental health evaluation. (PX 4) This evaluation took place on June 3, 2015, and Petitioner passed the psychological screening. Petitioner also attended pre-operational testing on July 10, 2015. (PX 4)

On July 20, 2015 Dr. Buck performed surgery to affix the percutaneous epidural lumbar spinal cord stimulator trial. (PX4) Petitioner was put under sedation for this procedure, and the device was installed at T12-L1 (PX 4). The device was tested at the hospital and was working properly. Petitioner informed his doctors that the external device was providing 60-70% relief and that he wished to go forward with the implantation of the internal device. (PX 4)

On August 21, 2015, Dr. Buck implanted a permanent spinal cord stimulator. (PX 4) The device was tested and found to be working properly. (PX 4) Petitioner was discharged and recommended to follow up on August 28, 2015. (PX 4)

At the follow-up visit on September 9, 2015, the doctor noted that the surgical site looked well-healed and the device was working properly. (PX 4)

On September 25, 2015, Dr. Buck ordered x-rays of the lumbar spine to check the status of the device. (PX 4) At that visit, Petitioner reported that a suture was poking out of his spine and felt low back pain after bending over a few days ago. (PX 4)

Due to Petitioner's complaints of back pain, he scheduled appointments with Dr. Ghanayem and Dr. Buck. (PX 4) On October 5, 2015, Dr. Ghanayem recommended physical therapy and a Medrol Dosepak. On October 7, 2015, Petition saw Dr. Buck. Dr. Buck stated that a CT scan might be needed if Petitioner continued to have pain. (PX 4)

Petitioner reported that he did not experience any pain relief from the physical therapy; therefore, a CT scan was ordered. Petitioner underwent a CT scan on October 27, 2015, which revealed post-surgical changes of the hardware of the fusion at L5-S1 with anterior plate and bilateral screws; no evidence of hardware failure; mild degenerative disc disease at L3-L4 and L4-L5 as well as mild spinal canal stenosis and bilateral neural foraminal stenosis at all three levels. (PX 4) Based on these results, Dr. Buck ordered a piriformis injection and administered it

on November 18, 2015 (PX 4). Petitioner reported that the injection did not provide much relief, and a follow-up appointment with Dr. Ghanayem was scheduled for December 16, 2015.

On December 16, 2015 Dr. Ghanayem stated that he believed that Petitioner had reached a treatment plateau and ordered an FCE (PX 4). The results of the valid FCE were reviewed on January 4, 2016. Dr. Ghanayem opined Petitioner had reached maximum medical improvement. The doctor gave Petitioner permanent work restrictions and rated Petitioner at the light physical demand level (PX.4)

On March 25, 2016, Petitioner saw Dr. Zaidi because the battery in his spinal cord stimulator failed (PX 4). On April 16, 2016, the battery and device leads were replaced by Dr. Buck and Dr. Zaidi. The battery was tested and found to be functioning properly (PX 4). Petitioner followed up with Dr. Buck on April 25, 2016. At this visit, the staples were removed from Petitioner's back. It was noted that the incision was healing well, and the device was functioning properly (PX 4). Petitioner continued to have check-ups with Dr. Buck every few months. Dr. Buck advised Petitioner to continue with his home exercises (PX 4).

Unable to return to his usual and customary position with the Respondent, Petitioner was placed into a vocational rehabilitation program to aid him in finding gainful employment within his restrictions. Respondent hired Vocamotive for that purpose.

During his initial evaluation on April 12, 2017 by Lisa Helma, CRC, of Vocamotive, Petitioner reported that he had a GED and that his previous occupations were motor truck driver, carpenter, and construction laborer. Ms. Helma opined that with Petitioner's permanent restriction, he would most likely be able to perform sedentary occupations. Ms. Helma stated that in order for Petitioner to be qualified for sedentary positions, he would need to have marketable computer skills. Petitioner also reported that he shared a vehicle with his wife and that she needed a car. It was noted that Petitioner's transportation concerns would need to be addressed prior to the implementation of vocational rehabilitation services. It was noted that Petitioner would need to be capable of commuting for vocational rehabilitation activities and employment opportunities. If necessary, public transportation options could be identified for Petitioner. Ms. Helma opined that Petitioner remains employable, and Petitioner should be able to locate employment in any position congruent with his previous experiences and physical capabilities.

Ms. Helma stated that positions available to Petitioner would be office clerk, administrative clerk, customer representative, dispatcher, and other occupations. She noted that marketable computer skills would be required for all the above noted occupations. (RX 4)

Ms. Helma further opined that Petitioner would have the potential of earning between $10.00 and $13.00 per hour. Ms. Helma stated that Petitioner is a viable rehabilitation candidate and that these services should be provided to him (Rx. 4). Ms. Helma completed the Initial Evaluation Report and the Rehabilitation Plan on May 16, 2017. (RX 4, RX 2)

Subsequently, formal vocational rehabilitation services were offered to Petitioner. However, Petitioner chose not to participate in the program. Petitioner declined to participate in the program because of his driving restrictions. Petitioner lives on the north side of Chicago and Vocamotive's office, where computer training was to take place, is located in Naperville, Illinois. Petitioner testified that the driving time from the north side of Chicago to Naperville exceeds his ½-hour driving restriction.

On April 24, 2017, due to Petitioner's complaints of ongoing pain, Dr. Ghanayem ordered a CT scan of the lumbar spine.

On May 18, 2017, a CT scan was done, which showed a disc herniation at L4-L5 above the fusion and also showed that all hardware and devices were properly aligned. (PX 4)

On June 5, 2017, Dr. Ghanayem reviewed the CT scan and recommended that Petitioner continue to use the spinal cord stimulator (PX 4). Dr. Ghanayem wrote the following:

> "Paul returns today in followup. He is just simply miserable with his back. The left leg continues to give out on him. He suffered a meniscal tear on routine surgery. I looked at the CT scan he had of his lumbar spine. There is a disc herniation at L4-L5 above his fusion. He has some degenerative changes at L3-L4. His fusion, however, looks fine. At this point he has developed transition to problems now 2 levels higher than his lumbar fusion. This includes L3-L4 and L4-L5. Given his poor response to interventional-type treatment to his back, I think the best

course of action is to just manage his symptoms medically. He has a spinal cord stimulator in place and he should continue with pain management. Occupationally, I believe he is disabled from all further occupational activities. I have taken him off work altogether. I do not see him returning back to work, and therefore, his disability is permanent." (PX 4, p. 782)

On August 30, 2017, Petitioner attended another Section 12 examination by Dr. Jesse Butler at the request of Respondent. On examination, Dr. Butler noted that Petitioner had a normal gait. In the lower extremities, straight-leg-raising test was negative and muscle strength was normal at 5/5. Petitioner had decreased ranges of motion of the lumbar spine. Neurologically, Petitioner was fully intact. Dr. Butler reviewed the medical records and treatment notes and diagnosed Petitioner with status post lumbar spinal fusion at L5-S1 and placement of spinal cord stimulator for chronic radiculopathy affecting the left lower extremity. Dr. Butler opened Petitioner does not require additional diagnostic testing. Petitioner underwent a CT scan, which confirmed the solid nature of the fusion at L5-S1. The doctor stated that Petitioner does not have significant adjacent level degeneration above his fusion. Dr. Butler opined Petitioner should consider additional treatment in the form of medication to manage the depression and anxiety that he currently manifests. Dr. Butler further stated that Petitioner should also have an occupational assessment performed to determine his vocational opportunities. Dr. Butler also opined that Petitioner "is expected to have permanent restrictions at a sedentary demand level." (RX 1)

Since Petitioner chose not to participate in Respondent's formal vocational rehabilitation program due to the driving time involved, Vocamotive closed its file. Lisa Helma conducted a labor market survey on September 25, 2017. In this report, Ms. Helma opined Petitioner is employable and would have the potential to earn between $12.00 and $15.00 per hour. Ms. Helma stated that Petitioner would be able to perform sedentary positions such as administrative clerk, receptionist, service clerk, dispatcher, and customer representative. Ms. Helma also noted that Petitioner would need to participate in a formal vocational rehabilitation program in order for him to obtain the recommended positions. (RX 4, RX 2, RX 3)

On April 21, 2018, Susan Entenberg, CRC, completed a vocational rehabilitation report at the request of Petitioner's attorney. In that report, Ms. Entenberg noted that that she met with Petitioner on March 3, 2016. She stated that Petitioner made a job search and that the job search log contains a total of 1,223 job contacts, which includes those for a general office clerk, dispatch, warehouse clerk, security, parts clerk, and other feasible openings available through job search engines such as Monster, Indeed, and Yahoo. Ms. Entenberg opined Petitioner has been performing a diligent job search without the support of professional rehabilitation resources and has not been successful with his endeavors. She further opined it is more likely than not he will be unable to secure stable and gainful employment even with the services of a rehabilitation professional, given his vocational profile. Ms. Entenberg opined that if Petitioner did find a job, he would have an earning capacity of approximately $8.50 to $10.00 per hour. (PX 9)

Petitioner has been conducting a self-directed job search and at the time of trial he submitted 1,533 applications for employment and has still not found an employer willing to hire him within his FCE limitations. (TX 73, PX 11, PX 12) Such limitations include no standing for long periods of time, no sitting for long periods of time, no sitting in a car for more than ½ hour one way, and no squatting for long periods of time. (TX 71)

On February 2, 2018, Petitioner saw Caitlin Loudon, D.O., a resident at Loyola University Medical Center. He returned to the clinic due to low back pain with radiation into the left foot and toe. There was no new injury or trauma. However, Petitioner reported that the pain is worse with standing, sitting for a long time, or laying on his back. Petitioner reported a baseline pain of 6/10, and at worst, 10/10. The Baclofen that was prescribed to him did not provide any pain relief. He also reported that his spinal cord stimulator has been "acting up" the last 2-3 weeks and noted that it does not feel like it is working while he is standing. (PX 4b, p. 762)

Petitioner testified that the accidental injury has brought about a total life change. He misses not being able to "go on the ground with [his] kids and play with [his] kids." (TX 75) He testified that he is 48 years old but feels "just beat up," like a 65-year-old in a 48-year-old body. (TX 77) In order to provide some relief for his back pain and to preserve the health of his kidneys and liver, Petitioner switched from heavy narcotic, opiate-based medication to Tylenol or Ibuprofen, and has the spinal cord stimulator permanently implanted in his back.

CONCLUSIONS OF LAW

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

The Arbitrator concludes that Petitioner has proven by a preponderance of the evidence that his present condition of ill-being relative to his back is causally related to his injury of April 8, 2013. This conclusion is based upon the credible testimony of Petitioner and the treating medical records.

To establish causation under the Illinois Workers' Compensation Act, 820 ILCS 305/1 et seq. (2012), a claimant must prove that some act or phase of his employment was a causative factor in his ensuing injury. It is not necessary to prove that the employment was the sole causative factor or even that it was the principal causative factor, but only that it was a causative factor. *Tolbert v. Ill. Workers' Comp. Comm'n, 2014 IL App (4th) 130523WC, ¶ 1, 11 N.E.3d 453.*

In the case at bar, Petitioner was driving a City of Chicago truck when the truck hit a dip in the street causing Mr. Alvarez to be violently ejected from his seat. (TX 25). The impact was so severe that it caused him to strike his head on the roof of the truck cab. (TX 25) In the process, Petitioner suffered a back injury. But for Petitioner's employment with the City of Chicago Department of Water Management, he would not have been driving a City truck westbound on Addison at Milwaukee Avenue. (TX 24)

It is evident that Mr. Alvarez's current condition of ill-being is causally related to the work accident of April 8, 2013. Petitioner has participated in physical therapy, has received several injections, has undergone fusion surgery, and has had a temporary and then a permanent spinal cord stimulator implanted in his back. (PX 4) Dr. Ghanayem and Dr. Buck continually kept Petitioner on light-duty or off work due to his work-related injury. (PX 4). Dr. Ghanayem and Dr. Buck both note that Mr. Alvarez had no issues with his lumbar spine before the accident of April 8, 2013. (PX 4).

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 Co. v. Indus. Comm'n*, 93 Ill.2d 59, 442 N.E.2d 908 (1982)

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

The Arbitrator finds that Respondent is liable for the outstanding medical bills. The Arbitrator bases his finding on Petitioner's credible testimony, the treating records, and the opinions of the treating physicians, particularly those of Dr. Ghanayem. Therefore, the Arbitrator finds Respondent liable for payment of the outstanding medical bill from LUMC in the amount of $278.10, the outstanding bill from Loyola University Physician Foundation in the amount of $742.05, and the outstanding medical bill from Swedish Covenant Hospital in the amount of $254.00, pursuant to Section 8(a) and subject to Section 8.2 of the Act.

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

The Arbitrator finds the opinions of Petitioner's treating physician and surgeon, Alexander J. Ghanayem, M.D., to be more persuasive than those of Respondent's examining physician and surgeon, Jesse P. Butler, M.D.

Dr. Ghanayem performed fusion surgery on Petitioner's lumbar spine on June 17, 2014 and saw Petitioner numerous times before and after such surgery. Dr. Ghanayem is The Dr. William M. Scholl Professor and Chairman of Orthopedic Surgery & Rehabilitation Director, Division of Spine Surgery, Loyola University Medical Center. (PX 4b, p. 783)

Dr. Butler examined Petitioner on the following two occasions: May 8, 2014 and August 30, 2017. Dr. Butler is a surgeon associated with Spine Consultants, LLC. (RX 1)

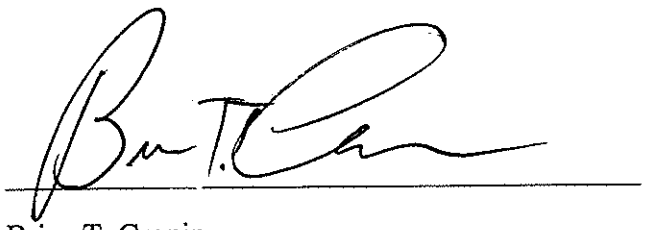
The Arbitrator finds that Dr. Ghanayem is in a better position to assess Petitioner's capabilities than is Dr. Butler.

Even if one of the medical witnesses was equivocal on the question of causation, it is for the Commission to decide which medical view is to be accepted and it may attach greater weight to the opinion of the treating physician. *International Vermiculite v. Indus. Comm'n*, 77 Ill. 2d 1, 394 N.E.2d 1166 (1979)

On August 30, 2017, Dr. Butler opined: "The patient is expected to have permanent restrictions at a sedentary demand level based upon his surgical procedures and overall poor outcome." (RX 1)

On June 5, 2017, Dr. Ghanayem wrote: "Occupationally, I believe he is disabled from all further occupational activities. I have taken him off work altogether. I do not see him returning back to work, and therefore, his disability is permanent." (PX 4b, p. 782)

Therefore, the Arbitrator finds that Petitioner is medically permanently and totally disabled, pursuant to Section 8(f) of the Act.



3-19-19

Brian T. Cronin

Arbitrator

Date

ILLINOIS WORKERS' COMPENSATION COMMISSION

Illinois Workers' Compensation Commission, Insurance Compliance Division, Petitioner, v. Jacek Drzewiecki, Individually and As president of Perfect Builders, Inc. Respondent.	)	No. 08 INC 461 20WC 000030

ORDER

This matter, after oral request by the Petitioner, The Illinois Workers' Compensation Commission – Insurance Compliance Division, by and through its attorney, the Office of the Illinois Attorney General, is dismissed. The Office of the Attorney General has advised this Commission it no longer seeks to proceed in this matter against Respondents, as this matter has settled.

JAN 23 2020

Commissioner L. Elizabeth Coppoletti

Dated: 12/20/19

STATE OF ILLINOIS)
)SS.
COUNTY OF DuPAGE)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Christiana Williams,

Petitioner,

vs. No. 15 WC 19886

Edward Hospital,

Respondent.

ORDER

Petition for Attorneys' Fees pursuant to Section 16 of the Illinois Workers' Compensation Act having been filed by attorney Timothy E. Takash of The Law Offices of Timothy E. Takash, and due notice having been given, this cause coming before Commissioner L. Elizabeth Coppoletti for hearing on December 20, 2019 in Chicago, Illinois. Petitioner, Ms. Christina Williams, appeared *Pro Se*. The Commission having jurisdiction over the persons and subject matter and after considering the entire record, grants the Petition for Fees as delineated herein for the reasons set forth below.

Statement of Facts

On June 24, 2015, Mr. Timothy E. Takash filed an Application for Adjustment of Claim on behalf of Christina Williams alleging injury to the low back which occurred on April 13, 2014. Following a hearing pursuant to Section 19(b) of the Act, Arbitrator Granada entered his decision on March 2, 2016 finding Petitioner entitled to benefits pursuant to Section 8(a) and 19(b) of the Act. On September 30, 2016, the Commission affirmed the decision of the arbitrator. On March 31, 2017, the Circuit Court of DuPage County affirmed the decision of the Commission. Throughout the hearing and subsequent appeals, Petitioner was represented by Mr. Takash who collected fees in the amount of $6,183.50 for the prosecution of Petitioner's case.

Following a second hearing pursuant to Section 19(b) of the Act, Arbitrator Steffen entered her decision on October 4, 2018 finding Petitioner not entitled to benefits pursuant to Section 8(a) and 19(b) of the Act. On October 23, 2018, despite still being represented by counsel, Petitioner filed a Petition for Review on a *pro se* basis. Given the clear breakdown in communication between Petitioner and her attorney, on January 24, 2019, Commissioner Coppoletti granted Mr. Takash's Motion for Withdrawal of Attorney. On February 1, 2019, Mr. Takash filed a Petition for Attorneys' Fees pursuant to Section 16 of the Act.

Petitioner subsequently agreed to a settlement on all issues in the amount of $17,500.00

with counsel for Respondent, Mr. Matthew Ignoffo of Keefe, Campbell & Associates. On December 16, 2019, Mr. Takash filed a Revised Memorandum in Support of Attorney's Fees. On December 20, 2019, a hearing was conducted before Commissioner Coppoletti in Chicago, Illinois on Mr. Takash's Petition for Attorney's Fees.

Conclusions of Law

An attorney who represents a client pursuant to a contingent fee agreement who is thereafter discharged by a client, with or without cause, is entitled to be paid for services rendered prior to the termination on a *quantum meruit* basis. *Rhoades v. Norfolk and Western Railway Company*, 78 Ill. 2d 217, 399 N.E.2d 969 (1979). "Moreover, the time and labor required in a case is but one factor to be considered in determining a reasonable attorney fee under the doctrine of *quantum meruit*. The other factors are the attorney's skill and standing, the nature of the cause and the novelty and difficulty of the subject matter, the degree and responsibility in managing the cause, the usual and customary charge in the community and the benefits resulting to the client. [citation omitted]." *Johns v. Klecan*, 198 Ill. App. 3d 1013, 1019, 556 N.E.2d 689 (1990). "If an attorney performed much of the work on a case before discharge and a settlement immediately follows the discharge, the factors used to determine a reasonable fee 'would justify a finding that the entire contract fee is the reasonable value of services rendered.'" *DeLapaz v. Selectbuild Constr., Inc.*, 394 Ill. App. 3d 969, 973-4, 917 N.E.2d 93 (2009), quoting *Wegner v. Arnold*, 305 Ill. App. 3d 689, 693, 713 N.E.2d 247 (1999).

Reviewing the record as a whole in the context of the standards established by *Johns and DeLapaz*, the Commission concludes Timothy E. Takash of The Law Offices of Timothy E. Takash is entitled to a fee in the amount of $3000.00 given his efforts over his approximate four-year period of representing Petitioner. Mr. Takash alleges he spent approximately ninety-four hours in representing Petitioner but much of this time related to the initial 19(b) hearing for which he recouped his costs ($743.00) and attorneys' fees ($6,183.50) in May of 2017. Further, in reviewing the time spent, there are several duplicate entries as well as some unexplained time for oral argument in September of 2019. Even such, Mr. Takash spend a considerable amount of time in proceeding to a second hearing pursuant to Section 19(b) of the Act. Although the ultimate outcome was not favorable to Petitioner, such was not due to a lack of effort on Mr. Takash's behalf.

As for the remaining factors established by *Johns*, Mr. Takash presented little evidence in support of the same. The Petition alleges a usual and customary hourly rate to equal $175.00 which is not challenged but appears excessive. Pursuant to *DeLapaz*, it is noted the offer of $17,500.00 was extended by Respondent to Petitioner while she was still represented by Mr. Takash and bound by the contingency agreement. Such factor is taken into consideration in arriving at the fee amount. Mr. Takash alleges costs in the amount of $199.00 but provided no supporting documentation. As such, the request for costs is denied.

During the hearing, Petitioner presented an audio recording of a message left by Mr. Takash on her voicemail on July 22, 2019 after his representation of Petitioner was terminated. In the message, Mr. Takash advised Petitioner of the hearing date of July 25, 2019 as well as Respondent's continued desire to resolve her claim via settlement. Mr. Takash also advised of outstanding fees equaling approximately $600.00 but made no mention of his desire to collect his attorneys' fees. T. 15-16. Petitioner inferred from this message that Mr. Takash was waiving his attorneys' fees. The Commission acknowledges Petitioner's position but disagrees. Such an inference is not reasonable given Mr. Takash's filing of his Petition for Attorneys' Fees on

February 1, 2019 which he continued to prosecute.

IT IS HEREBY ORDERED BY THE COMMISSION that *Pro Se* Petitioner, Christina Williams shall pay the sum of $3000.00 to Timothy E. Takash of The Law Offices of Timothy E. Takash pursuant to Sections 16 and 16a of the Act.

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: JAN 23 2020
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L. Elizabeth Coppoletti

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

JAMES HONDROS,

Petitioner,

vs. NO: 15 WC 38866

STATE OF ILLINOIS, DEPARTMENT OF CORRECTIONS,

Respondent.

20IWCC0049

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, temporary benefits, and the nature and extent of Petitioner's injuries, 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.

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 the testimony, exhibits, pleadings, and arguments submitted by the parties. The Commission is not bound by the Arbitrator's findings. Our Supreme Court has long held that it is the Commission's province "to assess the credibility of witnesses, resolve conflicts in the evidence, assign weight to be accorded the evidence, and draw reasonable inferences from the evidence." *City of Springfield v. Indus. Comm'n*, 291 Ill. App. 3d 734, 740 (1997) (citing *Kirkwood v. Indus. Comm'n*, 84 Ill. 2d 14, 20 (1981)). Interpretation of medical testimony is particularly within the province of the Commission. *A. O. Smith Corp. v. Indus. Comm'n,* 51 Ill. 2d 533, 536-37 (1972).

The Commission modifies the Arbitrator's Decision with respect to the award of maintenance and permanent total disability (PTD) benefits. The Commission instead finds that

SOTHCC00048

Petitioner is entitled to PTD benefits commencing July 31, 2015 – and not on March 13, 2019. The Commission therefore vacates the award of maintenance benefits in its entirety.

The Commission notes that on February 4, 2013, the date of accident, Petitioner, who was then 77 years old, worked as a maintenance worker for Respondent. The record demonstrates that following the work accident, and throughout Petitioner's treatment, Respondent could not and did not accommodate Petitioner's light duty restrictions. On July 30, 2015, Petitioner's treating physician, Dr. John Fernandez, placed Petitioner at maximum medical improvement (MMI) with permanent restrictions. After Petitioner was placed at MMI, Respondent confirmed in writing that it could not accommodate Petitioner's restrictions. Correspondence dated December 14, 2015 from the State of Illinois' Shared Services Program stated that Petitioner's position with Respondent was exempt from the program and that Petitioner must either resign or retire. At Respondent's request, a Transferable Skills Analysis was completed by Creative Case Management on October 10, 2016. Based on this vocational assessment, the vocational rehabilitation counselor concluded that Petitioner had limited transferable skills for jobs within his medical restrictions and Petitioner's ability to become gainfully employed was poor.

In light of the foregoing, the Commission finds that maintenance benefits were unnecessary as Petitioner was permanently and totally disabled as of July 31, 2015. Respondent's own evidence supports that Petitioner was permanently and totally disabled and that it was unlikely Petitioner was able to return to gainful employment. As such, the Commission vacates the award of maintenance benefits in its entirety, and instead awards PTD benefits commencing July 31, 2015.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator, filed April 12, 2019, is hereby modified as stated above, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is entitled to 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 pursuant to Section 8(j) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner temporary total disability benefits of $1,142.44 per week for 109 3/7 weeks, commencing February 5, 2013 through February 6, 2013, and from June 26, 2013 through July 30, 2015, that being the period of temporary total incapacity for work under Section 8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of maintenance benefits to Petitioner is hereby vacated in its entirety.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner permanent and total disability benefits of $1,142.44 per week for life, commencing July 31, 2015, as provided in Section 8(f) of the Act.

20IWCC0049

IT IS FURTHER ORDERED BY THE COMMISSION that commencing on the second July 15th after entry of this award, Petitioner may become eligible for cost-of-living adjustments, paid by the Rate Adjustment Fund, as provided in Section 8(g) of the Act.

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

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

DATED: JAN 23 2020

D. Douglas McCarthy

Stephen J. Mathis

L. Elizabeth Coppoletti

DDM/pm
O: 1-15-20
052

SOIACC0048

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HONDROS, JAMES
Employee/Petitioner

Case# **15WC038866**

IL DEPT OF CORRECTIONS
Employer/Respondent

20IWCC0049

On 4/12/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.39% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0700 GREGORIO & MARCO
SEAN C STEC
TWO N LASALLE ST SUITE 1650
CHICAGO, IL 60602

4980 ASSISTANT ATTORNEY GENERAL
COLIN KICKLIGHTER
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

1350 CENTRAL MANAGEMENT SERVICES
BUREAU OF RISK MANAGEMENT
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

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

APR 12 2019

Brendan O'Rourke, Assistant Secretary
Illinois Workers' Compensation Commission

STATE OF ILLINOIS)
)SS.
COUNTY OF WILL)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

James Hondros
Employee/Petitioner

Case # **15** WC **38866**

v.

State Of Illinois, Department of Corrections
Employer/Respondent

20IWCC0049

An *Application for Adjustment 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 **New Lenox**, on **March 12, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ 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 4, 2013**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did*** 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 $**89,110.08**; the average weekly wage was $**1,713.66**.

On the date of accident, Petitioner was **77** years of age, ***married*** with **0** dependent children.

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

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

Respondent shall be given a credit of $**128,736.20** for TTD, $**0** for TPD, $**168,995.95** for maintenance, and $**0** for other benefits, for a total credit of $**297,732.15**.

Respondent is entitled to a credit of $**71,697.90** under Section 8(j) of the Act.

ORDER

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

Respondent shall pay Petitioner temporary total disability benefits of **$1,142.44**/week for **109 3/7** weeks, commencing **February 5, 2013** through **February 6, 2013** and from **June 26, 2013** through **July 30, 2015**, as provided in Section 8(b) of the Act.

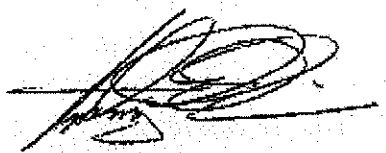
Respondent shall pay Petitioner maintenance benefits of **$1,142.44**/week for **188 4/7** weeks, commencing **July 31, 2015** through **March 12, 2019**, as provided in Section 8(a) of the Act.

Respondent shall pay Petitioner permanent and total disability benefits of **$1,142.44**/week for life, commencing **March 13, 2019**, as provided in Section 8(f) of the Act.

Commencing on the second July 15th after entry of this award, Petitioner may become eligible for cost-of-living adjustments, paid by the ***Rate Adjustment Fund***, as provided in Section 8(g) of the Act.

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

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



Arbitrator Anthony C. Erbacci

April 9, 2019
Date

APR 12 2019

FACTS:

James Hondros, (hereinafter "Petitioner"), a 77 year old maintenance worker at Stateville Prison, injured his left hand and wrist on February 4, 2013. Prior to February 4, 2013, Petitioner had never injured his left hand or wrist in any way. In addition, prior to February 4, 2013, Petitioner had never received medical care of any kind for his left hand or wrist. Further, Petitioner had not missed any time from work due to left hand or wrist problems prior to February 4, 2013.

On February 4, 2013, Petitioner was working for the State of Illinois Department of Corrections, (hereinafter "Respondent"). Petitioner was cutting a piece of Plexiglas that was 7/8" thick with a skill saw when the Plexiglas "kicked back" and struck Petitioner in the left wrist. The Arbitrator personally observed the scar on the inside of Petitioner's left wrist. The Arbitrator notes that Respondent admits that Petitioner sustained accidental injuries that arose out of and in the course of his employment on February 4, 2013. (Arbitrator's Exhibit #1).

On February 4, 2013, Respondent's business office received an Employee's Notice of Injury that was completed and signed by Petitioner on February 4, 2013. Petitioner indicated that on February 4, 2013 he was cutting Plexiglas with a table saw in the carpenter shop at Stateville prison when he injured his left hand. (Respondent's Exhibit #2).

Petitioner was treated at the emergency room at Provena Saint Joseph Medical Center on February 4, 2013. The history recorded by Dr. Steven N. Vulich states,

> "Patient was at work today and ____ subsequently a piece of plexiglass seemed to break off and struck him in the dorsal aspect of the left hand." Dr. Vulich diagnosed Petitioner with a laceration and sent Petitioner for x-rays of his left hand. (Petitioner's Exhibit #1).

An additional history recorded in the emergency department at Provena Saint Joseph Medical Center states,

> "...presents to ED after sustaining a laceration to the dorsum of the left hand. Patient is a maintenance worker at the local prison and was cutting a piece of Plexiglass on a table saw. Reportedly dislodged and the table saw struck him in the hand causing a 1 cm superficial laceration to the dorsum of the left hand." (Petitioner's Exhibit #1).

The diagnosis reached by the physician's assistant in the emergency department, Andrew Bramer was, "Laceration. Fracture. Foreign body." X-rays of Petitioner's hand were taken and reviewed at that time by Dr. Andrew Johanek. The doctor did not find any evidence of acute fracture or dislocation but did find positive ulnar variance within the distal ulnar epiphysis suggesting sequelae of Ulnolunate impaction. Petitioner's laceration was irrigated and repaired with two sutures and he was directed to remain off work for two days. In addition, Petitioner was directed to continue his care with an occupational medicine specialist or his family physician. (Petitioner's Exhibit #1).

Petitioner returned to work on February 7, 2013 and saw his family physician, Dr. Steven Nemeth, February 26, 2013, April 2, 2103, May 2, 2013 and June 4, 2013. (Petitioner's Exhibit #4).

On June 26, 2013, Petitioner was examined by Dr. John J. Fernandez. On the "New Patient Information Form" completed by Petitioner he identified "2/4/2013" as the date when his injury occurred and "State of IL – carpenter's workshop" as the location of the injury. Petitioner also stated, "I was cutting Plexiglass with a table saw" as how the injury occurred. (Petitioner's Exhibit #2).

The history recorded by Dr. Fernandez states,

> "[Petitioner] reports an injury, which occurred when he was 'cutting plexiglass with a table saw' on 02/04/2013. He denies any prior injuries and difficulties of a similar nature. He states that the 'plexiglass' 'hit his hand and wrist' and sustained a laceration. He developed subsequent pain and swelling and weakness, which did not resolve. The initial pain and swelling improved somewhat, but has now actually gotten worse over time." (Petitioner's Exhibit #2).

Dr. Fernandez examined Petitioner's left wrist and noted that he had associated weakness to grip with loss in motion particularly to flexion and with rotation to supination with associated pain. Petitioner complained to Dr. Fernandez of difficulty with heavier portions of his job and climbing ladders, along with left hand numbness and tingling in the index, middle and ring finger with activities involving gripping and grasping. Dr. Fernandez took x-rays of Petitioner's left wrist and hand and found,

> "...these revealed evidence of a relatively recent distal radius fracture with significant dorsal collapse of at least 30-40 degrees with significant for [sic] shortening with prominence of the ulna indicative of ulnocarpal impaction with local degeneration and cysts." (Petitioner's Exhibit #2).

Dr. Fernandez diagnosed Petitioner with a left wrist distal radius fracture malunion with significant ulnar prominence and left wrist carpal tunnel syndrome. Dr. Fernandez also stated, "[w]ithin a reasonable degree of medical and surgical certainty, I believe that [Petitioner's] current condition is work related to his injury of 02/04/13. I also believe that his condition should be treated as work-related and requires further treatment." Dr. Fernandez recommended that Petitioner proceed with two part left wrist surgery. Specifically, Dr. Fernandez recommended a volar approach distal radius osteotomy with application of locking plate and possible distal ulnar excision and carpal tunnel release surgery. Dr. Fernandez also provided Petitioner with work restrictions of limited force, repetition, and use of tools with the left hand of 5-10 pounds and no climbing or going on roofs. (Petitioner's Exhibit #2).

Petitioner testified that he was unable to perform his job because he needed both hands to do his work and he had not returned to work since June 26, 2013.

On November 20, 2103, Dr. Fernandez performed left wrist surgery for Petitioner. The surgery performed was a distal radius osteotomy with application of a volar locking plate and allograft bone grafting with cancellous bone chips, carpal tunnel release, tenolysis of the flexor pollus longus tendon and a brachioradialis tendon release. (Petitioner's Exhibit #5).

Petitioner continued his post-operative care with Dr. Fernandez and performed post-operative occupational therapy, as well as a home exercise program. (Petitioner's Exhibit 2). On February 11, 2014, Dr. Fernandez directed Petitioner to discontinue his formal therapy program and to continue with his home exercise program. Dr. Fernandez also directed Petitioner to begin daily use of a bone stimulator. (Petitioner's Exhibit #2).

On September 9, 2014, Dr. Fernandez determined that Petitioner had healed sufficiently from his first surgery and recommended that he proceed with the second part of the procedure, left wrist ulnar shortening osteotomy. (Petitioner's Exhibit #2).

On January 5, 2015, Dr. Fernandez performed left wrist arthroscopy with partial synovectomy and debridement of chondromalacia, lunotriquetral ligament and triangular fibrocartilage tear and left forearm shortening osteotomy at Gold Coast Surgicenter, L.L.C. (Petitioner's Exhibit #2).

On July 30, 2015, Petitioner returned to see Dr. Fernandez with complaints of continued loss of motion, weakness and pain. Petitioner also indicated that he was unable to engage in heavier activities because of pain. Dr. Fernandez indicated that Petitioner may benefit from proximal row carpectomy or surgery to remove the hardware in his wrist to alleviate pain in the future. In addition, Dr. Fernandez provided Petitioner with permanent work restrictions of 10 pounds of force with no repetitive activity, no climbing, and no significant use of tools or equipment. Dr. Fernandez also placed Petitioner at maximum medical improvement. (Petitioner's Exhibit #2).

On December 11, 2015, Respondent denied Petitioner's request for a light duty accommodation. (Petitioner's Exhibit #6). On December 14, 2015, Respondent directed Petitioner to resign or retire, based on his permanent work restrictions. (Petitioner's Exhibit #6). On December 18, 2015, counsel for Petitioner formally demanded vocational rehabilitation from Respondent. (Petitioner's Exhibit #6).

On October 10, 2016, Charlotte Bishop, a vocational rehabilitation counselor, met with Petitioner and authored a Transferable Skills Analysis. Ms. Bishop concluded that Petitioner had limited transferable skills for jobs within his medical restrictions and the outlook for Petitioner to become gainfully employed was poor. (Respondent's Exhibit #8).

On March 6, 2018, Petitioner returned to see Dr. Fernandez and reported difficulties with heavy activities involving pushing, grasping and twisting. Petitioner complained of numbness and tingling along the left hand ring and small finger with some radiation from the medial elbow. Dr. Fernandez diagnosed Petitioner with possible early cubital tunnel syndrome and residual pain and swelling of the left wrist with weakness. Dr. Fernandez and Petitioner once again discussed surgery to address his symptoms and Petitioner elected to "hold off" for the time being. Dr. Fernandez

recommended that Petitioner obtain an EMG of his upper extremities and continued Petitioner's sedentary to light work restrictions and directed him to return as needed. (Petitioner's Exhibit #2).

On May 23, 2018, Respondent's Section 12 medical examiner, Dr. Michael I. Vender issued a report. Dr. Vender stated that Petitioner sustained a laceration to his left hand on February 4, 2013, indicated that it was not clear to him why an osteotomy of the distal radius was performed for Petitioner, but that the surgery performed on January 7, 2015 was reasonable. Dr. Vender also indicated that it was his opinion that Petitioner's ulnar impaction pre-existed his work injury and that his current complaints were consistent with pre-existent degenerative arthritis. (Respondent's Exhibit #6).

On August 30, 2018, Petitioner was examined by Dr. Fernandez for the final time prior to hearing. Petitioner continued to complain of numbness and tingling in the left elbow and wrist. Once again, Dr. Fernandez diagnosed Petitioner with left hand numbness and tingling and left wrist residual pain and swelling. The doctor recommended that Petitioner obtain an EMG of his upper extremities and continued his permanent work restrictions. In addition, Dr. Fernandez specifically stated,

> "[i]t is my opinion with reasonable degree of medical and surgical certainty that his neurological condition and the need for treatment is related to the work injury. It is due to the fact that he had wrist injury requiring significant surgery and that this could cause or contribute to local swelling and thickening and subsequent neuropathy." (Petitioner's Exhibit #2).

On February 12, 2019, Dr. Vender authored an additional report. Dr. Vender reviewed the x-ray films that were performed on February 4, 2013. Dr. Vender stated that the x-rays represented "the residuals of a previous distal radius fracture" resulting in a malunion including radial shortening and dorsiflexion of the distal radius articular surface. Dr. Vender opined that the findings on the x-rays were not related to Petitioner's work injury on February 4, 2013. (Respondent's Exhibit #7).

Petitioner and Petitioner's wife, Antonia Hondros testified that the only injury Petitioner ever sustained to his left hand or wrist was his work accident on February 4, 2013. In addition, Petitioner testified that he has not returned to work in any capacity since June 26, 2013.

CONCLUSIONS:

In Support of the Arbitrator's Decision relating to (F.), Is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds and concludes as follows:

The Arbitrator finds that Petitioner's current condition of ill-being, as it relates to his left hand and wrist, is causally related to his work injury on February 4, 2013.

The Findings of Fact, as stated above, are adopted herein. On February 4, 2013, x-rays were taken in the emergency department at Provena Saint Joseph Hospital. Dr. Fernandez reviewed the x-ray report from the emergency department and compared them to the x-rays he took during Petitioner's first visit on June 26, 2013. Dr. Fernandez testified that, "...likely those x-rays looked very

similar to the emergency room meaning that those findings are not necessarily acute in nature." (Petitioner's Exhibit #3, p. 15). In addition, the x-ray films were reviewed by Dr. Vender who stated, "[t]he x-rays do not demonstrate an acute or new fracture." (Respondent's Exhibit #7).

Based on the foregoing, the Arbitrator finds that there is a medical agreement between Dr. Fernandez and Dr. Vender that the malunion in Petitioner's left wrist pre-existed his work accident on February 4, 2103.

The Arbitrator notes that in preexisting condition cases, recovery will depend on the employee's ability to show that a work-related accidental injury aggravated or accelerated the preexisting disease such that the employee's current condition of ill-being can be said to have been causally-connected to the work related injury and not simply the result of a normal degenerative process of the pre-existing condition. Sisbro, Inc. v. Industrial Commission, 207 Ill. 2d 193, 204 (2003).

In the instant case, while it is clear that Petitioner had preexisting degenerative changes and a malunion of a distal radius fracture in his left wrist that pre-dated his work accident on February 4, 2013, it is equally clear that the his work injury was a causative factor in his increased left hand and wrist symptoms, his inability to work, and his need for left wrist surgery on November 20, 2013 and January 7, 2015. In addition, his work accident is a causative factor in Petitioner's inability to return to work since June 26, 2013.

In support of this finding, the Arbitrator notes that both Petitioner and his wife testified that the only injury Petitioner sustained to his left wrist was his work accident on February 4, 2013. Petitioner was working full duty and had never had problems with his left wrist prior to that work accident. It is also clear from the medical records on the date of Petitioner's work accident and the scar on Petitioner's left wrist that he suffered a significant trauma to his left wrist and hand on February 4, 2013.

It is this proof of good health and absence of any evidence of problems with his left hand and wrist prior to February 4, 2013, in conjunction with a significant change in the condition of his left hand and wrist following his work accident upon which Dr. Fernandez bases his opinion regarding causal connection. Specifically, the Arbitrator notes that Dr. Fernandez testified that, "...the mechanism of injury, the temporal relationship of what brought him to those symptoms all seemed reasonable and it seemed to line up with causality." (Petitioner's Exhibit #3, p. 13).
Dr. Fernandez went on to explain,

> "...my impression was that he was doing well, wasn't having any significant complaints, wasn't having any significant treatment for his wrist and hand until the work accident happened. He had a work accident, mechanism being impact with a laceration, then he had subsequent pain and dysfunction that continued and didn't get better. So when I saw him he had findings indicative of impaction with a distal radius malunion. Clearly based on the radiographs from the ER, it looked like he had that walking into the ER, but it wasn't symptomatic or at least significantly symptomatic, So my opinion is that he aggravated a radius malunion with ulnar impaction that wasn't symptomatic or significantly symptomatic." (Petitioner's Exhibit #3, p. 18).

The Arbitrator finds that while Respondent's Section 12 medical examiner, Dr. Vender, opines that Petitioner's current condition is due to degenerative changes that pre-existed Petitioner's work accident on February 4, 2013, he fails to address whether Petitioner's work accident could have aggravated Petitioner's pre-existing condition. (Respondent's Exhibits #6 & #7).

In addition, the Arbitrator notes that Dr. Vender did not examine Petitioner, failed to identify any medical record or other evidence that demonstrates that Petitioner had left hand or wrist symptoms prior to February 4, 2013, and failed to review *any* of Petitioner's medical records from Dr. Fernandez from June 26, 2013 through March 11, 2014, when authoring his first report. (Respondent's Exhibit #6). For these reasons, the Arbitrator does not afford the opinion of Dr. Vender much weight. Further, the Arbitrator notes that Dr. Fernandez directly addresses the opinions of Dr. Vender regarding causation. Dr. Fernandez testified,

> "...there's no evidence that he had symptoms or problems before that. He was working full duty, he wasn't having treatment for those conditions. It wasn't until after the accident that he had problems requiring treatment. So what Vender is saying is that he had these findings or he had this condition before the accident. He had radiographic findings, that's true. In other words, the day he presented for the injury he had evidence of a malunion meaning it wasn't a fresh fracture. He had evidence of ulnar impaction. But so do a lot of people and they don't have symptoms, they don't have pain, they don't have problems, they don't have dysfunction. So I agree with Vender's assertion that he had those radiographic findings when he presented and likely had it beforehand. My assertion is not that the radius fracture occurred with that injury. I've never said that, and Vender is alluding to that in his report. My assertion is that the work injury aggravated that condition." (Petitioner's Exhibit #3, p. 37).

For the reasons cited above, the Arbitrator finds the opinions of Dr. Fernandez more persuasive than the opinions of Dr. Vender. Accordingly, the Arbitrator finds that Petitioner aggravated a previously asymptomatic distal radius malunion at the time of his work accident on February 4, 2013. Therefore, the Arbitrator finds that Petitioner has proved, by a preponderance of the evidence, that the condition of ill-being with respect to his left hand and wrist is causally connected to his work injury on February 4, 2013.

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

The Arbitrator finds that the Petitioner was temporarily totally disabled from February 5, 2013 through February 6, 2013 and from June 26, 2013 through July 30, 2015, a period of 109 3/7 weeks. In addition, the Arbitrator finds that Petitioner is entitled to maintenance benefits from July 31, 2015 through the date of hearing, March 12, 2019, a period of 188 4/7 weeks, pursuant to Section 8(a) of the Act.

The Findings of Fact and Conclusions of Law, as stated above, are adopted herein. The Arbitrator notes that Petitioner was examined in the emergency department at Provena Saint Joseph Hospital on February 4, 2013. At that time, he was directed to remain off work for 2 days. (Petitioner's Exhibit #1).

Petitioner then returned to work on February 7, 2013 and worked full duty until June 26, 2013, at which time Dr. Fernandez provided Petitioner with work restrictions of limited force, repetition, and use of tools with the left hand of 5-10 pounds and no climbing or going on roofs. (Petitioner's Exhibit #2). Petitioner testified that he was unable to perform his job with the work restrictions provided by Dr. Fernandez. In addition, the Arbitrator notes that Respondent did not offer any evidence that light duty work was offered to Petitioner.

Dr. Fernandez continued Petitioner's light duty work restrictions from June 26, 2013 until he placed him at maximum medical improvement on July 30, 2015. (Petitioner's Exhibit #2).

Based on the foregoing, the Petitioner has proved, by a preponderance of the evidence, that he was Temporarily Totally Disabled from February 5, 2013 through February 6, 2013 and from June 26, 2013 through July 30, 2015, a period of 109 3/7 weeks.

The Arbitrator also finds that Petitioner is entitled to maintenance benefits from July 31, 2013 through the date of hearing, March 12, 2019.

The Arbitrator notes that on July 30, 2015, Dr. Fernandez placed Petitioner at maximum medical improvement with a 10 pound force restriction and no repetitive work. Dr. Fernandez also indicated that Petitioner should not perform climbing and cannot engage in significant use of tools or equipment including cleaning or lifting materials. (Petitioner's Exhibit #2).

The Arbitrator notes that Respondent has not offered any evidence to dispute Petitioner's permanent work restrictions. In addition, on December 11, 2015, Respondent denied Petitioner's request for a light duty accommodation. On December 14, 2015, Respondent directed Petitioner to resign or retire, based on his permanent work restrictions. Further, on December 18, 2015, counsel for Petitioner formally demanded vocational rehabilitation from Respondent. (Petitioner's Exhibit #6). Despite Petitioner's request for vocational rehabilitation, none has been provided by Respondent.

On October 10, 2016, Charlotte Bishop, a vocational rehabilitation counselor retained by Respondent, met with Petitioner and authored a Transferable Skills Analysis. Ms. Bishop concluded that Petitioner had limited transferable skills for jobs within his medical restrictions and the outlook for Petitioner to become gainfully employed was poor. (Respondent's Exhibit #8).

Based on the foregoing, the Arbitrator finds that Petitioner has proved, by a preponderance of the evidence, that he is entitled to maintenance benefits, pursuant to Section 8(a) of the Act, from July 31, 2015 through the date of hearing, March 12, 2019, a period of 188 4/7 weeks.

In Support of the Arbitrator's Decision relating to (L.), What is the nature and extent of the injury, the Arbitrator finds and concludes as follows:

The Arbitrator finds that Petitioner is permanently and totally disabled as a result of his work injury, effective March 12, 2019. Therefore, the Arbitrator finds that Respondent shall pay Petitioner permanent and total disability benefits of $1,124.44 per week for life, commencing March 12, 2019, as provided in Section 8(f) of the Act.

The Findings of Fact and Conclusions of Law, as stated above, are adopted herein. In support of his decision, the Arbitrator adopts the opinion of Charlotte Bishop, the vocational rehabilitation counselor retained by Respondent. Ms. Bishop met with Petitioner and reviewed his training education and background. In addition, Ms. Bishop considered Petitioner's permanent work restrictions, as provided by Dr. Fernandez. Ms. Bishop concluded that Petitioner had limited transferable skills for jobs within his medical restrictions and the outlook for Petitioner to become gainfully employed was poor. Ms. Bishop also specifically noted that, prior to his work injury, Petitioner did not plan to retire. (Respondent's Exhibit #8).

The Arbitrator also notes that, at the time of hearing, Petitioner was 83 years of age. The Arbitrator finds it unreasonable to expect that Petitioner will be able to secure alternative work within his permanent restrictions given his advanced age. For that reason, the Arbitrator finds that Petitioner falls within the "odd lot" category of permanent total disability.

Based on the foregoing, the Arbitrator finds that Petitioner has proved, by a preponderance of the evidence that he is permanently and totally disabled as a result of his work injury, effective March 12, 2019.

STATE OF ILLINOIS)
) SS.
COUNTY OF JEFFERSON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

KEVIN NORRIS,

Petitioner,

vs. NO: 17 WC 31437

ALLIANCE COAL-HAMILTON COUNTY MINE,

Respondent.

20IWCC0050

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by Respondent herein and notice given to all parties, the Commission, after considering the issues of temporary total disability, medical expenses and prospective medical, 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 7, 2019, 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.

SOTHCC0020

20IWCC0050

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: JAN 23 2020
KAD/mav
O: 12/3/19
42

Kathryn A. Doerries

Thomas J. Tyrrell

Maria E. Portela

Document

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

NORRIS, KEVIN
Employee/Petitioner

Case# **17WC031437**

ALLIANCE COAL-HAMILTON COUNTY MINE
Employer/Respondent

20IWCC0050

On 5/7/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.38% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in 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 RICH RICH & COOKSEY PC
THOMAS C RICH
6 EXECUTIVE DR SUITE 3
FAIRVIEW HTS, IL 62208

0693 FEIRICH MAGER GREEN RYAN
D BRIAN SMITH
2001 W MAIN ST PO BOX 1570
CARBONDALE, IL 62903

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)

Kevin Norris
Employee/Petitioner

v.

Alliance Coal - Hamilton County Mine
Employer/Respondent

Case # 17 WC 31437

Consolidated cases: n/a

20IWCC0050

An *Application for Adjustment 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 Mt. Vernon, on March 7, 2019. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ 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, September 12, 2017, Respondent was operating under and subject 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 $68,785.81; the average weekly wage was $1,372.80.

On the date of accident, Petitioner was 29 years of age, single with 2 dependent child(ren).

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

Respondent shall be given a credit of $47,091.08 for TTD, $0.00 for TPD, $0.00 for maintenance, and $0.00 for other benefits, for a total credit of $47,091.08.

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 for medical treatment provided to Petitioner, as identified in Petitioner's Exhibit 1, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit of amounts paid for medical benefits that have been paid and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall authorize and pay for prospective medical treatment including, but not limited to, the shoulder surgeries as recommended by Dr. George Paletta.

Respondent shall pay Petitioner temporary total disability benefits of $915.20 per week for 51 1/7 weeks commencing October 26, 2017, through April 1, 2018, and April 4, 2018, through October 22, 2018, as provided in Section 8(b) of the Act.

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

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

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

William R. Gallagher, Arbitrator
ICArbDec19(b)

May 3, 2019
Date

MAY 7 - 2019

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged he sustained an accidental injury arising out of and in the course of his employment by Respondent on September 12, 2017. According to the Application, Petitioner sustained an injury to the "Person as a whole" when a "Boulder fell from roof" (Arbitrator's Exhibit 2). This case was tried in a 19(b) proceeding and Petitioner sought an order for payment of medical bills and temporary total disability benefits as well as prospective medical treatment. In regard to temporary total disability benefits, Petitioner claimed he was entitled to temporary total disability benefits of 51 1/7 weeks, commencing October 26, 2017, through April 1, 2018, and April 4, 2018, through October 22, 2018. Respondent agreed Petitioner was temporarily totally disabled for five and one-sevenths (5 1/7) weeks, commencing October 26, 2017, through December 1, 2017, but disputed liability for the remaining 46 weeks. In regard to prospective medical treatment, the medical treatment sought by Petitioner was shoulder surgery as recommended by Dr. George Paletta. Respondent stipulated Petitioner sustained a work-related accident on September 12, 2017, but disputed liability on the basis of causal relationship as well as the reasonableness and necessity of both past and prospective medical treatment (Arbitrator's Exhibit 1).

Petitioner worked for Respondent as a coal miner. On September 12, 2017, Petitioner was down on all fours (hands/knees) when a rock fell from the ceiling striking him in the back of the head. Petitioner reported the accident to Respondent and an Event Report Form was completed. In this report, Petitioner identified the injured anatomical areas as being the head, neck and upper back (Respondent's Exhibit 9).

Following the accident Petitioner was evaluated by Dr. James Goris, an orthopedic surgeon. Dr. Goris initially saw Petitioner on September 19, 2017. At that time, Petitioner had numerous complaints including pain in the back of the neck, upper back with radiation into both shoulders and arms as well as numbness/tingling in both hands, stiffness, weakness, popping/catching and a limited range of motion. Dr. Goris opined Petitioner had sustained a contusion and strain of the left and right trapezius muscles. He prescribed medication and imposed work/activity restrictions (Petitioner's Exhibit 3).

Dr. Goris saw Petitioner on September 26, 2017. At that time, Petitioner's primary complaint was neck and upper back pain with numbness/tingling down the arm (the record did not specify right or left). Because of Petitioner's ongoing symptoms, Dr. Goris ordered an MRI scan of the cervical spine (Petitioner's Exhibit 3).

The MRI was performed on October 5, 2017. According to the radiologist, the MRI revealed minor degenerative changes at C5-C6 (Petitioner's Exhibit 6).

Petitioner was seen by Dr. Goris on October 9, 2017, and Dr. Goris reviewed the MRI scan. He opined it did not reveal any acute injury and advised Petitioner to participate in a cervical rehabilitation program (Petitioner's Exhibit 3).

Petitioner was again seen by Dr. Goris on October 30, 2017. Petitioner continued to complain of upper back pain. Dr. Goris noted that an MRI scan of Petitioner's thoracic spine had been

performed on October 18, 2017, which did not reveal any abnormalities. He reaffirmed his diagnosis of a contusion and strain of the left and right trapezius muscles. Dr. Goris ordered EMG/nerve conduction studies of Petitioner's right upper extremity (Petitioner's Exhibit 3).

EMG/nerve conduction studies of both the right and left upper extremities were performed on November 1, 2017. The studies were abnormal in regard to both the right and left median nerves. Dr. Goris saw Petitioner that same day and reviewed the diagnostic studies. He opined Petitioner sustained strains of both shoulders and upper arms, as well as a contusion to the back. He recommended referral to a pain management specialist for consideration of injection treatment (Petitioner's Exhibit 3).

At the direction of Respondent, Petitioner was examined by Dr. Russell Cantrell, a physical medicine/rehabilitation specialist, on December 11, 2017. In connection with his examination of Petitioner, Dr. Cantrell reviewed medical records and the MRI films which were provided to him by Respondent. When examined by Dr. Cantrell, Petitioner continued to complain of neck and upper back symptoms which were worsened with movement of both shoulders. Petitioner also complained of numbness/tingling in both hands. On examination, Petitioner complained of pain in the neck with side bending on both the right and left. Petitioner also had some restriction of the range of motion of both shoulders. Dr. Cantrell reviewed the MRI of Petitioner's cervical spine and noted it revealed degenerative changes at C5-C6 (Respondent's Exhibit 1).

Dr. Cantrell opined the findings he noted in Petitioner's cervical spine MRI were degenerative and were neither caused nor aggravated by the accident. He also opined the electrode diagnostic studies did not reveal any cervical radiculopathy. He diagnosed Petitioner with cervical and thoracic myofascial pain and recommended Petitioner receive three additional weeks of physical therapy. Upon completion of the physical therapy, Dr. Cantrell anticipated Petitioner would be at MMI. He saw no basis for referring Petitioner to pain management or injection therapy (Respondent's Exhibit 1).

Petitioner was evaluated by Dr. Matthew Gornet, an orthopedic surgeon, on January 20, 2018. At that time, Petitioner complained of severe neck pain, pain in both traps/shoulders, pain down the arms to the elbows, forearms and hands with numbness/tingling between his shoulder blades. Dr. Gornet noted he previously saw Petitioner in 2011 for neck and upper back pain following a motor vehicle accident. However, Dr. Gornet only saw Petitioner on one occasion and released him from care. Petitioner denied any significant neck symptoms prior to the accident and had been working full duty. On examination, Petitioner's range of motion of the neck was severely restricted, in particular with right and left rotation. Dr. Gornet reviewed the MRIs of Petitioner's cervical and thoracic spine and described both of them as being of "moderate quality." In regard to the MRI of the cervical spine, Dr. Gornet opined there was a strong suggestion of a disk injury at C5-C6 with a central disc protrusion. Dr. Gornet ordered a high resolution MRI of Petitioner's cervical spine and imposed work/activity restrictions (Petitioner's Exhibit 7).

The MRI was performed on January 20, 2018. According to the radiologist, it revealed a central left foraminal protrusion and central annular tear at C5-C6, a central annular tear at C6-C7 without significant disc bulge or protrusion and a right foraminal disc protrusion at C3-C4 (Petitioner's Exhibit 8).

Dr. Gornet saw Petitioner after the MRI was performed and opined it revealed disc injuries at C5-C6 and C6-C7 with large annular tears that were either not observed because of motion or poor quality of the prior film. He referred Petitioner to Dr. Kaylea Boutwell for injections at C5-C6 and C6-C7 (Petitioner's Exhibit 7).

Petitioner was seen by Dr. Boutwell on February 8, 2018, and she administered an epidural injection at C5-C6. Petitioner was again seen by Dr. Boutwell on March 1, 2018, and she administered an epidural injection at C6-C7 (Petitioner's Exhibit 9).

Dr. Gornet saw Petitioner on March 26, 2018. At that time, Petitioner advised the injections had given him temporary relief, but the symptoms were returning. However, Petitioner wanted to attempt to return to work and Dr. Gornet gave him a full duty release. Dr. Gornet noted that if Petitioner's symptoms flared up again, he would return Petitioner to light duty work and proceed with surgery (Petitioner's Exhibit 7).

Petitioner attempted to return to work at full duty; however, when he did so, he had to shovel for eight hours a day. Petitioner contacted Dr. Gornet's office by telephone on April 4, 2018, and advised the symptoms had increased since he had returned to work. Light duty restrictions were reinstated at that time (Petitioner's Exhibit 7).

Dr. Gornet saw Petitioner on May 7, 2018, and Petitioner continued to complain of neck pain and pain in both traps/shoulders with numbness/tingling. At that time, Dr. Gornet recommended Petitioner undergo disc replacement surgery at C5-C6 and C6-C7. Because of Petitioner's continued shoulder symptoms, Dr. Gornet referred Petitioner to Dr. George Paletta, an orthopedic surgeon associated with Dr. Gornet (Petitioner's Exhibit 7).

Dr. Paletta evaluated Petitioner on May 7, 2018, in regard to his shoulders. When seen by Dr. Paletta, Petitioner complained of pain in both shoulders extending down the arms below the elbows as well as numbness in the hands. On examination, Dr. Paletta noted tenderness with palpation at the AC joints. Dr. Paletta opined Petitioner had bilateral shoulder symptoms likely of cervical origin and AC joint pain. He ordered MRI scans of Petitioner's shoulders, but opined Petitioner should proceed with the cervical disc replacement surgery as recommended by Dr. Gornet (Petitioner's Exhibit 11).

MRIs of both shoulders were performed on May 11, 2018. In regard to the MRI of the right shoulder, the radiologist opined it revealed supraspinatus insertional tendinopathy, acromioclavicular osteoarthrosis and acromioclavicular undersurface hypertrophy resulting in mild supraspinatus, myotendinous compression. In regard to the MRI of the left shoulder, the radiologist opined it revealed supraspinatus and infraspinatus insertional tendinopathy and acromioclavicular osteoarthrosis resulting in supraspinatus myotendinous compression (Petitioner's Exhibit 8).

Dr. Paletta reviewed the MRI scans and his interpretation was consistent with that of the radiologist. He also noted degenerative changes of both AC joints, more on the right than left. He recommended Petitioner undergo an injection in the right AC joint (Petitioner's Exhibit 11).

On May 29, 2018, Dr. Gornet performed disc replacement surgery at C5-C6 and C6-C7. Dr. Gornet subsequently saw Petitioner on June 11, 2018, and Petitioner's neck pain and radiating pain in the traps/shoulders had improved as well as the numbness/tingling. However, Petitioner continued to have shoulder pain for which he was being seen by Dr. Paletta (Petitioner's Exhibit 7).

Petitioner was again seen by Dr. Gornet on July 9, 2018. Petitioner's neck symptoms continued to improve; however, Petitioner still had bilateral shoulder symptoms. Dr. Gornet opined Petitioner could return to work without restrictions in regard to his cervical spine (Petitioner's Exhibit 7).

On July 9, 2018, Petitioner was seen by Dr. Helen Blake (referred by Dr. Paletta). Dr. Blake administered a right AC joint injection (Petitioner's Exhibit 14).

Dr. Paletta saw Petitioner on September 10, 2018, and Petitioner advised the injection that was performed on July 9, 2018, did not give him any relief of his symptoms. Petitioner continued to complain of bilateral pain referable to the AC joints. Dr. Paletta recommended Petitioner defer any further treatment in regard to the shoulders until he was determined to be at MMI for the cervical spine (Petitioner's Exhibit 7).

At the direction of Respondent, Dr. Michael Treister, an orthopedic surgeon, conducted a review of Petitioner's medical records/reports. Dr. Treister's report dated September 12, 2018, was received into evidence at trial. Dr. Treister was asked to opine as to whether the cervical spine MRI performed on January 20, 2018, the epidural injections performed on February 8, and March 1, 2018, and the cervical disc replacement surgery of May 29, 2018, were medically necessary and reasonable procedures. In addition to his review of the medical records, Dr. Treister also spoke to Dr. Gornet by telephone (Respondent's Exhibit 5).

In reaching his opinions, Dr. Treister reviewed and relied upon the Official Disability Guidelines (ODG) for epidural steroid injections and disc replacement surgery as well as the recommendation of the manufacturer of the artificial discs. Dr. Treister opined that none of the preceding medical procedures were reasonable and necessary. In regard to the MRI, Dr. Treister noted that an MRI had just been performed three weeks prior and the MRI of January 20, 2018, did not provide any significant additional information. He opined that, pursuant to the ODG, neither of the epidural steroid injections were medically reasonable and necessary because there was no evidence that Petitioner had radicular pain and conservative treatment options had not been exhausted. Dr. Treister also noted that in regard to the second epidural injection, there was insufficient time to determine the extent of pain relief following the first injection. In regard to the cervical disc replacement surgery, Dr. Treister noted that ODG and FDA only approves of disc replacement at one level (Respondent's Exhibit 5).

At the direction of Respondent, Petitioner was examined by Dr. Richard Lehman, an orthopedic surgeon, on October 11, 2018, in regard to his bilateral shoulder condition. In connection with his examination of Petitioner, Dr. Lehman reviewed medical records/reports and diagnostic studies provided to him by Respondent. On examination, the range of motion of both shoulders

was full and there was no evidence of instability. Dr. Lehman opined Petitioner had bilateral degenerative arthritis at the AC joints which was long term and pre-existing. Dr. Lehman opined the mechanics of the injury would not have impacted or exacerbated the pre-existing degenerative arthritis. He also noted there was an eight month gap between the accident and Petitioner having been referred to Dr. Paletta (Respondent's Exhibit 7).

At the direction of Respondent, Dr. Andrew Zelby, a neurosurgeon, conducted a review of Petitioner's medical records/reports and the MRI scans. Dr. Zelby's medical report dated October 17, 2018, was received into evidence at trial. Dr. Zelby opined the cervical MRI scans did not reveal any post traumatic changes and the second MRI of Petitioner's cervical spine was not reasonable and necessary because it provided no useful information in regard to Petitioner's treatment. Dr. Zelby opined Petitioner sustained a soft tissue cervical and thoracic strain as a result of the accident, and after three to four weeks of physical therapy, Petitioner was at MMI. He also opined the epidural injections and disc replacement surgery were not medically necessary (Respondent's Exhibit 3).

Dr. Cantrell was deposed on October 18, 2018, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Cantrell's testimony was consistent with his medical report and he reaffirmed the opinions contained therein. In regard to causality, Dr. Cantrell testified the accident did not cause or aggravate Petitioner's degenerative conditions in the cervical spine. This opinion was based, in large part, on the lack of any radiculopathy in the C6 nerve distribution (Respondent's Exhibit 1; pp 13-14).

On cross-examination, Dr. Cantrell stated he did not have Petitioner's medical records and diagnostic tests for the last nine months of Petitioner's treatment. Dr. Cantrell agreed he could not comment on any treatment Petitioner received after he was seen by him, but could comment on Petitioner's condition at the time he examined him (Respondent's Exhibit 1; pp 21-22).

Dr. Treister was deposed on October 24, 2018, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Treister's testimony was consistent with his medical report and he reaffirmed the opinions contained therein. Dr. Treister testified the physical findings described by Dr. Gornet did not correlate to any of Petitioner's cervical spine. Dr. Treister stated the MRI of October 5, 2017, did not reveal a disc injury at C5-C6. He opined the MRI of January 20, 2018, revealed a very small annular tear at C5-C6, but he did not see a significant disc injury. Based on the preceding, Dr. Treister stated the MRI of January 20, 2018, was not medically reasonable and necessary. He also testified the epidural steroid injections were not medically reasonable and necessary because there was no evidence of bilateral cervical radiculopathy as well as the ODG (Respondent's Exhibit 6; pp 22-29).

In regard to the two level cervical disc replacement surgery, Dr. Treister testified this was also not medically reasonable and necessary. This was based on his opinion that Petitioner's pain complaints were, in fact, not correlated to the cervical spine. He also noted the lack of pathology at both levels of the cervical spine when the surgery was performed, the ODG and the lack of FDA approval for disc replacement surgery at more than one level (Respondent's Exhibit 6; pp 34-42).

On cross-examination, Dr. Treister agreed that, pursuant to the ODG, any disc replacement surgery for more than one level would be automatically noncertified. He also agreed that the FDA does not regulate the practice of medicine (Respondent's Exhibit 6; pp 49-51, 80).

Dr. Zelby was deposed on November 19, 2018, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Zelby's testimony was consistent with his medical report and he reaffirmed the opinions contained therein. Dr. Zelby testified Petitioner was at MMI as of December, 2017, and that all of the treatment Petitioner received thereafter was not causally related to the accident and was not medically reasonable and necessary. Dr. Zelby reviewed the MRI scans of Petitioner's cervical spine and testified he disagreed with Dr. Gornet's interpretation of the scan of January 20, 2018, and stated that while it revealed annular tears in the cervical spine, they were chronic and not post traumatic (Respondent's Exhibit 4; pp 15-19).

On cross-examination, Dr. Zelby agreed that Petitioner being struck in the back of the head could "hypothetically" cause disc injuries or aggravate pre-existing pathology in his neck. While Dr. Zelby opined there was no difference between the MRIs of Petitioner's cervical spine, he did not review the radiologist reports of these diagnostic studies (Respondent's Exhibit 4; pp 43-47).

Petitioner was evaluated by Dr. Gornet on December 10, 2018. At that time, most of Petitioner's neck symptoms had resolved, but he continued to have bilateral shoulder symptoms, more on the right than left. Dr. Gornet opined Petitioner's current symptoms were not related to his cervical spine and opined Petitioner was at MMI in regard to the cervical spine. He also again stated Petitioner could return to work without restrictions in regard to the neck (Petitioner's Exhibit 7).

Dr. Paletta saw Petitioner on December 10, 2018, and Petitioner continued to complain of pain referable to both AC joints. Dr. Paletta noted that the neck surgery had resolved Petitioner's neck symptoms, but had no effect on Petitioner's bilateral shoulder complaints. He recommended Petitioner either undergo injections in both AC joints or undergo arthroscopic surgery with distal clavicle excisions (Petitioner's Exhibit 11).

Petitioner's counsel provided a copy of Dr. Lehman's report to Dr. Paletta. Dr. Paletta prepared a report dated January 24, 2019, wherein he commented on Dr. Lehman's report. In regard to the eight month gap in treatment, Dr. Paletta noted that during this time, Petitioner was receiving medical treatment and it was not as though Petitioner had no symptoms at all referable to his shoulders. He also noted that Dr. Lehman commented that the injection did not provide any relief; however, Dr. Paletta noted that the purpose of the injection was to confirm the source of Petitioner's pain and to provide relief. While the injection did not provide relief, it was positive from a diagnostic point of view because it identified the source of Petitioner's pain as being the AC joints (Petitioner's Exhibit 11).

Dr. Gornet was deposed on January 24, 2019, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Gornet's testimony was consistent with his medical records and he reaffirmed the opinions contained therein. Dr. Gornet testified Petitioner had axial neck pain and the MRI of January 20, 2018, revealed disc injuries at C5-C6 and C6-C7. Dr. Gornet testified he performed disc replacement surgery at those levels on May 29, 2018, and

subsequently released Petitioner to return to work at full duty in regard to his cervical spine (Petitioner's Exhibit 15; pp 16-29, 34).

Dr. Gornet was also questioned about the ODG and he stated that they are not considered authoritative. The guidelines do not regulate the practice of medicine and he noted that they do not allow for anything more than a single level disc replacement surgery (Petitioner's Exhibit 15; pp 37-39).

At trial, Petitioner testified he continues to have bilateral shoulder pain. He wants to proceed with the treatment as recommended by Dr. Paletta.

Conclusions of Law

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

The Arbitrator concludes Petitioner's current condition of ill-being is causally related to the accident of September 12, 2017.

In support of this conclusion the Arbitrator notes the following:

There was no dispute Petitioner sustained a work-related injury on September 12, 2017, when a rock fell from the ceiling striking him in the back of the head.

Petitioner previously sought treatment for neck and upper back pain in 2011 from Dr. Matthew Gornet; however, he only saw Dr. Gornet on one occasion and was released. There was no evidence of Petitioner had any ongoing neck or shoulder complaints prior to the accident of September 12, 2017.

Petitioner had complaints referable to the neck and both shoulders when evaluated by Dr. Goris on September 19, 2017. Dr. Goris subsequently diagnosed Petitioner has having sustained strains of both shoulders when he saw him on November 1, 2017. It was not clear whether Petitioner's bilateral shoulder complaints were, in fact, distinct from his neck complaints until after Petitioner had undergone cervical disc replacement surgery, recovered from that procedure and was found to be at MMI and released to return to work without restrictions.

Based upon the preceding, Respondent's position that Petitioner did not seek medical treatment for his bilateral shoulder symptoms until eight months post injury is contrary to the medical evidence.

While Petitioner had pre-existing degenerative changes in both the cervical spine and AC joints, Petitioner did not have any symptoms referable to both areas of the anatomy until after the accident of September 12, 2017.

Dr. Gornet opined Petitioner sustained disc injuries at C5-C6 and C6-C7 and performed disc replacement surgery at those levels, after which, most of Petitioner's neck complaints resolved.

Respondent's Section 12 examiner, Dr. Cantrell, saw Petitioner on December 11, 2017, which was prior to Petitioner being treated by Dr. Gornet. Dr. Cantrell did not have the benefit of examining Petitioner subsequent to the disc replacement surgery and did not review any of the medical records for treatment Petitioner received subsequent to his examination. The Arbitrator finds Dr. Cantrell's opinions to be of minimal probative value.

Neither Dr. Treister nor Dr. Zelby examined Petitioner and only reviewed medical records and diagnostic tests. While both Dr. Treister and Dr. Zelby opined Petitioner had sustained just a cervical/thoracic strain, neither were able to provide an explanation for Petitioner's continued neck complaints and the fact that the cervical disc replacement surgery performed by Dr. Gornet resulted in an almost complete resolution of same.

Once Petitioner was released to return to work without restrictions and found to be at MMI in regard to his neck, Dr. Paletta noted Petitioner had continued symptoms referable to both AC joints. In noting his disagreement with Dr. Lehman's opinion regarding causality, Dr. Paletta noted Petitioner had no symptoms referable to his shoulders prior to the accident and the injection confirmed the AC joint was the source of Petitioner's pain symptoms.

Based upon the preceding, the Arbitrator finds the opinions of Dr. Gornet and Dr. Paletta to be more persuasive than those of Dr. Cantrell, Dr. Zelby, Dr. Treister and 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 Respondent is liable for payment of the medical bills incurred therewith.

Respondent shall pay reasonable and necessary medical services as identified in Petitioner's Exhibit 1, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit of amounts paid for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

In support of this conclusion the Arbitrator notes the following:

As noted in disputed issue (F) the Arbitrator found the opinions of Dr. Gornet and Dr. Paletta to be more persuasive than those of Dr. Cantrell, Dr. Zelby, Dr. Treister and Dr. Lehman.

The Arbitrator is not persuaded by Dr. Treister's reliance on the ODG for treatment. Those guidelines do not regulate the practice of medicine and, further, exclude any disc replacement surgeries that involve more than one level.

The Arbitrator is likewise not persuaded by Dr. Treister's reliance on the FDA guidelines because they do not regulate the practice of medicine.

Dr. Treister and Dr. Zelby were, in effect, attempting to determine the reasonableness and necessity of medical treatment after the treatment had been provided. In spite of the fact that

Petitioner achieved a positive surgical result, Dr. Treister and Dr. Zelby attempted to second-guess treatment decisions made by Petitioner's treating physicians.

The fact that Dr. Gornet's cervical disc replacement surgery was reasonable and necessary is amplified by the fact that following surgery, Petitioner had an almost complete resolution of his neck symptoms.

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

The Arbitrator concludes Petitioner's entitled to prospective medical treatment including, but not limited to, the bilateral shoulder surgeries as recommended by Dr. Paletta.

In support of this conclusion the Arbitrator notes the following:

As noted herein, Petitioner continued to have bilateral shoulder complaints after he was found to be at MMI and released to return to work without restrictions in regard to his neck. Dr. Paletta has recommended additional medical treatment.

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

The Arbitrator concludes Petitioner is entitled to temporary total disability benefits of 51 1/7 weeks commencing October 26, 2017, through April 1, 2018, and April 4, 2018, through October 22, 2018.

In support of this conclusion the Arbitrator notes the following:

Petitioner was authorized to be off work and under active medical treatment during the aforestated periods of time.

William R. Gallagher, Arbitrator

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

LEONARD LUDTKE,

Petitioner,

vs.

NO: 16 WC 009295
19 IWCC 712

COUNTY OF DeKALB,

Respondent.

ORDER OF RECALL OF CORRECTED DECISION UNDER SECTION 19(f)

Pursuant to Section 19(f) of the Act, the Commission, *sua sponte*, finds that a clerical error exists in the Corrected Decision and Opinion on Review dated January 16, 2020, in the above captioned matter, mistakenly naming Respondent as the party filing the Motion for a Corrected Decision.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Corrected Decision and Opinion on Review dated January 16, 2020 is hereby vacated and recalled pursuant to Section 19(f) for a clerical error contained therein.

IT IS FURTHER ORDERED BY THE COMMISSION that a Second Corrected Decision and Opinion on Review shall be issued simultaneously with this Order.

DATED: JAN 24 2020
o: 12/19/19
BNF/kcb
45

Barbara N. Flores

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 on Accident	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify Choose direction	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

LEONARD LUDTKE,

Petitioner,

vs.

NO: 16 WC 9295
19 IWCC 712

COUNTY OF DeKALB,

Respondent.

SECOND CORRECTED 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, partial permanent disability, and penalties, and being advised of the facts and law, reverses the Decision of the Arbitrator as stated below.

I. FINDINGS OF FACT

A. Background

On December 30, 2015, Petitioner was employed by Respondent as a Maintenance Worker II. Petitioner testified he had been employed by Respondent for approximately 17 years. Petitioner stated his job duties included general maintenance, snow removal, light electrical and plumbing work, and cleaning. Petitioner added that he was available to assist others or fill in for unavailable co-workers. Petitioner was 56 years old at the time of his injury.

On December 30, 2015, Petitioner was generally assigned to the DeKalb County Courthouse. He could not recall how long he had been assigned to the courthouse but estimated it had been a couple of years. Petitioner testified the campus of Respondent in Sycamore, Illinois

included the courthouse at the corner of State and Main, along with the Public Safety Building (commonly known as the jail), the Legislative Center and the Administration Building. According to Petitioner, the jail was across Main Street, directly east of the courthouse, while the Legislative Center and Administrative Building were north of the courthouse. Petitioner described the campus as an L-shape, with the Administration building at the top or furthest north, with the courthouse to the west. Petitioner acknowledged there is metered parking on the public streets surrounding the courthouse.

Petitioner testified that prior to December 30, 2015, there had been a substantial improvement of the courthouse, including an addition to the north side. He later clarified that the improvements were constructed years earlier and there was no ongoing construction. Petitioner stated that after the addition was completed, additional parking was created on the north side of the building, directly adjacent to the addition. He testified that part of the street was taken as in-line parking for the courthouse. He described the parking as angled spaces just off the street, generally reserved for courthouse employees from 8:00 or 8:30 a.m. through 4:30 p.m. Petitioner stated that his department (facilities management) maintained those parking stalls, including snow removal, ice removal, salting and the like.

Petitioner also testified that the public entered the courthouse only through the main entrance on the south side of the building but there were four other entrances available for employees. According to Petitioner, there was a main employee entrance on the north side of the courthouse, as well as entrances at the east side, northwest corner, and the west side. Petitioner stated the employee entrances required entering a code into a keypad.

B. Accident

Petitioner testified that on December 30, 2015, his shift was from 7:00 a.m. to 3:30 p.m. He stated he arrived on the campus that day at approximately 6:45 to 6:50 a.m. Petitioner acknowledged he was not called into work early and was not paid for the time before his shift.

Petitioner testified he parked in one of the spaces on the north side of the courthouse. According to Petitioner, these spaces were reserved for particular employees, including judges. Petitioner stated that other employees generally parked in the main parking lot east of the Legislative Center, but to his knowledge, they were not required to do so.

Petitioner explained that he parked in a space reserved for another county employee to drop off his lunch and coffee; he wanted to avoid carrying it across the campus because he generally ate lunch at the courthouse. He explained that his coffee would have become cold carrying it from the main lot to the Public Safety Building to sign in for work before going to the courthouse. Petitioner stated he typically would deposit his lunch, drive to and park in the main lot, and enter the Public Safety Building to sign in on his time sheet.

Petitioner acknowledged he could have parked elsewhere and was not required to eat lunch at the courthouse. He later added that he had occasionally been telephoned to respond to emergencies while off-site during lunch.

Petitioner testified that after parking, he entered the courthouse through the northwest entrance and dropped off his lunch in the shop area. He stated that while entering the building, he noticed there was a thin layer of ice covering the parking lot, but the sidewalk seemed clear. According to Petitioner, it did not appear that anyone had cleared ice or snow, or salted the parking lot, but he observed ice melt on the sidewalk. Petitioner acknowledged it was icy throughout the city and there was snow around. He also acknowledged that he walked through snow to reach the public sidewalk and his shoes may have become wet.

Petitioner testified that after dropping off his lunch, he exited the building. Petitioner stated that as he was returning to his car, he slipped and fell in the parking area, approximately five or six feet away from his car. He added that his feet came out from under him and he landed heavily on his left shoulder and arm. Petitioner agreed there was no crack or defect in the sidewalk, or anything other than ice that caused him to fall.

According to Petitioner, he experienced extreme pain in his left shoulder and further examination revealed very limited mobility of the arm with extreme pain. Petitioner also testified that prior to his fall, he had never injured or received medical treatment involving his left shoulder and arm. Petitioner testified he notified his supervisor of the incident and drove himself to the emergency room at Kishwaukee Hospital.

C. Medical Treatment

On December 30, 2015, Petitioner presented to the emergency department at Kishwaukee Hospital. The medical records indicate Petitioner informed the staff he was outside at work and slipped on the ice, landing on the left shoulder/humerus; he denied any head injury, neck pain, chest pain, abdominal pain, or syncope. According to the records, two X-rays of the left shoulder showed no fracture, dislocation, focal bony abnormality or degenerative changes. Two X-rays of the left humerus showed similar results. A report on a CT scan of the head indicated no evidence of acute intracranial abnormality. Another report on a CT scan of the cervical spine indicated: no fractures; straightening of the normal cervical lordosis, which may be secondary to patient positioning or can be seen with muscle spasm; and multilevel cervical spondylosis.

Petitioner was diagnosed with a left shoulder contusion, with the notation of no obvious fracture or dislocation. The patient summary report also indicates instructions were given for a shoulder sprain. Petitioner was discharged to home care with instructions for rest, heat, ice and a shoulder sling as needed.

On January 4, 2016, Petitioner was seen at the Midwest Orthopedic Institute by Marcus Roman, assistant to Dr. Tony Choi. After providing a history of the incident, Petitioner

complained of pain with sleeping, especially on the left shoulder. Petitioner also complained of pain with overhead movements. Roman noted Petitioner previously had a right rotator cuff repair performed by Dr. Choi.

Roman's physical examination indicated the range of motion on both shoulders actively was 160/60/T9. Roman noted that on the left, he could forward elevate Petitioner to 160 degrees with a little pain. Strength was 4/5 in forward elevation on the left, 5/5 with external rotation but with pain, and 5/5 with internal rotation. Roman's impression was left shoulder pain, with suspicion of a rotator cuff tear. Roman recommended obtaining an MRI to rule out a rotator cuff tear. Roman also issued a work note stating Petitioner could not return to work.

The MRI of Petitioner's left shoulder was performed on January 7, 2016. The interpreting radiologist's impressions were: (1) complete full-thickness tear supraspinatus tendon and full-thickness tear of the anterior-most infraspinatus tendon with more mild diffuse infraspinatus tendinosis; (2) full-thickness tear of the cephalad 2/3 subscapularis tendon; (3) moderately severe acromioclavicular degenerative change; and (4) moderately large hemarthrosis freely communicating with the subacromial-subdeltoid bursa.

On January 11, 2016, Roman reviewed the MRI results and recommended surgical fixation for Petitioner's acute rotator cuff tears, to which Petitioner agreed. Roman noted that Dr. Choi also reviewed the MRI. On February 5, 2016, Petitioner saw Dr. Choi, whose notes confirm he reviewed the MRI and recommended arthroscopic rotator cuff surgery (as opposed to open surgery).

On February 11, 2016, Dr. Choi performed a left shoulder arthroscopic double row subscapularis repair and supraspinatus repair, subacromial decompression and biceps tenodesis. Dr. Choi's pre- and post-operative diagnoses were the same: left shoulder massive rotator cuff tear supraspinatus, infraspinatus, subscapularis. Petitioner was also referred to Dr. Manav Salwan on this date for post-operative medical management and diabetic management.

On February 12, 2016, Dr. Choi noted Petitioner was doing well and the plan would be to discharge him home. The doctor also noted he was trying to arrange home health therapy, as Petitioner had troubles with transportation due to living alone.

On February 19, 2016, Petitioner followed up with Roman, rating his pain at 1/10 at rest and 6/10 with activity. Petitioner also reported his pain was moderately controlled with Norco. Roman scheduled another visit in a week to remove Petitioner's sutures. Roman noted Petitioner would continue physical therapy and transition from home health to outpatient therapy the next week. Roman also continued Petitioner's use of a sling and abductor wedge. On February 24, 2016, Petitioner began twice-weekly occupational therapy. On February 26, 2016, Roman continued therapy, as well as the sling and abductor wedge, scheduling a visit with Dr. Choi in two weeks.

On March 11, 2016, Petitioner saw Dr. Choi, reporting his physical therapy was going well. Petitioner reported he was not taking Norco most days but would occasionally for neck pain. Dr. Choi noted Petitioner externally rotated passively relatively easy to 45 degrees with forward elevation of approximately 90 degrees. The doctor noted Petitioner was progressing well and removed the abduction portion of the sling. He also scheduled a follow-up visit with Roman in four weeks.

Petitioner saw Roman again on April 8, 2016. The record indicates Petitioner complained of some left shoulder pain at night. Roman's physical examination showed an active range of motion for the left shoulder of 90/45/L5, while the passive range of motion was 140/50/L5. The range of motion for the right shoulder was 170/60/T10. Roman continued Petitioner's physical therapy and ordered a follow-up visit in four weeks.

On May 6, 2016, Petitioner's only complaint to Roman was of left shoulder pain in the mornings, which improved with exercises and extra-strength Tylenol. Roman's examination showed the range of motion of the left shoulder was 150/60/L1, while the right shoulder was 170/60/T10. Petitioner's strength in forward elevation was 4/5, while his strength in internal and external rotation was 5/5. Roman again continued Petitioner's physical therapy and scheduled a visit in four weeks.

On June 3, 2016, Petitioner reported to Roman that he had no change in his shoulder pain, but felt his left shoulder was getting a little stiff. The range of motion and strength measurements were the same as his prior visit. Roman noted that in that morning's therapy, Petitioner only reached 130 degrees in forward elevation, but was able to get to 150 degrees when tested at the clinic. Roman extended Petitioner's physical therapy and scheduled another monthly visit, noting Petitioner would remain off work because there was no light duty work available.

Petitioner saw Dr. Choi on July 1, 2016. The record indicates Petitioner's range of motion for his left shoulder remained the same, but the strength in forward elevation was 4+/5. Dr. Choi noted Petitioner was still weak in forward elevation, but gradually improving. The doctor ordered continued physical therapy, with a follow-up in four weeks.

On July 9, 2016, Petitioner complained to Dr. Choi that earlier in the week, he was exercising during physical therapy and felt a pop in his neck/trapezius region, resulting in soreness around the neck which made it difficult to progress in the protocol. Dr. Choi found Petitioner's range of motion in the left shoulder was 160/60/T11, while strength in forward elevation remained 4+/5. Dr. Choi noted that Petitioner may have strained something and recommended possible deep tissue massage in addition to physical therapy. The doctor also recommended continuing strengthening exercises for endurance.

On August 26, 2016, Petitioner reported some remaining weakness to Dr. Choi, but stated the physical therapy was going well. Dr. Choi's examination found Petitioner's range of motion

in the left shoulder was 160/60/T9, while strength in forward elevation was 5-/5. Dr. Choi noted that Petitioner's residual weakness should improve with further endurance strengthening in physical therapy. The doctor also discussed work with Petitioner, who stated his boss would not let him return until he reached 100 percent. Dr. Choi hoped to return Petitioner to work after another four-week evaluation.

On September 30, 2016, Dr. Choi found Petitioner's range of motion in the left shoulder was 160/60/T9, while strength in forward elevation was 5/5. Dr. Choi noted that Petitioner still had a little endurance-limited weakness but was able to hold against forward elevation for quite some time before he fatigued. As Petitioner was not experiencing pain and his strength was near normal, Dr. Choi believed he would advance Petitioner to full-duty work and consider placing him at MMI in four weeks.

Petitioner last visited Dr. Choi on October 28, 2016. Petitioner's range of motion in the left shoulder and strength in forward elevation remained the same. Dr. Choi noted he sent Petitioner back to work after the prior visit and Petitioner reported tolerating it well, with little to no discomfort. Dr. Choi placed Petitioner at MMI and indicated he would see Petitioner on an as-needed basis.

D. Narrative Report by Dr. Choi

On June 29, 2016, Dr. Choi wrote a two-page report on his treatment of Petitioner. In the report, Dr. Choi briefly recounts Petitioner's history, the MRI results, the surgery, and the post-operative follow-up visits. Dr. Choi then opined with a reasonable degree of medical certainty that the fall on December 30, 2015 in the workplace parking lot did cause the acute rotator cuff tear on Petitioner's left shoulder.

E. Section 12 Examination by Dr. Weiss

On February 8, 2017, Petitioner was examined by Dr. Stephen Weiss, an orthopedic surgeon, at Respondent's request. Dr. Weiss prepared a report on February 17, 2017 wherein, following a review of Petitioner's medical records and a physical examination, Dr. Weiss diagnosed Petitioner with a full-thickness rotator cuff tear of the left shoulder, and a right shoulder rotator cuff repair by history (approximately seven years prior). Dr. Weiss also provided ratings according to the AMA Guides of a 7% upper extremity impairment, equivalent to a 4% whole person impairment.

F. Additional Information

Petitioner testified that between December 30, 2015 and October 3, 2016, he did not return to work, excepting a half-day on January 2 or 3, 2016. Petitioner also testified that $92,699.94 was paid by his group health insurer for treatment of his left shoulder injury, and that after his $225.00 out-of-pocket payments, there was an outstanding balance of $12,172.74.

Petitioner further testified he has returned to his full job as a maintenance worker, earning slightly more than he did prior to his injury. Petitioner stated he is right arm dominant.

Regarding his current condition of ill-being, Petitioner testified that upon returning to work for Respondent, he has had to self-modify his work to compensate for lifting and moving heavy objects such as file boxes, copy paper, and bags of ice melt or water softener salt. Petitioner acknowledged he lifts items weighing over 50 pounds himself but is more careful about how he balances the load and stacks items. Petitioner added that climbing vertical ladders on the roof of the Public Safety Building (where he now works) to check the roof and exhaust fans is difficult; shoveling snow can be painful. Petitioner testified he has continued to exercise at home, though it was not prescribed.

II. CONCLUSIONS OF LAW

A. Petitioner's Work-Related Accident

The Arbitrator found Petitioner failed to prove by a preponderance of evidence that he sustained an accident that arose out of and in the course of his employment which resulted in a disabling injury. The Arbitrator concluded the danger of slipping on the ice was not peculiar to his work and his exposure to the risk was not greater than that of the general public.

The issue of whether an injury arose out of and in the course of employment is generally a question of fact. *Suter v. Illinois Workers' Compensation Comm'n*, 2013 IL App (4th) 130049WC, ¶ 15. "However, when the facts are undisputed and susceptible to but a single inference, the question is one of law subject to *de novo* review." *Id.* In this case, the material facts are not susceptible to a single inference, the chief examples being whether the parking lot at issue is a public lot or provided to Respondent's employees when its use is restricted to particular employees for much of the day. Accordingly, the issue remains a question of fact.

"To obtain compensation under the Act, a claimant bears the burden of showing, by a preponderance of the evidence, that he has suffered a disabling injury which arose out of and in the course of his employment." *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill. 2d 193, 203 (2003). An injury "arises out of" employment when "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." *Sisbro*, 207 Ill. 2d at 203.

The question of whether a claimant's injury arose out of his or her employment depends upon the type of risk to which he or she was exposed. *Baldwin v. Illinois Workers' Compensation Comm'n*, 409 Ill. App. 3d 472, 478 (2011). "There are three categories of risk to which an employee may be exposed: (1) risks that are distinctly associated with one's employment, (2) risks that are personal to the employee, such as idiopathic falls, and (3) neutral risks that have no particular employment or personal characteristics, such as those to which the

general public is commonly exposed." *Dukich v. Illinois Workers' Comp. Comm'n*, 2017 IL App (2d) 160351WC, ¶ 31.

"[B]oth our supreme court and our appellate court have repeatedly held that accidental injuries sustained on property that is either owned or controlled by an employer within a reasonable time before or after work are generally deemed to arise out of and in the course of employment when the claimant's injury was sustained as a result of the hazardous condition of the employer's premises." *Dukich*, 2017 IL App (2d) 160351WC, ¶ 40 (and cases cited therein); see also *Mores-Harvey v. Industrial Comm'n*, 345 Ill. App. 3d 1034, 1038 (2004) (and cases cited therein). "The presence of a 'hazardous condition' on the employer's premises renders the risk of injury a risk incidental to employment; accordingly, a claimant who is injured by such a hazardous condition may recover benefits without having to prove that she was exposed to the risk of that hazard to a greater extent than are members of the general public." *Dukich*, 2017 IL App (2d) 160351WC, ¶ 40. "In other words, such injuries are not analyzed under 'neutral risk' principles; rather they are deemed to be risks 'distinctly associated' with the employment." *Id.*

The Arbitrator, in focusing on whether Petitioner's exposure to the risk of the ice was greater than that of the general public, appears to have analyzed this case as a "neutral risk" situation and did not consider whether it was a "hazardous condition" situation. The "hazardous condition" cases generally involve injuries caused by the natural accumulation of snow or ice in a parking lot or other outdoor space owned or controlled by the employer. *Dukich*, 2017 IL App (2d) 160351WC, ¶ 41; see also *Mores-Harvey v. Industrial Comm'n*, 345 Ill. App. 3d 1034, 1038 (2004) (and cases cited therein).

In this case, the unrebutted evidence shows that Petitioner was injured after falling due to ice and show in a parking area controlled by Respondent. Indeed, Petitioner's department was responsible for ice and snow removal in this parking area. Therefore, it cannot be said that Petitioner would never be expected to be in this parking area in the course of his work duties. Moreover, Respondent controlled when the parking lot was to be used solely by employees and when it was open to other members of the public.

Respondent argues that Petitioner fell in a public parking lot and not one designated for employees. This is not strictly true. The parking area at issue is restricted to particular courthouse employees from 8:00 or 8:30 a.m. through 4:30 p.m. Respondent also permits members of the public to park in this area during "non-business" hours, including at the time of the injury in this case. However, in *Mores-Harvey*, our appellate court considered that dual usage of a parking lot was not the issue:

> "Whether a parking lot is used primarily by employees or by the general public, the proper inquiry is whether the employer maintains and provides the lot for its employees' use. If this is the case, then the lot constitutes part of the employer's premises. The presence of a hazardous condition on the employer's premises that causes a claimant's injury supports the finding of a compensable claim." *Mores-*

Harvey, 345 Ill. App. 3d at 1040 (citing *Archer Daniels Midland Co. v. Industrial Comm'n,* 91 Ill. 2d 210, 216 (1982)).

In *Wal-Mart Stores, Inc. v. Industrial Comm'n,* 326 Ill. App. 3d 438 (2001), however, the appellate court reversed an award based in part on the fact that the employer's parking lot was open to both employees and the public. See *id.* at 445 (distinguishing *Hiram Walker & Sons, Inc. v. Industrial Comm'n*, 41 Ill. 2d 429, 430-31 (1968), and *American Electric Cordsets v. Industrial Comm'n,* 198 Ill. App. 3d 87, 91(1990)). Respondent also notes that the *Mores-Harvey* court, relying in part on *Homerding v. Industrial Comm'n,* 327 Ill. App. 3d 1050 (2002), ruled in favor of the claimant in part because "the general public was free to park anywhere in the lot, [but] claimant's choices were restricted. Therefore, claimant's exposure to risk was necessarily greater than that of the general public." *Mores-Harvey*, 345 Ill. App. 3d at 1042.

Respondent overlooks that the *Mores-Harvey* court, *after* concluding that a hazardous condition in the parking lot supported finding a compensable claim, discussed *Wal-Mart Stores* and *Homerding* as cases which considered *only* the second exception to the "general premises" rule. See *Mores-Harvey*, 345 Ill. App. 3d at 1040. This second exception permits recovery for off-premises injuries where "'the employee's presence at the place where the accident occurred was required in the performance of his duties and the employee is exposed to a risk common to the general public to a greater degree than other persons.'" *Id.* at 1038 (quoting *Illinois Bell Telephone Co. v. Industrial Comm'n,* 131 Ill. 2d 478, 484 (1989)). The *Mores-Harvey* court concluded the claimant would also recover under the second exception. *Mores-Harvey*, 345 Ill. App. 3d at 1042. But it was not required to do so, having already concluded the first exception applied because the parking lot, even if dual-use, was maintained and provided for employees' use.[1]

Respondent contends Petitioner was also required to prove he had begun his work day, and that he was required to park in the lot where the injury occurred. The latter asserted requirement is based on the discussion of *Homerding* in *Mores-Harvey*. The former asserted requirement is not entirely accurate. Rather, the injury must be sustained "within a reasonable time before or after work." *Dukich*, 2017 IL App (2d) 160351WC, ¶ 40; see also *Hiram Walker & Sons, Inc. v. Industrial Comm'n*, 41 Ill. 2d 429 (1968) (affirming award where employee arrived 40-50 minutes early and slipped in parking lot before proceeding to breakfast at a nearby café). In this case, Petitioner's shift began at 7:00 a.m. He arrived on Respondent's campus at approximately 6:45 to 6:50 a.m. A gap of 10 to 15 minutes is within a reasonable time before or after Petitioner's shift.

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[1] This first exception was recently discussed by the Illinois Appellate Court in *Walker Brothers, Inc. v. Illinois Workers' Compensation Comm'n*, 2019 IL App (1st) 181519WC. The *Walker Brothers* court observed that "'[t]he decisive issue in parking lot cases usually is whether or not the lot is owned by the employer, or controlled by the employer, or is a route required by the employer.'" *Id.* ¶ 22 (quoting *Maxim's of Illinois, Inc. v. Industrial Comm'n*, 35 Ill. 2d 601, 604 (1966)). Here, the lot was controlled by Respondent.

Respondent notes Petitioner was not required to keep his lunch or coffee in the courthouse. This objection is consistent with Respondent's reliance on *Illinois Bell Telephone Co.*, but, as noted above, that case involved the second exception to the "general premises" rule, not the first. In a "hazardous condition" case, "[t]he rationale for awarding compensation is that the employer-provided parking lot is considered part of the employer's premises." *Mores-Harvey*, 345 Ill. App. 3d at 1038 (citing L. Larson, Larson's Workers' Compensation Law § 13.04[2][a], [b], at 13--40-13--41 (2002)).

The amount of control Respondent exercised over Petitioner's lunch arrangements, however, is relevant to establish that Petitioner's depositing of his lunch and coffee in the courthouse before parking in the main lot was a reasonably necessary act of personal comfort.

The personal comfort doctrine provides:

> "'Employees who, within the time and space limits of their employment, engage in acts which minister to personal comfort do not thereby leave the course of employment, unless the * * * method chosen is so unusual and unreasonable that the conduct cannot be considered an incident of the employment.'" *Karastamatis v. Industrial Comm'n*, 306 Ill. App. 3d 206, 211 (1999) (quoting 2 A. Larson & L. Larson, Workers' Compensation Law § 21.00, at 5-5 (1998)).

Moreover:

> "'If the employee voluntarily and in an unexpected manner exposes himself to a risk outside any reasonable exercise of his duties, the resultant injury will not be deemed to have occurred within the course of the employment. [Citation.] The employer may, nevertheless, still be held liable for injuries resulting from an unreasonable and unnecessary risk if the employer has knowledge of or has acquiesced in the practice or custom,'" *Karastamatis*, 306 Ill. App. 3d at 211 (quoting *Eagle Discount Supermarket v. Industrial Comm'n*, 82 Ill. 2d 331, 340 (1980)).

The personal comfort doctrine generally encompasses acts such as eating and drinking, obtaining fresh air, seeking relief from heat or cold, showering, resting, and smoking. *Karastamatis*, 306 Ill. App. 3d at 211 (citing 2 A. Larson & L. Larson, Workers' Compensation Law § 21.10, at 5-5 (1998)).

In this case, Petitioner sought relief from the cold for himself, his coffee and food during the short period before his shift. Using the nearest dual-use parking lot was foreseeable, not unreasonable or unexpected; parking south or west of the courthouse was metered while the east side was bounded by a major thoroughfare with no parking. The risk of ice in the area is not outside any reasonable exercise of Petitioner's duties; his department is responsible for clearing

snow and ice in the parking area. Petitioner's morning routine was not so unusual and unreasonable that the conduct cannot be considered an incident of the employment. Rather, it was a reasonably foreseeable act of personal comfort.

Lastly, Respondent argues Petitioner was not exposed to a risk greater than that to which the general public was exposed. This is again either dependent on *Illinois Bell Telephone Co.* (which involved the common area of a mall, not a parking lot controlled by an employer) or on characterizing this case as involving a "neutral risk." Accordingly, the Commission rejects the argument for the reasons stated above. Moreover, as Petitioner notes, he was accessing the courthouse using an employee entrance from an area where the public also was permitted to park, but would not be expected to park, given that the public entrance was on the other side of the courthouse.

For all of the aforementioned reasons, the Commission concludes that Petitioner proved by a preponderance of evidence that he sustained an accident which arose out of and in the course of his employment.

B. Causal Connection

The Commission next considers whether Petitioner's current condition of ill-being is causally related to the accident. In his narrative report, Dr. Choi opined with a reasonable degree of medical certainty that the fall on December 30, 2015 in the workplace parking lot did cause the acute rotator cuff tear on Petitioner's left shoulder. In his IME report, Dr. Weiss does not offer a contrary view. Petitioner testified regarding his continuing weakness and limitations at work. Given this record, the Commission concludes Petitioner's current condition is causally connected to the accident.

C. Temporary Total Disability

Petitioner claims he was entitled to temporary total disability benefits in the amount of $508.39 per week for the 39-week period from January 4, 2016 through October 3, 2016, pursuant to §8(b) of the Act. The parties stipulated in the Request for Hearing that Petitioner's average weekly wage, calculated pursuant to section 10 of the Act, was $762.59. Accordingly, Petitioner's claim represents the statutory two-thirds of his average weekly wage. See 820 ILCS 305/8(b)1 (West 2018). Respondent disputed this claim by denying the accident arose out of the course of Petitioner's employment. Having found Petitioner's accident compensable, the Commission awards Petitioner the claimed temporary total disability benefits.

D. Medical Expenses

Petitioner claims Respondent should pay outstanding reasonable and necessary medical expenses of $12,172.74 pursuant to the fee schedule and reimburse him $225.00 for out-of-pocket medical expenses pursuant to §§8(a) and 8.2 of the Act. Petitioner also acknowledges

Respondent should be given a credit of $92,699.94 for medical benefits paid by its group medical carrier and hold Respondent harmless for any claims for which it receives credit, pursuant to §8(j) of the Act. Respondent again disputed this claim by denying the accident arose out of the course of Petitioner's employment. Having found Petitioner's accident arose out of his employment, the Commission awards Petitioner the claimed medical expenses, and awards Respondent the credit under §8(j) of the Act as stipulated by the parties in the Request for Hearing.

E. Permanent Partial Disability

Petitioner further seeks permanent partial disability benefits representing a 15% loss of the person as a whole. Subsection (b) of section 8.1b of the Act lists five factors upon which the Commission must base its determination of the level of permanent partial disability benefits to which a claimant is entitled, including: (i) the level of impairment contained within a permanent partial disability impairment report; (ii) the claimant's occupation; (iii) the claimant's age at the time of injury; (iv) the claimant's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. 820 ILCS 305/8.1b(b) (West 2018). However, "[n]o single enumerated factor shall be the sole determinant of disability." *Id.* § 305/8.1b(b)(v).

Regarding the level of impairment contained within a permanent partial disability impairment report, the Section 12 examiner, Dr. Weiss, provided ratings according to the AMA guidelines of a 7% upper extremity impairment, equivalent to a 4% whole person impairment. Petitioner did not submit an impairment rating. The Commission gives some weight to this factor.

Regarding the claimant's occupation, Petitioner is employed by Respondent as a maintenance worker, a position which involves lifting and moving heavy objects such as file boxes, copy paper, and bags of ice melt or water softener salt. Some of these items weigh over 50 pounds. Petitioner's occupation also involves climbing vertical ladders to perform maintenance checks. Petitioner additionally performs light plumbing and electrical work, and shovels snow. The Commission places greater weight on this factor.

As for the claimant's age, Petitioner was 56 years old at the time of his injury. This is an age at which it may be expected that not only is Petitioner truly at MMI and unlikely to recover further, but also young enough that he may be expected to work for a number of years with lingering symptoms and the limitations he has imposed upon himself to complete his job duties. The Commission places some weight on this factor.

The claimant's future earning capacity appears to be undiminished. Petitioner has returned to his full job as a maintenance worker, earning slightly more than he did prior to his injury. Accordingly, the Commission places no weight on this factor.

Lastly, the Commission considers the evidence of Petitioner's disability corroborated by the treating medical records. Petitioner was diagnosed by Dr. Choi with left shoulder massive

rotator cuff tear supraspinatus, infraspinatus, subscapularis. Dr. Weiss also diagnosed Petitioner with a full-thickness rotator cuff tear of the left shoulder. To treat this condition, Petitioner underwent a left shoulder arthroscopic double row subscapularis repair and supraspinatus repair, subacromial decompression and biceps tenodesis. Petitioner then participated in approximately eight months of physical therapy and rehabilitation. Petitioner's medical records are entirely consistent with his lingering difficulty with job duties which include lifting and moving heavy objects, climbing vertical ladders, and shoveling snow. The Commission places greater weight on this factor.

Weighing the five factors pursuant to Section 8.1b of the Act, which does not simply require a calculation, but rather a measured evaluation of which no single factor is conclusive on the issue of permanency, the Commission agrees that Petitioner sustained a 15% loss of use of the whole person.

F. Penalties and Fees

Petitioner sought penalties from Respondent under section 19(k) of the Act, which provides:

> "In case[s] where there has been any unreasonable or vexatious delay of payment or intentional underpayment of compensation *** then the Commission may award compensation additional to that otherwise payable under the Act equal to 50% of the amount payable at the time of such award." 820 ILCS 305/19(k) (West 2018).

Petitioner also sought an award of attorney fees pursuant to Section 16 of the Act which provides for an award of attorney fees when an award of additional compensation under section 19(k) is appropriate. 820 ILCS 305/16 (West 2018). Section 19(k) penalties and section 16 fees are intended to address situations where the delay is deliberate or the result of bad faith or improper purpose. *Jacobo v. Illinois Workers' Compensation Comm'n*, 2011 IL App (3d) 100807WC, ¶ 24. The imposition of penalties under section 19(k) and fees under section 16 is discretionary. *Id.*

The Commission has in the past vacated an award of penalties and fees where the Respondent had a good faith argument regarding liability for a fall in a parking lot, in part due to the sometimes confusing state of the law regarding such injuries. See, *e.g.*, *Plucinski v. White Castle Systems, Inc.*, 5 IWCC 456. Given the record in this case, Respondent had a good faith argument regarding liability. Accordingly, the Commission declines to award penalties and fees in this case.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 14, 2017, is hereby reversed for the reasons stated above.

IT IS FOUND BY THE COMMISSION that Petitioner proved he sustained an accident arising out of and in the course of his employment with Respondent on December 30, 2015.

IT IS FURTHER FOUND BY THE COMMISSION that Petitioner proved his current condition of ill-being is causally connected to the accident.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner the temporary total disability benefits that have accrued from January 4, 2016 through October 3, 2016 at the rate of $508.39 per week, pursuant to §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is liable to pay Petitioner's outstanding reasonable and necessary medical expenses of $12,172.74 pursuant to the fee schedule and also to reimburse Petitioner $225.00 for out-of-pocket medical expenses pursuant to §§8(a) and 8.2 of the Act. Respondent is awarded a credit of $92,699.94 for medical benefits paid by its group medical carrier and is held harmless for any claims for which it receives credit, pursuant to §8(j) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $457.55 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 a 15% loss of use of Petitioner's person as a whole.

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

No county, city, town, township, incorporated village, school district, body politic or municipal corporation is required to file a bond to secure the payment of the award and the costs of the proceedings in the court to authorize the court to issue such summons. 820 ILCS 305/19(f)(2). Based upon the named Respondent herein, no bond is set by the Commission. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JAN 2 4 2020
d: 12/19/19
BNF/kcb
045

Barbara N. Flores

Deborah L. Simpson

Marc Parker

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

Dirk Jennings,

Petitioner,

vs. NO: 16 WC 33291

Peoria County Highway Department

Respondent.

20IWCC0051

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 11, 2018, 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.

20IWCC0051

No county, city, town, township, incorporated village, school district, body politic or municipal corporation is required to file a bond to secure the payment of the award and the costs of the proceedings in the court to authorize the court to issue such summons. 820 ILCS 305/19(f)(2). Based upon the named Respondent herein, no bond is set by the Commission. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JAN 24 2020
o010920
BNF/mw
045

Barbara N. Flores

Deborah L. Simpson

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

JENNINGS, DIRK
Employee/Petitioner

Case# **16WC033291**

PEORIA COUNTY HIGHWAY DEPARTMENT
Employer/Respondent

20IWCC0051

On 5/11/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.00% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4707 LAW OFFICE OF CHRIS DOSCOTCH
DAMON YOUNG
2708 N KNOXVILLE AVE
PEORIA, IL 61604

5354 STEPHEN KELLY LAW OFFICE
MATT BREWER
2710 N KNOXVILLE AVE
PEORIA, IL 61604

ACP0503W1/2

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

Dirk Jennings
Employee/Petitioner

v.

Peoria County Highway Department
Employer/Respondent

Case # **16** WC **33291**

Consolidated cases: **N/A**

20IWCC0051

An *Application for Adjustment 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 **Peoria**, on **March 21, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ 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 **9/19/16**, Respondent ***was*** operating under and subject 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 $**66,560.00**; the average weekly wage was $**1,280.00**.

On the date of accident, Petitioner was **41** years of age, ***married*** with **4** 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 $**9,504.88** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**9,504.88**.

Respondent is entitled to a credit of $**14,426.33** under Section 8(j) of the Act.

ORDER

Petitioner failed to prove the issue of causation. Therefore, all benefits are denied.

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

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

Signature of Arbitrator

5/11/18
Date

MAY 11 2018

FINDINGS OF FACT

20IWCC0051

This case involves a Petitioner alleging injuries sustained while working for the Respondent on September 19, 2016. Respondent disputes Petitioner's claims and the issues in dispute are: 1) causation; 2) medical expenses; 3) TTD; and 4) nature and extent.

The Petitioner testified that he began working for the Respondent in 2002. He worked for Respondent as a laborer but also did some work as a truck driver and had other various positions that were laborious in nature. The Petitioner testified that on September 19, 2016, he was working on a job to replace a 24 inch, 30 feet long field culvert into a ditch. The Petitioner testified he was in the hole where the culvert was to be placed. He described the culvert as having chains around it, connected to a backhoe that was used to lower the culvert into the ditch. He was in the ditch at the time of the accident and holding with his left hand the chain, which was around the culvert. He described holding the chain above his head. The Petitioner testified that his left arm was yanked down when the culvert rolled, as there was some slack in the chain which broke loose. He testified that he then fell backwards and slammed into the back of the ditch – striking the back side of his left shoulder against the back side of the ditch.

Petitioner testified that he then exited the ditch and felt a popping and burning sensation in his shoulder. He thought his shoulder was possibly dislocated, but he continued to work and "walked it off". He reported his accident to his supervisor, Randy Garner. He initially took ibuprofen, but continued to have complaints until he sought care.

The Petitioner testified that prior to this accident, he had left shoulder pain and had sought treatment for the same. On January 22 and January 29, 2016 he received injections into his left shoulder at the Midwest Orthopaedic Center in Peoria. He testified that the injections did provide him some temporary relief. He worked full duty from January of 2016 through September of 2016. He described his duties during this time involved heavy lifting and laborious activities that included shoveling, digging holes, and working with blacktop. He testified that in July, 2016, his symptoms in his left shoulder returned and he sought an additional injection at Midwest Orthopaedic Center due to soreness in his left shoulder. The records show Petitioner complained of sharp pain shooting down the back of his arm. He testified that he had no complaints to his left shoulder following his July 2016 injection leading up to his September 2016 accident.

On September 21, 2016, Petitioner went to the Illinois Work Injury Resource Center (IWIRC) where he indicated complaints of popping and burning symptoms. On that day, Physicians at IWIRC examined Petitioner and released him to full duty work status. At his September 26, 2016 follow-up visit at IWIRC, Petitioner received an injection and an order for physical therapy. He was also given work restrictions of lifting 20 pounds occasionally, 10 pounds frequently, and no overhead work. He returned to IWIRC on September 29, 2016 and reported continued symptomology with no improvement from physical therapy. He was kept off work with a recommendation for an MRI. At his October 19, 2016 follow-up visit, Petitioner was diagnosed with a left AC sprain. His MRI results revealed severe AC joint arthropathy, bursitis, with both his rotator cuff and biceps tendons intact.

On October 21, 2016, Petitioner initially saw Dr. Michael Merkley at the Midwest Orthopaedic Center – who diagnosed him with AC joint arthritis and bursitis. Dr. Merkley did not believe that the initial MRI study from October 6, 2016, was optimal and ordered an MR arthrogram. The November 4, 2016 MR arthrogram results revealed AC arthritis and no tear of either the rotator cuff or labrum. Dr. Merkley recommended surgery at Petitioner's November 18, 2016 follow-up visit Dr. Merkley performed an arthroscopic procedure involving a

distal clavicle resection on Petitioner's left shoulder on December 16, 2016. Dr. Merkley gave Petitioner work restrictions as of February 6, 2017 before he determined the Petitioner to have reached maximum medical improvement and releasing him to return to work with no restrictions as of April 17, 2017.

Dr. Merkley testified via evidence deposition on September 29, 2017. He is a board certified orthopedic surgeon who specializes in treatment of the shoulders and knees. Dr. Merkley testified that in addition to providing treatment to the Petitioner, he also reviewed the Petitioner's prior medical records, including those relating to the Petitioner's left shoulder injections from January and July 2016. Based on his review of the MR arthrogram, Dr. Merkley's impression was that Petitioner had an AC joint arthropathy with synovitis and subdeltoid bursitis. He opined that the Petitioner's accident involving a direct blow to his shoulder caused an aggravation of the Petitioner's preexisting AC joint arthrosis resulting in an increase in pain and a rotator cuff strain. Dr. Merkley also explained that the Petitioner's left shoulder bursitis was caused by the accident and reason why the surgery to Petitioner's left shoulder was necessary. He explained that there was no evidence of the Petitioner having bursitis before the alleged accident date. Dr. Merkley confirmed that the surgery – which involved arthroscopic subacromial decompression and distal clavicular incision – had a good result leading to the Petitioner's full duty release on April 12, 2016. He explained that surgery was also necessary because the Petitioner's left shoulder condition did not respond to injections in the past. On cross-examination, Dr. Merkley testified that regardless of the Petitioner's accident, he may have needed the surgery in the future.

On March 6, 2017, Dr. Mitchell Rotman examined Petitioner at Respondent's request. Dr. Rotman testified via evidence deposition on January 29, 2018. Dr. Rotman is a board certified orthopedic surgeon with an added qualification in upper extremity work, who has performed thousands of surgeries involving the upper extremities and treats patients with both acute and chronic upper extremity conditions. Dr. Rotman opined that Petitioner's accident did not cause, aggravate or accelerate his left shoulder condition based on his examination of Petitioner and his review of the Petitioner's medical records. Dr. Rotman pointed out that the arthritis and bursitis found in Petitioner's left shoulder clearly pre-existed the Petitioner's alleged September 19, 2016 work accident as evidenced by the medical treatment Petitioner received for his left shoulder only months before the alleged accident date. Dr. Rotman did not believe the mechanism of injury described by Petitioner would have been the type to aggravate Petitioner's shoulder conditions. This would include the Petitioner's bursitis – a condition that Dr. Rotman pointed out was previously noted in Petitioner's medical records from January, 2016. Dr. Rotman further indicated that the Petitioner's December 15, 2016 surgery findings were consistent with the the prior MRI studies in that they did not reveal any acute findings and confirmed that the Petitioner's left shoulder conditions were degenerative and longstanding in nature. Consistent with his opinions on causation, Dr. Rotman did not believe Petitioner's medical treatment was related to his alleged accident or that he required any work restrictions related to the alleged accident.

The Petitioner testified at the time of trial that he was "now 100 percent better." He described having occasional soreness but believed that he had regained all of his strength and that the surgery had alleviated all of his symptoms. Following his full duty release in April 2017, Petitioner has continued to work full duty with no restrictions. The Petitioner confirmed that he has had no further medical care since April 2017 and he does not have any future appointments scheduled with Dr. Merkley.

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 left shoulder is not causally related to his September 19, 2016 accident. In support of this finding, the Arbitrator relies on the medical evidence – all of which show that the Petitioner had pre-existing, degenerative conditions of arthropathy and bursitis in his left shoulder. The Arbitrator is not persuaded by Petitioner's surgeon Dr. Merkley – who opined that the Petitioner's conditions were aggravated by the September 19, 2016 due to the direct blow to the Petitioner's shoulder. None of the medical evidence shows any acute findings that would support that opinion. Dr. Merkley testified that he believed the Petitioner's bursitis was directly caused by the trauma because it was a condition that was not present before the alleged accident date. However, as Dr. Rotman notes, the Petitioner's prior medical records show evidence of bursitis prior to his alleged accident date. Dr. Merkley also opined that surgery was necessary because Petitioner was not responding to injections in his left shoulder. However, the evidence shows and Petitioner testified that he did experience relief following the injections. The fact that the Arbitrator finds most compelling in this case is that after being confronted with evidence on cross-examination that contradict many of his points, Dr. Merkley indicated that Petitioner may have needed surgery to his left shoulder regardless of his accident based on the pre-existing conditions in his shoulder. Given the contradictions and rebuttals in Dr. Merkley's testimony, and in reviewing the medical evidence as a whole, the Arbitrator finds persuasive the opinions of Dr. Rotman on this issue. Accordingly, the Arbitrator concludes that the Petitioner's current condition of ill-being in his left shoulder is not causally related to his September 19, 2016 accident and denies all benefits claimed for said injury.

2. Based on the Arbitrator's findings with regard to the issue of causation, all other issues are rendered moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
SANGAMON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Randy Warman,
Petitioner,
vs.

NO: 18 WC 00294

JB Hunt Transport SVS, Inc.,
Respondent.

20IWCC0052

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 10, 2019, is hereby affirmed and adopted.

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

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

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

DATED: JAN 24 2020
o120519
BNF/mw
045

Barbara N. Flores

Deborah L. Simpson

Marc Parker

S0IACC0025

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

WARMAN, RANDY
Employee/Petitioner

Case# **18WC000294**

JB HUNT TRANSPORT SVS INC
Employer/Respondent

20IWCC0052

On 6/10/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission, Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.25% shall accrue from the date listed above to the day before date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5983 CARAWAY FISHER & BROOMBAUGH
JASON R CARAWAY
9423 W MAIN ST
BELLEVILLE, IL 62223

0725 LAW OFFICE OF CRAIG A HANSEN
ANDREW KOVACS
1299 ZURICH WAY SUITE 480
ST LOUIS, MO 63127

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)

RANDY WARMAN
Employee/Petitioner

v.

JB HUNT TRANSPORT SVS, INC.
Employer/Respondent

Case # **18** WC **00294**

Consolidated cases: _____

20IWCC0052

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Christina Hemenway**, Arbitrator of the Commission, in the city of **Springfield**, on **March 22, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **June 23, 2016**, Respondent ***was*** operating under and subject 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 $**62,294.44**; the average weekly wage was $**1,197.97**.

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

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

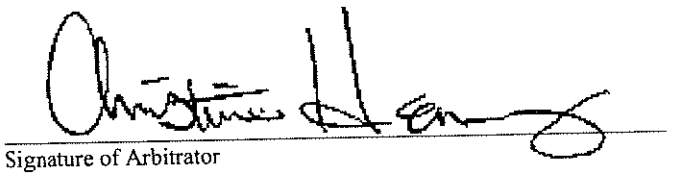
ORDER

As explained in the Arbitration Decision, Petitioner failed to prove by a preponderance of the evidence that he sustained an accident that arose out of and in the course of his employment on June 23, 2016, which resulted in injury. All benefits are denied. All other issues are moot and the Arbitrator makes no conclusions as to those issues.

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

June 5, 2019
Date

ICArbDec19(b)

JUN 10 2019

STATE OF ILLINOIS)
) SS
COUNTY OF SANGAMON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

RANDY WARMAN
Employee/Petitioner

v. Case #: **18 WC 00294**

JB HUNT TRANSPORT SVS, INC.
Employer/Respondent

20IWCC0052

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

This cause came before the Arbitrator on Petitioner's Section 19(b) Petitioner. Arbitration began on December 19, 2018, and proofs were closed on March 22, 2019. The parties placed into dispute the issues of accident, causal connection, past and prospective medical treatment, and temporary total disability benefits.

Petitioner testified that on June 23, 2016, he was employed as a truck driver for Respondent and had been so employed since March 30, 2015. On that date, he was driving his semi-truck and trailer southbound on Interstate 55 near mile marker 48 when the left front wheel of his truck came off. He testified that the tire axle assembly under his seat came unattached to the assembly harness. He was able to keep the vehicle under control without it hitting other vehicles or flipping over. He testified that during this process he was "completely jolted around...like a pinball", despite wearing his seatbelt. He was able to bring the truck to a stop. He called his dispatcher, Dino, and the company sent out a repair unit to fix the truck. Because of the delay that the waiting and repairs caused, Petitioner was "out of driving hours" allowed for the day. He drove to a truck stop at mile marker 30 and parked the truck for the night. Petitioner testified that he again called Dino and told him he was "not feeling right", then he went to sleep.

Petitioner testified that the next morning he received a phone call from his fleet manager, Steven Houston, who was concerned that the load of shingles on the truck had not been delivered. He testified that he told Mr. Houston he wasn't feeling well and that "something wasn't right". He completed the delivery of the load on his truck and then went to the terminal in St. Louis, where he talked with Mr. Houston in person. He then picked up another load and drove it to Kansas City, where he lives. He testified that he was "in a daze" and aching all over while driving to Kansas City. After making the delivery, he parked his truck and trailer at the local yard owned by Respondent and drove home in his personal vehicle. That was the last day he worked for Respondent.

Petitioner testified that he filed for short-term and long-term disability, which he received. He also applied for social security disability, which was granted in December 2016. Petitioner testified he was terminated from his employment with Respondent via a letter dated October 28, 2016. The letter stated in part, "if your leave did not qualify for FMLA, or if you have exhausted your personal leave time and you are unable to return to work from your personal leave by 10-31-16 your employment with JB Hunt will end." PX9. Petitioner was thereafter terminated by Respondent.

Petitioner testified that he had been a truck driver for close to 40 years. Based on his experience, he did not believe it would be safe for him to drive a tractor trailer, due to the headaches and dizziness. With regard to the difference in his back and leg symptoms prior to and after the accident, he testified he had no feeling in his feet, his back and lower leg was in constant pain, he had no balance, and he had fallen down many times.

On cross-examination, Petitioner was asked about his demeanor with Mr. Houston the day after the incident. He testified that he was hurting and "a little confused". When asked if he told Mr. Houston that he believed he was injured in the accident, he stated, "I told him I did not feel good and I was hurt." Petitioner denied calling Mr. Houston on June 27 and June 28 to advise he was sick due to a sinus infection. He acknowledged that he called Respondent's home office in Arkansas on June 29, and testified that he talked to "Sarah", and was given a "work comp number". He testified that after that conversation he was mailed FMLA paperwork, which he completed and returned. He was questioned about the paperwork he completed for short-term and long-term disability, and why he checked "No" as to whether his disability was work related. He testified, "I wasn't sure at the time what was going on with them. I was told to file it immediately, and I filed it." Petitioner continued to insist that he told Dr. Steiner about the incident on June 23, 2016, and that he was seen by Dr. Steiner on June 29, despite the certified record containing no evidence of such a statement or such an encounter.

Steven Houston testified on behalf of Respondent. He is a supervisor/dispatcher and has worked for Respondent for 17 years. He was an operations supervisor on the day of the incident and described his position as the front-line supervisor between drivers and upper management. As such, he was Petitioner's direct supervisor on June 23, 2016. He testified that he became aware of the incident in question on the day that it occurred, when Petitioner called dispatch. He noted that Petitioner reported the incident as a flat tire.

Mr. Houston testified that when he met Petitioner on June 24, Petitioner was in no visible distress, nor did he mention that he was having any physical difficulties. He testified that he talked to Petitioner on June 27, at which time Petitioner called off work due to a sinus infection. Petitioner called in sick again on June 28. Mr. Houston talked to Petitioner again on June 29, at which time Petitioner advised he was "having neurological issues" and would not be returning to drive a truck. Mr. Houston sent paperwork to him for FMLA leave. Petitioner called again on June 30, and advised Mr. Houston, for the first time, that he was claiming his condition was related to the incident on June 23, 2016. Mr. Houston testified that at that time he followed company protocol and turned the situation over to his HR department for further handling. When asked about the damage to the truck following the incident on June 23, he testified that it was cosmetic only and was not repaired.

Petitioner was recalled as a witness, at which time he testified that when he last talked to Mr. Houston on June 30, 2016, he had threatened to testify against him about the work comp case. Mr. Houston was recalled as a witness, and categorically denied any such threat. He testified that if he had not followed procedure when Petitioner reported the claim as work comp, then his own job would have been in jeopardy He testified that there are no financial incentives or disincentives relative to accident reporting or number of accidents with Respondent.

On June 26, 2016, Petitioner presented to Centerpointe Medical Center emergency room with complaints of dizziness, lightheadedness, headaches and nausea. There was no mention of the June 23, 2016, incident, and Petitioner acknowledged during testimony that he did not tell them about the incident. There was no mention of low back pain. He had an elevated white blood cell count and signs of sinusitis. Of note, Petitioner showed "no signs of other acute neurologic symptoms". He was discharged with a diagnosis of dizziness caused by sinusitis. PX1. Petitioner testified that he never experienced these symptoms until after the June 23, 2016 incident. However, an examination of records from Centerpointe Medical Center shows that he was evaluated again at Centerpointe Medical on October 31, 2016, where he gave a history of falling after stepping out of a hotel shower November 1, 2015, hitting his head. He further stated that he had "leg numbness and tingling [that] started with the fall". He did recount the June 23, 2016, incident to the providers on this date, however it is clear from the discussion of the provider that the issues complained of were from the fall in November 2015. PX1.

Petitioner testified that he did not mention the June 23, 2016, incident initially to the providers at Centerpointe because "I really wasn't in no condition to even think about telling them". He testified that he presented to Dr. Steiner on June 29, 2016, told him about the truck incident, and was taken off work. However, the Arbitrator notes that there is no record of such an encounter with Dr. Steiner in the doctor's record. There is an off-work slip, but not an office note. Dr. Steiner informed Petitioner on June 30, 2016, that he could no longer be his physician. Interestingly, also in Dr. Steiner's records is a treatment note from June 3, 2016, 20 days prior to the tire incident, wherein Petitioner stated that he had "numbness intermittently and tingling sensation in his legs for at least the past six months". The Arbitrator notes this complaint coincides with the information in the Centerpointe records regarding Petitioner's fall in a hotel room November 1, 2015. PX1, PX6.

Petitioner testified that he believed Dr. Steiner "fired" him because of issues surrounding the truck incident. In Dr. Steiner's record is a note from a phone conversation between Petitioner and the doctor's office on June 30, 2016, that states, "He just happened to think that he did have a tire blown off rim … much vibration with no accident … but thought he would mention it at the urging of his friend and daughter". PX6.

On July 1, 2016, Petitioner underwent an EMG/NCS by Dr. Richard Killman, who noted a greater than one-year history of "deadness" in both feet and intermittent lack of sensation in both lower extremities. He further noted a history of ligament repair in both ankles 15-20 years prior and right knee arthroscopy in the 1980's. There was no mention of the truck tire incident on June 23, 2016, and no mention of low back pain. The EMG/NCS was read as positive for severe, chronic asonal sensorimotor peripheral polyneuropathy affecting predominantly the lower extremities. Dr. Killman noted that "a very similar clinical and electrodiagnostic picture can also be seen with chronic, severe, multilevel lumbosacral spinal stenosis". There was no evidence of acute lumbosacral radiculopathy or myopathy. PX3.

On July 13, 2016, Petitioner was seen by Dr. Daniel Sleve, an ENT. Petitioner testified that he was referred to Dr. Sleve because he had light-headedness and dizziness and wanted to find out what was going on. Dr. Sleve recorded a history of vertigo which had begun a month prior, and noted Petitioner had gone to the emergency room for vertigo on June 26, 2016. There was no mention of the truck incident on June 23, and no mention of low back pain. It was noted "We discussed the nature of the symptoms and the possible differential diagnosis including benign paroxysmal positional vertigo, acute labyrinthitis, vestibular/cochlear hydrops, and systematic neurological conditions such as early MS or ALS. The symptoms are not characteristic of BPPV since the dizzy symptoms are lasting most of the day and do not correlate with specific head movements or positional changes. The rest of the neurological examination is normal, there is no suggestion of systemic disease, and the risk of intracranial masses or MS/ALS are unlikely. The character and duration of symptoms is more consistent with labyrinthitis. Etiology and treatment options were discussed. If symptoms are not resolving in the next couple of weeks, I have suggested returning to consider an MRI and further work up." Dr. Sleve's assessment was bilateral sensorineural hearing loss and vertigo. PX2.

On August 23, 2016, Petitioner was evaluated by Dr. Walter Jacobsen. He reported he had been having low back pain for approximately three years, radiating into the left lower extremity, with a gradual onset. It was also noted, "the patient was in a MVA and has had dizziness and light headedness, as well as low back pain and numbness in feet since then.". PX7. The Arbitrator notes this is the first mention in any medical record of low back pain. During arbitration, Petitioner was asked to explain his history of low back pain. He testified, "I have arthritis in my back very badly. I have been dealing with that for a long time, and that's just what I have to deal with." With regard to his back pain before and after the truck incident, he testified that the pain was "different" after the incident. He elaborated, "Where I am having the back pain is in a different spot in my lower left above the hip and well, above the left buttock area and radiating down the leg." Dr. Jacobsen ordered imaging studies, including MRIs of the brain, cervical spine, thoracic spine and lumbar spine. PX7.

Petitioner returned to Dr. Jacobsen on October 20, 2016, and reported continued numbness in the legs. The imaging studies were reviewed. Cervical imaging showed degeneration, worse at C6-7, with no real nerve root compression. The brain MRI showed no obvious masses. Thoracic MRI showed hyperkyphosis with no cord compression. Dr. Jacobsen noted that the lumbar MRI was not completed, and he could not be certain whether there was nerve root compression; however, from what could be seen on the thoracic MRI, there was no complete spinal canal obliteration. He further noted, "I would not expect symmetric equal numbness in the legs from lumbar pathology." Assessment was peripheral polyneuropathy and postural kyphosis of the thoracic region. He referred Petitioner for a functional capacity evaluation (FCE). PX7.

Petitioner testified that he had not had the lumbar MRI because he needed a sedated MRI with a larger opening, as he was highly claustrophobic and "a larger feller", and that he would like to have the MRI. He further testified that he had not undergone the FCE because his primary insurance would not cover it.

On August 30, 2016, Petitioner presented to Dr. Anne Arey, his primary care physician, who noted a "long history of chronic back pain" and further noted he had last been seen in the

office over a year ago and had been seeing another physician who was cutting back on his practice. Petitioner described two separate events in the past six to twelve months which aggravated his back issues and led to him being off work. The first was a fall at a hotel on a marble floor, and the second was a motor vehicle accident. Following examination, assessment was benign paroxysmal positional vertigo, chronic pain, gout, headache, and morbid obesity. He was prescribed Topamax. PX8.

With regard to the fall in the hotel on November 1, 2015, Petitioner testified, "I stepped out of a shower at a hotel on to a marble floor that was wet, and I slipped and fell on my back and struck my head on the wall." He noted this occurred at a casino in Kansas City. After the fall, he presented to a North Kansas City Hospital and reported cervical and low back pain. He was discharged with instructions to apply ice and heat, take Ibuprofen, and follow up with his primary care physician. PX4. Petitioner testified that he did not follow up with his primary care doctor, as he was on the road.

Dr. Arey's notes also indicate a third "accident", a fall which occurred in November 2017. PX8. Petitioner testified, "I was just walking to the car and my cane was in the car and I just fell face forward onto the concrete and knocked myself out." He sought treatment at the emergency room. He attributed this November 2017 fall to his truck driving accident, as he had never fallen like that before. He testified he has experienced new and different back pain from the date of the truck driving accident throughout the entire time leading up to his arbitration hearing.

CONCLUSIONS OF LAW

The Arbitrator hereby incorporates by reference above Findings of Fact, and the Arbitrator's and parties' exhibits are made a part of the Commission's file. After review of the evidence and due deliberations, 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 which arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds the following:

To obtain compensation under the Illinois Workers' Compensation Act, a claimant must show by a preponderance of the evidence that he suffered a disabling injury arising out of and in the course of his employment. 805 ILCS 305/2; *Metropolitan Water Reclamation District of Greater Chicago v. Illinois Workers' Compensation Comm'n*, 407 Ill.App.3d 1010, 1013 (1st Dist. 2011); *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill.2d 52, 57 (1989). Both elements must be present at the time of the claimant's injury in order to justify compensation. *Illinois Bell Telephone Co. v. Industrial Comm'n*, 131 Ill.2d 478, 483 (1989).

The Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that he sustained an accident that arose out of and in the course of his employment which resulted in injury. While there was undoubtedly an incident involving a blown tire on June 23, 2016, the preponderance of the evidence leads to the conclusion that Petitioner suffered no injury in that incident. In so concluding, the Arbitrator finds significant that the initial medical records do not support Petitioner's testimony that he was injured in the incident and, in fact, contradict

his testimony in most instances. In that regard, the Arbitrator found Petitioner to be lacking in credibility.

Specifically, the first medical record from Centerpointe of June 29, 2016, make no reference to the tire incident whatsoever and no reference to any back complaints. Petitioner's only complaints at that time were of dizziness, lightheadedness, headaches, and nausea. Lab results showed an elevated white blood cell count and signs of sinusitis. It was noted that there were "no signs of other acute neurologic symptoms". Further, there is no mention of the truck incident or of low back pain to Dr. Killman on July 1, 2016, or to Dr. Sleve on July 13, 2016. The first mention in the records of low back pain is to Dr. Jacobsen on August 23, 2016, two months after the truck tire incident.

Mr. Houston credibly testified that Petitioner called off work on June 27 and June 28 because of a sinus infection and that he did not mention any back injury relative to the tire incident on June 23. Further, Mr. Houston credibly testified that he personally observed Petitioner the day after the tire incident, that he was in no visible distress, and that he did not mention any injury.

Petitioner testified that he presented to Dr. Steiner on June 29, 2016, told him about the truck incident, and was taken off work. However, there is no record of such an encounter with Dr. Steiner in his notes. There is an off-work slip, which states only that he should be "off work until well", but no corresponding examination note. As such, the Arbitrator is left to speculate as to the reason for the off-work slip. Given the lack of a treatment note from Dr. Steiner, and the substance of the record from Centerpointe on the same day, a logical conclusion would be that Petitioner was taken off work due to the diagnosed sinus infection. In either event, contrary to Petitioner's testimony, there is no evidence in the record that he reported the truck incident and an injury resulting therefrom to Dr. Steiner on June 29, 2016. In fact, Dr. Steiner's record of June 30, 2016, contradicts that testimony. At that time, Petitioner called Dr. Steiner's office to report he "just happened to think" that he had a tire blown off the rim with much vibration and "thought he would mention it at the urging of his friend and daughter".

With regard to the remaining medical records, the Arbitrator notes that the histories contained therein are inconsistent at best and, further, do not contain a statement regarding medical causation. The records do, however, establish a long-standing history of low back pain and lower extremity polyneuropathy. In fact, Dr. Steiner's record of June 3, 2016, just 20 days prior to the tire incident, establishes that Petitioner complained of numbness and tingling in his lower extremities present for about six months, which coincides with his fall in the hotel room.

In addition, Petitioner acknowledged that he completed short-term and long-term disability forms, on which he affirmatively stated that his disability was not work-related.

Based on the foregoing and the record in its entirety, the Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that he sustained an accident that arose out of and in the course of his employment which resulted in injury. All benefits are denied. The remaining issues are rendered moot and the Arbitrator makes no conclusions as to those issues.

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

William Smith,
Petitioner,
vs.

NO: 16 WC 05750

Caterpillar, Inc,
Respondent.

20IWCC0053

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 9, 2018, 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 $45,200.00. 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: JAN 24 2020
o120519
BNF/mw
045

Barbara N. Flores

Deborah L. Simpson

Marc Parker

SOIACC0023

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SMITH, WILLIAM
Employee/Petitioner

Case# **16WC005750**

CATERPILLAR INC
Employer/Respondent

20IWCC0053

On 10/9/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.33% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0192 CUSACK GILFILLAN & O'DAY
DANIEL P CUSACK
415 HAMILTON BLVD
PEORIA, IL 61602

2851 CATERPILLAR INC
ELIZABETH Z LeBARON
PO BOX 348 A-11
AURORA, IL 60507

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

20IWCC0053

William Smith
Employee/Petitioner

v.

Caterpillar, Inc.
Employer/Respondent

Case # **16** WC **5750**

Consolidated cases: **N/A**

20IWCC0053

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Peoria**, on **August 14, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

20IWCC0053

FINDINGS

On **December 4, 2015**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did*** 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.

Per the stipulation of the parties, in the year preceding the injury Petitioner earned **$50,398.40**; the average weekly wage was **$969.20**.

On the date of accident, Petitioner was **52** 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** for TTD, **$0** for TPD, **$0** for maintenance, and **$13,569.56** in non-occupational indemnity disability benefits, for a total credit of **$13,569.56.**

Respondent is entitled to a credit for medical bills paid in the amount of **$47,021.14** through its group medical plan for which credit may be allowed under Section 8(j) of the Act.

ORDER

Respondent shall pay for medical services **as set forth in Petitioner's Exhibit 6** as provided in Sections 8(a) and 8.2 of the Act as stipulated to by the parties at the time of arbitration. Respondent is to hold Petitioner harmless for any claims for reimbursement from any health insurance provider and shall provide payment information to Petitioner relative to any credit due. Respondent is to pay unpaid balances with regard to said medical expenses directly to Petitioner. Respondent shall pay any unpaid, related medical expenses **as set forth in Petitioner's Exhibit 6** according to the fee schedule and shall provide documentation with regard to said fee schedule payment calculations to Petitioner. Respondent is entitled to a credit for all bills paid under its group medical plan for which credit may be allowed under Section 8(j) of the Act.

Respondent shall pay Petitioner temporary total disability benefits of **$646.13**/week for **20 5/7** weeks, **for the timeframe of February 5, 2016 through June 30, 2016,** as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the sum of **$581.52 week** for a period of **50 weeks**, as provided in **Section 8(d)2** of the Act, because the injuries sustained caused **10% loss of use of the person-as-a-whole.**

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$13,569.56** in non-occupational indemnity disability benefits, for a total credit of **$13,569.56.**

Respondent is entitled to a credit for medical bills paid in the amount of **$47,021.14** through its group medical plan for which credit may be allowed under Section 8(j) of the Act.

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

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

Signature of Arbitrator

10/5/18
Date

OCT 9 - 2018

20IWCC0053

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

William Smith
Employee/Petitioner

Case # **16** WC **5750**

v.

Consolidated cases: **N/A**

Caterpillar, Inc.
Employer/Respondent

20IWCC0053

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that he began working for Respondent in November of 1998 when he was hired in at the Morton warehouse facility and that he eventually became a drill specialist in 2006. He testified that as a drill specialist, his primary job duty is that of balancing parts. He testified that he uses a dual plane balancer, which balances transmission parts similar to balancing the tires on a vehicle. He testified that he places the part on the dual plane balancer which then spins the part, and that the machine tells him where and how deep to drill the holes. He testified that he then places the part back on the balancer and spins it, repeating this process until the part is in balance. He testified that when the parts arrive from the machine operators, there are holes in the parts called shaft bores. He testified that a pin goes through the hole gearing and that if the hole is too small, he uses a roll burnisher which he places in the hole and further drills through the hole to expand it or stretch it.

Petitioner testified that he went online and obtained a video of a drill press machine which depicts his movements while operating the drill press, and that the video that he obtained is shown in Petitioner's Exhibit 8. He testified that the online video depicts a machine which is larger than the machine that he uses, but that the functions and movements are the same.

With regard to prior medical treatment, Petitioner testified that he had occasional problems with his right shoulder before the alleged date of accident. He testified that he had injections in his right shoulder by his primary care physician in June of 2014, August of 2014, December of 2014, February of 2015 and August of 2015. Petitioner testified that he continued working full duty during this period of time. He testified that in October of 2015, he was hospitalized with an unrelated problem and was off work for approximately one month. He testified that upon his return to work, he had to be seen by Caterpillar First Aid in order to be cleared to return to work. He testified that during that visit to Caterpillar First Aid his right shoulder pain came up, and that Dr. Splitter referred him to Dr. Miller (also with Caterpillar First Aid) for an appointment on December 4, 2015. He testified that he also scheduled an appointment to see Dr. Orlevitch, who was the orthopedic surgeon who had previously performed surgery on his left shoulder.

Petitioner testified that Dr. Orlevitch ordered an MRI of the right shoulder and that upon obtaining those results, he referred him to his partner, Dr. Rameriz, for surgery. Petitioner testified that he continued to work full duty until his surgery which was performed on February 5, 2016, that he was off work from February 5, 2016 through June 30, 2016 and that he returned to work full duty for Respondent on July 1, 2016.

Petitioner also testified that when he returned to work in November of 2015, the forklift trucker had been laid off and business was slow, so he would also operate the fork truck. He testified that prior to the lay-off, he would very seldomly operate the fork truck.

Petitioner testified that in December of 2015, he saw Dr. Miller, Brett Beck (who was the Caterpillar safety man), Ryan Moore (his supervisor) and Shawn Stanley (who is Mr. Moore's supervisor). He testified that he saw Dr. Miller pushing and pulling on the drill and turning the wheels. He testified that he did not see anyone taking any force measurements. He testified that again in January of 2016, he observed a second visit to his machine which again included Dr. Miller, Ryan Moore, Brett Beck and the workers' compensation adjustor. He testified that at that time they were looking at the burnisher and the activities performed by Petitioner while performing that aspect of his job.

Petitioner testified that he prepared a job description which is contained in Petitioner's Exhibit 7 and that it accurately depicted his daily job duties. Petitioner testified that the movements in his video (*i.e.*, Petitioner's Exhibit 8), although they admittedly were in fast motion, accurately display the movements that he performed while working on a daily basis. He testified that they also described his movements with regard to Petitioner's Exhibit 7A, B, and C regarding the traverse wheel and the spindle handle. Petitioner agreed that the video submitted as Respondent's Exhibit 7 was also accurate.

As to the particular parts that he drilled since he became a drill press operator in 2006, Petitioner testified that he was required to keep extensive notes which formed the basis of Petitioner's Exhibit 7. He testified that those listed on Petitioner's Exhibit 7 were all the parts that he drilled on. He testified that he also noted that he was at or above shoulder-level on the machines approximately 65% of the time.

Petitioner described burnishing as a procedure where he uses a hand-held tool to widen some of the holes that are not made wide enough by the drill. He testified that sometimes when performing the burnishing activity, the pressure of the machine attempting to torque will cause the entire drill to rip out of his hands. He testified that this is what is known as a "kick out." Petitioner estimated that burnishing kick outs happen approximately 15% of the time. Petitioner testified that he did not see any testing of the burnishing by any Caterpillar safety personnel or by Dr. Miller when he came to examine the workplace.

Petitioner testified that the number of holes he drills a day can vary depending upon how the parts are made and that it can range from 3 holes to 30 or more holes for each part. He estimated that the parts vary in height to 30 inches tall. He testified that to get an accurate measurement of the height, one needed to consider the height of the part on which you would be drilling. He testified that Petitioner's Exhibit 7 on page 1 contained measurements from ground floor to the traverse wheel, the spindle handle and the manual speed.

On cross examination, Petitioner admitted that in 2008 he reported to Caterpillar First Aid with pain in both of his shoulders. He agreed that at that time he had sharp pain in his left shoulder and a dull pain in his right. He agreed that had surgery performed on his left shoulder in 2008 and was released to return to work full duty. He testified that he continued to work full duty even though his right shoulder would bother him periodically, even though he had received several injections from Dr. Brune, his primary care physician.

Jason Pettit was called as a witness by Respondent at the time of arbitration. Mr. Pettit testified that has worked for Respondent for 14 years and is currently the EHS (Environmental Health and Safety) manager for Buildings KK and HH, which he has done since January of 2017. Mr. Pettit testified that he performed an ergonomic assessment of Petitioner's job duties in January of 2017. He testified that it was unusual to perform the assessment so long after the injury and that he was asked to "fill in some gaps" in the initial investigation. He testified that the initial investigation report was not available for his review when he prepared his report.

Mr. Pettit testified that he prepared Respondent's Exhibit 3, which contains his conclusions of the ergonomic assessment that he performed. While Mr. Pettit attempted to explain the various parts of the drill, he readily admitted that he was "not very mechanically inclined." He testified that the drill in Petitioner's Exhibit 7 operated similarly to the drill Petitioner used, but that the drill in Petitioner's Exhibit 7 was larger in size.

On cross examination, Mr. Pettit admitted he did not perform his examination until January 19, 2017. He testified that he was unaware that two other evaluations had been done. He admitted that no parts were being drilled in the pictures of his demonstration as contained in Respondent's Exhibit 3. He also admitted that the drill would move up or down depending on the height of the part.

On cross examination, Mr. Pettit admitted that he was not familiar with the parts that Petitioner would have drilled from 2006 until the present. When asked about specific part numbers that were referenced in Petitioner's Exhibit 7, Mr. Pettit admitted that he had no idea what the parts looked like. He agreed that it would be good to know how many parts Petitioner worked on. He also admitted that he had no idea whether Petitioner worked on medium or high parts. He testified that Petitioner spent some 60% of his time on a forklift before the alleged incident, but admitted that he did not have any documentation that would support that assumption.

On rebuttal, Petitioner testified that before December 4, 2015, he spent approximately 15% of his time on the forklift. He testified that before October of 2015, he was rarely on the forklift. He testified that when he came back from being in the hospital in the first part of November of 2015, the forklift trucker was laid off and that it was only at that point that he had to use the forklift more frequently.

The transcript of the deposition of Dr. Miguel Ramirez was entered into evidence at the time of arbitration as Petitioner's Exhibit 1. Dr. Ramirez testified that he is board-eligible in orthopedic surgery. (PX1).

Dr. Ramirez testified that he first saw Petitioner on January 7, 2016 at the referral of Dr. Orlevitch. He testified that the history provided by Petitioner was that he had seen Dr. Orlevitch in the past, that he had had a previous shoulder injury but that it was worse the four months prior to that, that he had pain that woke him up from sleep and that the pain had gotten worse at work. He testified that when he saw Petitioner, he had a massive tear by MRI so given his age, activity level and work occupation, he felt that they needed to go right to surgery as they did not want the tear to be any larger. He testified that he performed a rotator cuff repair, that the surgery went very well, that Petitioner did therapy and that by the last time that he saw him, Petitioner was doing well and went back to all activities. He testified that Petitioner returned to work at five months. He testified that he has not seen Petitioner since June 30, 2016 and that he had an excellent result. He testified that Petitioner had a very large rotator cuff tear, that the majority of patients were typically not back to 100% and that there was usually some element of weakness or pain here and there. (PX1).

When asked if he had any independent knowledge or remembered having any discussions about what Petitioner did at work, Dr. Ramirez responded that he did not go into specifics with him and that he stated that he operated heavy machinery. After having been given a hypothetical description of Petitioner's job duties and having been asked whether he had an opinion whether his job activities had any role in the problem for which he treated him, Dr. Ramirez responded that the type of work that Petitioner did put stress on the rotator cuff and that he did repetitive rotator cuff-challenging types of activities. He testified that he could not say that it caused it, but that he thought there was a reasonable amount of correlation between the amount of what Petitioner did and the stress that it put on the rotator cuff. (PX1).

On cross examination, Dr. Ramirez agreed that when he saw Petitioner on January 7, 2016, he had access to the records of Dr. Orlevitch and that he was able to review the December 10, 2015 right shoulder

MRI. He denied having had any opportunity to review any of the medical records of Caterpillar or Petitioner's primary care physician at the time of his first office visit with him. He agreed that Dr. Orlevitch noted that Petitioner had had right shoulder pain since at least 2009 and that Petitioner had reported that his pain had increased over the last two months, which would have been approximately October of 2015. (PX1).

On cross examination, Dr. Ramirez testified that he was not aware that Petitioner was treating for a left calf MRSA infection in early October of 2015. When asked whether he thought that Petitioner's symptoms would improve if he were not working during the timeframe of October 6, 2015 to November 2, 2015, Dr. Ramirez responded that they likely would because if one were not testing it, the symptoms should improve somewhat when not working. When asked whether he asked Petitioner if he was using any devices such as crutches or a cane to assist him with walking while he was treating for his left calf MRSA or cellulitis, Dr. Ramirez responded that he did not discuss Petitioner's cellulitis with him. He testified that it was possible that using crutches or a cane in connection with the left calf infection could possibly be the kind of activity that might aggravate a right shoulder condition. (PX1).

On cross examination, Dr. Ramirez testified that he did not document any of Petitioner's hobbies or activities outside of the workplace, nor did Dr. Orlevitch. He testified that he would not have any reason to question the accuracy of the report of the physical therapist who, on March 17, 2016, documented that Petitioner's hobbies were softball and bowling. He testified that both softball and bowling could aggravate a rotator cuff or shoulder pathology. (PX1).

On cross examination, Dr. Ramirez agreed that when Petitioner saw Dr. Orlevitch on December 7, 2015, he reported that two activities were more consistently painful including overhead and behind-the-back activities. He testified that he did not have any general knowledge about the drill specialist position other than the hypothetical provided by Petitioner's attorney. When asked whether the history of his having had multiple steroid injections to the shoulder with no relief was a history given to him by Petitioner, Dr. Ramirez responded that he believed that that was discussed with him because he had been seeing Dr. Orlevitch for some time. He testified that he did not recall having seen any medical records of Great Plains Orthopaedics or OSF Orthopedics showing that Dr. Orlevitch had provided a steroid injection to the right shoulder. He testified that he did not know when those injections were performed, nor did he know how many Petitioner had had. (PX1).

On cross examination, Dr. Ramirez agreed that he thought that the right shoulder MRI films were interpreted correctly and that they showed a full-thickness width supraspinatus tendon tear with retraction to the glenohumeral joint with moderate muscle atrophy. He testified that the retraction referred to the severity and that the more retraction there was, the larger the tear. He testified that the atrophy referred to how much degeneration occurred in the muscle and that it gave him an idea of whether there was a good chance of being repaired or if it would re-tear later. He testified that atrophy could play a role in determining when the tear occurred, but that there was no data to show exactly how much. When asked if it would suggest that the tear occurred before or after October of 2015, Dr. Ramirez responded that it was a tough question and that in generalities the more atrophy there was in the rotator cuff the more chronic the tear was, but that they did not know from person to person how much atrophy one would see from one type to another as everyone atrophied at a different rate. He testified that at least by history, he would say that this was not an acute injury to the rotator cuff because he did not get a history that Petitioner was moving machinery and felt a pop. (PX1).

On cross examination, Dr. Ramirez agreed that he released Petitioner for care of his right shoulder on June 30, 2016 and that he returned him to unrestricted work. He agreed that he has not seen Petitioner since June 30, 2016 for his right shoulder. He testified that he did not review Petitioner's physical therapy discharge note but agreed that if the therapist reported that he had had 100% improvement since starting

therapy, it would be consistent with his findings on June 30, 2016. He agreed that Petitioner did not require any additional medical care to his right shoulder on that date. (PX1).

On cross examination, Dr. Ramirez agreed that in giving the opinions that he gave, he was relying on the radial drill lesson given by Petitioner's attorney and the history given to him by his patient. He agreed that if the history or information was inaccurate or incomplete, it could impact the opinions that he had given on causation. He testified that he did not recall whether Petitioner ever told him that part of his job responsibilities required him to drive a forklift. When asked whether the fact that Petitioner spent 50-60% of his time driving a forklift during the timeframe of 2014-2015 would impact his opinions, Dr. Ramirez responded that it did not change anything because all it took was one real impact to cause damage. (PX1).

On cross examination, Dr. Ramirez testified that he did not know what changes, if any, had been made to Petitioner's work station since March of 2009. He testified that when evaluating whether there was a causal relationship between rotator cuff pathology and an employee's work duties, one would need to know the length of time the patient had been doing the job, the weight and amount of stresses that the shoulder received on a daily basis and when the pain started in relation to that or if there was a particular injury if it was something that had been developing over time. When asked if it was his opinion that his right rotator cuff pathology was caused by repetitive work duties or was caused by a specific trauma that Petitioner may or may not remember doing at his workplace, Dr. Ramirez responded that there was no way for him to know that, that it could be either a combination of the two or could just as easily be that at one time the tool got caught and pulled, causing the tear or small cumulative tears over time. He testified that most of the time, he did not know the cause of a patient's rotator cuff pathology. (PX1).

On cross examination, Dr. Ramirez testified that based on what he read from Dr. Orlevitch's note and from his interaction with him, it seemed that Petitioner was able to do his job prior to the surgery on February 5, 2016. He testified that it bothered Petitioner to do it, but he was able to complete it. (PX1).

On redirect, Dr. Ramirez agreed that if one had a massive rotator cuff tear and sat around for a month doing nothing, the massive tear did not get better but the symptoms could become lessened. He agreed that this could be either be repetitive or a singular trauma, and that his and Dr. Orlevitch's notes did not reveal a singular trauma. He agreed that the concepts of atrophy and retraction did not really help put a date on whether something partially tore or whether it tore at one time. He testified that retraction and atrophy told him that it likely did not occur right before he saw the patient, but how much longer before that he could not speculate. (PX1).

On further cross examination, Dr. Ramirez agreed that it was impossible to date when a tear occurred simply by looking at diagnostic films and that he relied on the history. He agreed that Petitioner's history was that his symptoms increased two months before he saw Dr. Orlevitch on December 7, 2015. (PX1).

The medical records of Great Plains Orthopaedics were entered into evidence at the time of arbitration as Petitioner's Exhibit 2. The records reflect that Petitioner was seen on June 30, 2016, at which time it was noted that he was five months status post rotator cuff repair and was back to doing all activities of daily living without any problems. It was noted that Petitioner had no complaints. Petitioner was released to activities as tolerated and was instructed to return on an as-needed basis. At the time of the May 5, 2016 visit, it was noted that Petitioner was three months status post massive rotator cuff repair and was doing extremely well. It was noted that Petitioner had very minimal pain, that he had improved with physical therapy and that he had no complaints. Petitioner was recommended to continue physical therapy, was to return in two months and was to be off work until then. At the time of the April 7, 2016 visit, it was noted that Petitioner was eight weeks status post right shoulder massive rotator cuff repair and was doing very well. It was noted that Petitioner had very minimal pain, that he had worked on physical therapy and

was doing well and that he had no other complaints. Petitioner was recommended to continue physical therapy for the next four weeks focusing on range of motion of the shoulder. Petitioner was also instructed to return in four weeks. (PX2).

The records of Great Plains Orthopaedics reflect that Petitioner was seen on March 10, 2016, at which time it was noted that he was almost five weeks status post right shoulder massive rotator cuff repair and subpectoral biceps tenodesis. It was noted that Petitioner was doing very well, that he had minimal pain, that he was off his pain medicine completely and that he had no complaints. Petitioner was recommended to start physical therapy for gentle range of motion only. It was noted that Petitioner was going to be in a sling for two more weeks and then he could come out. Petitioner was also instructed to return in one month for re-evaluation. At the time of the February 15, 2016 visit, it was noted that Petitioner was 10 days status post right shoulder massive rotator cuff repair, subacromial decompression, distal clavicle excision and subpectoral biceps tenodesis. It was noted that Petitioner stated that he had been doing very well, that he had minimal pain and that he had no fever, chills or other complaints. Petitioner was recommended to remain in his sling and bolster for three weeks and to do waist-level activities as tolerated. Petitioner was recommended to not lift anything heavier than a coffee cup. Petitioner was also recommended to return in three weeks, at which point he was to start physical therapy. (PX2).

The records of Great Plains Orthopaedics reflect that Petitioner was seen on January 7, 2016 in consultation for Dr. Orlevitch. It was noted that Petitioner was seen for examination of his right shoulder, that he had injured his shoulder several years ago but had gotten worse in the past four months and that he felt that the pain was waking him up from sleep. It was noted that Petitioner's shoulder had gotten aggravated while using it at work, that he had some popping and grinding and that he had seen Dr. Ramirez's partner, who diagnosed a massive rotator cuff tear. It was noted that Petitioner had had multiple corticosteroid injections to the shoulder with no relief, that he had also had physical therapy and had not improved and that he was taking Ibuprofen for pain, but that it had not improved his pain. It was noted that the MRI was reviewed which showed that Petitioner had a very large rotator cuff tear with retraction almost to the glenoid, that he had some mild muscle atrophy and that he had some fluid in his biceps sheath as well as his AC joint. The assessment was noted to be that of a massive rotator cuff tear. Petitioner was recommended to undergo surgery, but it was noted that it was possible that it could not be repaired given the chronicity and amount of retraction and that it may require open repair plus or minus graft if it failed. (PX2).

The records of Great Plains Orthopaedics reflect that Petitioner was seen by Dr. Orlevitch on December 21, 2015, at which time it was noted that he was there for right shoulder MRI results. It was noted that Petitioner still had the ability to elevate his arm and that he still had tightness on the right side to L1-T12 as compared to his opposite side. It was noted that the MRI results showed that Petitioner had a very large rotator cuff tear, that he had a large gap with retraction of the cuff to the glenohumeral joint, that he still had a stump remaining on the greater tuberosity and that it may be a difficult one to mobilize. Petitioner was recommended to undergo repair and was referred to Dr. Ramirez for consultation. At the time of the December 7, 2015 visit, it was noted that Petitioner had had years of right shoulder pain and that even when Dr. Orlevitch was seeing him for his left shoulder he was having occasional pain then off and on, but that it had been more consistently painful with overhead and behind-the-back activities over the last two months. It was noted that Petitioner recalled no specific injury, that he worked as a drill specialist at Caterpillar and had done so for years, and that he had had surgery on his left shoulder in 2009 which was that of an acromioplasty and anterior-superior labral debridement for a type I tear, as well as a Buford complex. It was noted that Petitioner was discharged to full duty in March of 2009. It was noted that Petitioner stated that, with using different ergonomics at work he had been able to deal with his on-and-off pain over the years, but now it was more persistent and more severe. It was noted that Petitioner had non-traumatic left [*sic*] shoulder pain, off and on for years, worse over the last two months. Petitioner was

recommended to undergo an MRI to rule out rotator cuff pathology. Petitioner was also instructed on posterior capsule stretches given his tightness. (PX2).

Included within the medical records of Great Plains Orthopaedics was an interpretive report for an MRI of the right shoulder performed on December 10, 2015, which was interpreted as revealing (1) full-thickness full width supraspinatus tendon tear with retraction to the glenohumeral joint with moderate muscle atrophy; mild infraspinatus insertional tendinosis; (2) mild acromioclavicular degenerative joint disease. The records reflect that a Work Slip was issued on June 30, 2016, allowing Petitioner to return to work without restrictions as of June 30, 2016; that a Work Slip was issued on May 5, 2016, indicating that Petitioner was unable to work for two months; that a Work Slip was issued on March 10, 2016, indicating that Petitioner was unable to work until the next office visit; and that a Work Slip was issued on February 15, 2016, indicating that Petitioner was unable to work until his next appointment in three weeks. (PX2).

The medical records of OSF St. Francis Medical Center dated January 22, 2016 were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The records appear to pertain to MRSA-related testing. (PX3).

The medical records of OSF St. Francis Medical Center dated February 5, 2016 were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. The records reflect that on February 5, 2016 Petitioner underwent surgery by Dr. Ramirez, which was that of right shoulder arthroscopic rotator cuff repair; right shoulder arthroscopic extensive intra-articular debridement; rights shoulder arthroscopic decompression acromioplasty; right shoulder arthroscopic distal clavicle resection; and right shoulder open biceps tenodesis for pre- and post-operative diagnoses of right shoulder degenerative full-thickness rotator cuff tear, right shoulder biceps tendonitis and right shoulder persistent subacromial impingement. (PX4).

The medical records of OSF IMPR were entered into evidence at the time of arbitration as Petitioner's Exhibit 5. The records reflect that Petitioner underwent a physical therapy evaluation on March 17, 2016, at which time it was noted that he underwent right rotator cuff tear repair and biceps tendon repair on February 5, 2016, that he stated that no specific injury occurred and that it occurred over time, that he was right-handed and worked as a drill operator and that he stated that he was fighting work comp at that time. It was also noted that Petitioner stated that his hobbies were softball and bowling. Petitioner was discharged on June 30, 2016 and it was noted that he had 100% improvement since starting therapy. (PX5).

The Medical Bills Exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibit 6.

Petitioner's Job Description was entered into evidence at the time of arbitration as Petitioner's Exhibit 7. The Online Video was entered into evidence at the time of arbitration as Petitioner's Exhibit 8.

The medical records of Dr. Daniel Brune were entered into evidence at the time of arbitration as Petitioner's Exhibit 9. The records reflect that at the time of the March 2, 2017 visit, the assessment was noted to include, among other issues, high cholesterol and right knee pain. At the time of the June 15, 2016 visit, the assessment was noted to be that of cellulitis. At the time of the August 24, 2016 visit, it was noted that Petitioner's right shoulder doing "pretty good" and that he was getting stronger. The assessment was noted to be that of high cholesterol and degenerative joint disease of the right shoulder. At the time of the February 26, 2016 visit, it was noted that Petitioner was seen for high cholesterol and his right shoulder. The assessment was noted to be that of high cholesterol, obesity and right shoulder rotator cuff tear status post repair. (PX9).

The records of Dr. Brune reflect that Petitioner was seen on October 22, 2015, at which time it was noted that he was seen for Staph cellulitis. The assessment was noted to be that of MRSA abscess/cellulitis of the left leg. At the time of the October 5, 2015 visit, it was noted that Petitioner had a lesion on his calf.

The assessment was noted to be that of abscess of the left calf and cellulitis of the left calf. The records reflect that Petitioner underwent Kenalog injections to the right shoulder and right knee on August 18, 2015 and that he underwent a Kenalog injection to the right shoulder on February 2, 2015. At the time of the August 18, 2015 visit, it was noted that Petitioner wanted a cortisone shot in his right shoulder and right knee. It was noted that the injection had helped his shoulder in February and that he was planning on seeing Dr. Orlevitch in January. The assessment was noted to be that of impingement of the right shoulder, among other issues. At the time of the February 2, 2015 visit, it was noted that Petitioner was seen for high cholesterol as well as his right shoulder and right knee. It was noted that Petitioner did a lot of overhead activities. The assessment was noted to be that of right shoulder impingement, among other issues. (PX9).

The records of Dr. Brune reflect that Petitioner was seen on December 8, 2014, at which time it was noted that he had a painful right shoulder, among other issues. The assessment was noted to be that of right shoulder impingement, among other issues. Petitioner underwent a Kenalog injection to the right shoulder on that date. At the time of the August 11, 2014 visit, it was noted that Petitioner was complaining of right knee and right shoulder pain, among other issues. It was noted that Petitioner's right shoulder was a little sore after moving gravel with a wheelbarrow. The assessment was noted to be that of right shoulder impingement, among other issues. Petitioner underwent a Kenalog injection to the right shoulder on that date. At the time of the June 2, 2014 visit, it was noted that Petitioner was complaining of right knee and right shoulder pain, among other issues. The assessment was noted to be that of right shoulder impingement, among other issues. Petitioner underwent Kenalog injections to the right shoulder and right knee on that date. At the time of the February 24, 2014 visit, Petitioner was seen for issues related to high cholesterol. At the time of the September 24, 2013 visit, it was noted that Petitioner had had an abnormal EKG and also had high cholesterol, among other issues. (PX9).

The records of Dr. Brune reflect that Petitioner was seen on August 22, 2013, at which time it was noted that he was complaining of right knee and right shoulder pain, among other issues. It was noted that Petitioner worked overhead a lot and that his right shoulder was sore. The assessment was noted to be that of left [*sic*] shoulder impingement, among other issues. Petitioner underwent a Kenalog injection to the right shoulder on that date. At the time of the March 5, 2013 visit, Petitioner was seen for his right knee and high cholesterol, among other issues. At the time of the June 26, 2012 visit, Petitioner was seen for bilateral knee pain. At the time of the October 31, 2012 visit, Petitioner was seen for a fracture of the right 5th metatarsal. At the time of the July 17, 2012 visit, Petitioner was seen for knee pain. At the time of the October 3, 2012 visit, Petitioner was seen for a fracture of the right 5th metatarsal. (PX9).

The Caterpillar Medical Records were entered into evidence at the time of arbitration as Respondent's Exhibit 1. The Caterpillar Employee Incident Form dated December 4, 2015 noted that Petitioner reported that the injury happened over time, that he had a lot of overhead work and that he had sharp pain the right shoulder when moving his arm up and forward. It was noted that Petitioner denied having received any medical care for this injury outside of Caterpillar and that the machines involved were that of M176858 & M21773. The Initial Licensed Health Care Professional Incident/Injury Form dated December 4, 2015 noted a date of injury/illness of December 4, 2015. It was noted that Petitioner stated that he had a history of left shoulder surgery in 2009 to repair his rotator cuff and remove spurs, that he stated that at that time his right shoulder was also bothering him but was told it was not bad enough for surgery, that he stated that over time the pain had gotten worse and that he believed working on his machine had been a contributor because he worked with his hands over shoulder-level and did a lot of torqueing. It was noted that Petitioner rated his pain "8/10 sharp" when it was at its worst but 2/10 on that date, and that he displayed normal range of motion and no bruising, swelling or deformity. It was noted that Petitioner was requesting to see a company physician and that an appointment was given. (RX1).

The Caterpillar records reflect that a Progress Note was prepared dated December 5, 2015, at which time it was noted that Petitioner related that he had been experiencing right shoulder pain ("top") over time

since about 2009, that Dr. Orlevitch operated on the left shoulder in 2009 and that he worked at KK and operated a radial drill which required overhead work. It was noted that Petitioner also did torqueing activities, and that the frequency and duration would vary throughout the work week. It was noted that Petitioner would use over-the-counter medications as needed as well as applying ice, and that there were no neck pain or radicular features other than some numbness in the ulnar nerve distribution of the right hand. The assessment was noted to be that of right shoulder pain – WRP. Petitioner was instructed to continue full duty and use over-the-counter medications per label instructions. It was noted that Petitioner was to follow-up on December 17, 2015 with Dr. Miller. (RX1).

The Caterpillar records reflect that a Progress Note was prepared dated December 16, 2015, at which time it was noted that Petitioner worked at the drill press (three times) with reportedly low force and that there was insufficient force per safety. It was noted that the safety investigator had done the job previously and had deemed it low force, that Petitioner last did the job one month ago and that he would need to review all outside relevant provider records. At the time of the December 17, 2015 visit, it was noted that Petitioner reportedly had had the MRI but the results were unknown, that he wanted the work comp adjuster and Dr. Miller to look at his job and that he was only implicating the drill press operation. It was noted that a viewing of Petitioner's job would be arranged as well as a review of his safety analysis in January, and that precautions were advised. (RX1).

The Caterpillar records reflect that a Progress Note was prepared dated January 5, 2016, at which time it was noted that Dr. Miller had reviewed the job description with the safety investigator, the area manager and Petitioner, and that the only risk factor that Dr. Miller saw in the drill press operation was movement of the press with the arms at or above shoulder-level, but that very low force was required to move it or the drill bit itself into place. It was noted that the only risk factor that Dr. Miller saw in the burnishing job was the unknown force applied by the right arm when burnishing larger parts where the arm was extended toward shoulder-level, as well as the unknown force of what was reported as an occasional kick out by the tool further jerking or extending the right arm. It was noted that the reported frequency and duration of this activity seemed low. It was noted that the force to move the hoist about exerted on the right arm which operated the control seemed low, though it was not measured. It was noted that given that there was no specific incident formerly cited by Petitioner and after consideration of all risk factors, Dr. Miller saw insufficient evidence presently to support definitive work-related causation or aggravation presently as per the OSHA threshold for work-relatedness. (RX1).

The Caterpillar records reflect that a Progress Note was prepared dated January 28, 2016, at which time it was noted that Petitioner brought in a copy of his MRI report which showed a full-thickness supraspinatus tendon tear with retraction and moderate muscle atrophy. It was noted that the retraction distance was 4.9 cm and therefore was not a recent occurrence. At the time of the June 30, 2016 visit, it was noted that Petitioner was status post-surgery of the right shoulder and that he had been released by the orthopedist without restriction. It was noted that Petitioner was off all pain medications. It was noted that Dr. Miller agreed with the fact that Petitioner should be able to perform his job without restriction. (RX1).

The Caterpillar records reflect that an Employee Incident Report was prepared dated September 15, 2008, which noted both shoulders to have been affected. It was noted that Petitioner had sharp pain in the left shoulder, that he had dull pain in the right shoulder and that he had hand numbness. It was noted that Petitioner believed that his work contributed to his injury/illness. The report was signed by Petitioner on September 15, 2008. The Initial Nursing Assessment noted that the reported date of injury/illness was that of September 15, 2008 and that Petitioner's job was that of a parts balancer. It was noted that Petitioner was there for his scheduled appointment with CNS with complaints of bilateral shoulder pain and that when questioned by the nurse as to when the pain began initially, Petitioner stated "a couple of months ago." (RX1).

The Caterpillar records reflect that a Progress Note was prepared dated September 30, 2008, at which time it was noted that Petitioner had right shoulder general diffuse ache which was constant, and that he had left shoulder sharp pain with raising the arm at shoulder-level with an onset of a few months but only in 2008. It was noted that there was a gradual insidious onset with worsening over time, and that there was no definitive trauma or specific known injurious mechanism in or out of work. The assessment was noted to be that of left greater than right shoulder pain with possible impingement on the left. It was noted that Petitioner's job was that of having been in the present job for 1½ years as a Drill Specialist III. At the time of the October 3, 2008 visit, it was noted that safety reported that Petitioner was doing well with preventative restrictions and was doing all essential routine job requirements. It was noted that it was work-related and that it was not recordable. At the time of the October 21, 2008 visit, it was noted that Petitioner's right shoulder was resolved and that his left was still bothering him. At the time of the November 11, 2008 visit, it was noted that Petitioner's left shoulder was improving some and that his right shoulder pain had resolved. It was noted that Petitioner was set up for an MRI, that he was to continue working with the same restrictions and that it was work-related and recordable. It was noted that Petitioner reported that he was to get an electric hoist instead of a manual one. At the time of the November 18, 2008 visit, it was noted that Petitioner's claim was accepted as compensable, that he was to work with the same restrictions and that he was referred to an orthopedist. At the time of the April 23, 2009 visit, it was noted that Petitioner was tolerating moderate weight lifting well as compared to the opposite arm, and that his restrictions were removed. (RX1).

The transcript of the deposition of Dr. Kent Miller was entered into evidence at the time of arbitration as Respondent's Exhibit 2. Dr. Miller testified that he is employed by Caterpillar and has been so employed since July of 1997. He testified that his current position is that of Regional Medical Director. He testified that he is board-certified in occupational medicine and that he was previously also board-certified in family practice. (RX2).

Dr. Miller testified that the role that he plays in OSHA recordkeeping is that of giving an opinion as to what medically may be related to work-relatedness, including diagnoses. He testified that the safety team ultimately made the decision as to whether a particular incident is work-related for OHSA recordkeeping purposes. He testified that he does not play a role in determining whether a claim is compensable under the Illinois Workers' Compensation Act. (RX2).

Dr. Miller testified that the first time that Petitioner made right shoulder complaints to him was back in 2008 and that he first saw him on September 30, 2008. He testified that as to the right shoulder, Petitioner was having a diffuse ache at that time that was constant and that he was also having some stiffness and soreness. He testified that Petitioner stated that the onset had been a few months back but only in 2008 and that it was gradually occurring and worsening over time, but that no specific cause or incident was known. He testified that Petitioner indicated that he had been in this job description about 1½ years as a Drill Specialist III and that he called out pushing and pulling on a manual hoist at variable heights, where he would have to place his arm to push and pull. He testified that sometimes when they had painted the hoist tracks, it could temporarily get harder to push and pull. He testified that Petitioner also called out that aside from a potential concern about the manual hoist, maneuvering and positioning a radial drill and then a sander, sometimes doing that at shoulder-level. He testified that these were activities that Petitioner did at shoulder-level. He testified that Petitioner mentioned that he liked to play softball and that he had no known injury that he was aware of, and that he did yardwork and housework as well. He testified that Petitioner's right shoulder symptoms fortunately improved and that they had resolved as of October 21, 2008. He testified that he continued to follow Petitioner for his left shoulder complaints and that they resolved after he had surgery and rehabilitation. (RX2).

Dr. Miller testified that Petitioner next reported right shoulder problems to Caterpillar Medical on December 4, 2015 and that between April 23, 2009 and December 4, 2015, their medical department did

not have any record that Petitioner continued to have right shoulder complaints. He testified that their department did not receive any records that Petitioner was receiving any right shoulder treatment between those dates. He testified that their department did not routinely receive an employee's medical records from their family physician or an outside specialist, and that he had no records if Petitioner received right shoulder medical treatment from his primary care physician, Dr. Brune, between August of 2013 and August of 2015. (RX2).

Dr. Miller testified that after the nurse evaluation on December 4, 2015, Petitioner was seen by Dr. Splitter on December 8, 2015. He testified that Dr. Splitter was another occupational health physician in Caterpillar's medical department. He testified that according to the history taken by Dr. Splitter, Petitioner indicated that he had been having right shoulder discomfort, moreso on the top side of his shoulder, over time since about 2009, and that he had acknowledged that he had had left shoulder surgery. He testified that Petitioner stated that the right shoulder was not symptomatic enough to warrant surgery. He testified that Petitioner called out again that he operated a radial drill which required some overhead work, and that he mentioned some torqueing activities of variable frequency and duration. He testified that there was a statement that he had no previous shoulder injury or pain, that he used to work as a fitter at Mapleton without injury to the right shoulder and that he had been seen by Dr. Orlevitch recently regarding the right shoulder, that he had had some x-rays taken which showed some spurs and that he had an MRI scheduled for December 21st. (RX2).

Dr. Miller testified that he personally learned of the incident on December 9th and that it was brought to his attention as he was responsible for reviewing all the new claims weekly, with facility safety, of the areas where the incidents occurred and to help them evaluate for OSHA determinations. He testified that he would have discussed the incident with Brett Beck, the facility safety representative at the time. He testified that he had a note on December 16th that he had talked to Mr. Beck again and that he indicated that he had only worked at that particular drill press three times and that in his view, there was insufficient exposure for probable injury. He testified that based on what the safety department was telling him at the time, it was considered not occupational because he had not had opportunity to evaluate the job himself or to make any independent determination on his own. (RX2).

Dr. Miller testified that he first examined Petitioner on December 17, 2015, at which time he performed a physical examination. He testified that Petitioner made a request that he wanted the adjuster to look at his job description. He testified that it was his understanding that, at that time, Petitioner was only implicating the drill press portion of the operation. He testified that he was going to contact safety to arrange a viewing of Petitioner's job in January. He testified that on January 5th he was able to review Petitioner's job and that at that time the area operations manager, Petitioner and the safety investigator were present. When asked of the significance of the review of the drill press operation, Dr. Miller responded that at times Petitioner's arm could be at shoulder-level or slightly above. He testified that the significance of this was that, as one took the arm away from the body moving it to shoulder-level and above, dependent on the force, the frequency and the duration, these would increase or magnify the risk for potential concern. He testified that he did not make a notation of the frequency of Petitioner having moved his shoulder into this posture and that his impression was that the relative force was low. (RX2).

Dr. Miller testified that as to the burnishing job, the concern that Petitioner brought up was that at times when he did this not only could his right arm be elevated but that it had a tendency to kick out, fully extending the arm or jerking a little which, to him, was uncomfortable at times. When asked if the burnishing job presented a risk of injury to the right shoulder, Dr. Miller responded that the force could not be quantified, that the reported frequency and duration of the activity was low and that when considered together, there did not seem to be a significant risk to him. He testified that Petitioner did not report a specific occasion where his right shoulder was injured by the burnishing job. He testified that he talked about and looked at the hoist operations at Petitioner's workstation and that it seemed that what had

previously been a manual operation had been made an automated operation. He testified that operating the hoist did not present a risk of injury to the right shoulder. (RX2).

Dr. Miller testified that in his review of the MRI report, it was significant that Petitioner had a full-thickness tendon tear and had actually retracted almost 5 cm and that, because it was no longer intact, had atrophied to a moderate level. When asked if the findings told him anything about the tear, Dr. Miller responded that it had occurred some time ago and that it implied more of a chronic picture. (RX2).

When asked whether he had reached an opinion as to whether Petitioner's job duties aggravated, caused, or accelerated his right shoulder condition, Dr. Miller responded that it was his opinion that there was insufficient evidence to support definitive work-related causation or aggravation. He testified that OSHA used a standard of more likely than not and that, in his opinion, he did not see that in this case. (RX2).

Dr. Miller testified that at no time between December 4, 2015 and February 5, 2016 did Petitioner receive any work restrictions from either Dr. Orlevitch or Dr. Ramirez regarding his right shoulder. He testified that he did not feel it was appropriate to write any work restrictions during that same timeframe for Petitioner's right shoulder. He testified that at no time during that time period did Petitioner complain that he was unable to perform his full job. When asked if Petitioner's ability to perform his full job, even given his right shoulder condition, suggested anything about the risks of the job, Dr. Miller responded that it suggested that the risks were relatively low. He testified that he last saw Petitioner for the right shoulder after his surgery and that it occurred on June 30, 2016. He testified that Petitioner's condition at that time was that he had been released by the orthopedist without restriction, that Petitioner was in agreement that he felt that he was ready to work without restriction and that he agreed that he felt that Petitioner should be able to perform his job without restriction as of July 1st. He testified that he has not seen Petitioner since and that he believed that he continued to work at Caterpillar. (RX2).

Dr. Miller testified that a shoulder moment was an ergonomic tool used to try to appreciate the risk to the shoulder pertinent to causation of injury, and that it was a tool he might use in assessing a workstation. When asked of the significance of a shoulder moment ratio of below .5, Dr. Miller responded that for most workers the risk would be low unless the frequency was very high. He testified that it would be low risk for most workers, but did not mean that there was no risk. (RX2).

On cross examination, Dr. Miller testified that he had no indication that Petitioner did not want to work and that he seemed willing to work. Dr. Miller testified that unless he had the opportunity to see the job himself and learn additional detail, the information supplied to him was from safety. He agreed that he would have relied upon it as 100% accurate. He testified that the safety investigator in the process that had done the job before was Brett Beck. (RX2).

On cross examination, Dr. Miller agreed that as to the notation in the January 5, 2016 note about implicating the drill press operation, he had asked Petitioner what he thought had caused it. He testified that he recalled talking to Petitioner and that at some point in time he had brought up a concern about the burnishing operation. When asked about what Petitioner did with the drill press for which he would need to raise his hands above shoulder-level, Dr. Miller responded that he would need to do so in order to reach the areas where one had to move the various pieces to get the machine to move. When asked if he knew how many times a day Petitioner would raise his hand at or above shoulder-level, Dr. Miller responded that he did not document the exact frequency, but was told that it was on the lower side. He testified that it was not entirely dependent on what safety had told him and that Operations had very detailed records as to what was required in terms of how many piece parts went through the machine. He testified that because the operations manager was there along with safety they would have discussed frequency and duration, but that he did not put any detail in his report. (RX2).

On cross examination, Dr. Miller testified that the reported frequency and duration of the activity having been low was information that came from safety and operations. He testified that outside of occupational medicine, no one was interested in OSHA thresholds. He agreed that the basis for his evaluation was that of the OSHA threshold. He testified that he had no knowledge of the OSHA thresholds having been withdrawn. (RX2).

On cross examination, Dr. Miller testified that his role was not to decide compensability. He testified that the adjusters made their own independent decisions, many times which may vary from the OSHA documentation. He agreed that the adjusters valued his opinion, but to what degree that impacted their final decision was up to them. (RX2).

On cross examination, Dr. Miller testified that he was not going to give an opinion on whether Petitioner needed the surgery because it would depend on the orthopedist's expert opinion as to whether they felt it would be beneficial. He testified that he would defer to the orthopedist on this issue. (RX2).

On cross examination, Dr. Miller testified that the frequency at or above shoulder, to his understanding of what was described to him, was low. He testified that an attempt was made to measure the force of moving the radial drill into position and that, per Jason Pettit, it appeared that there was 12.2 pounds of force. He testified that Mr. Pettit also attempted to measure the burnishing gun kickback, and that it came out anywhere from 5.3 pounds to 15.2 pounds of force. He testified that the measurements came to him after he had formed his opinion. (RX2).

On redirect, Dr. Miller testified that he would consider 12.2 to be low force, that moderate force was somewhere between 20-40 pounds of force and that higher force was generally over 40 pounds. He testified that OSHA did not have a specific number or specific target of force that could be applied to the upper extremities. (RX2).

The Ergonomic Evaluation dated January 2017 was entered into evidence at the time of arbitration as Respondent's Exhibit 3.

The Short-Term Disability Payment History was entered into evidence at the time of arbitration as Respondent's Exhibit 5. The Group Medical Insurance Payment History was entered into evidence at the time of arbitration as Respondent's Exhibit 6.

The Radial Drill Operation Video was entered into evidence at the time of arbitration as Respondent's Exhibit 7.

CONCLUSIONS OF LAW

With respect to disputed issues (C), (E) and (F), given the commonality of facts and evidence relative to those issues, the Arbitrator addresses those concurrently.

The Arbitrator concludes that Petitioner has met his burden of proving that he sustained accidental injuries that arose out of and in the course of his employment with Respondent on December 4, 2015, that timely notice of the accident was given to Respondent and that Petitioner's current condition of ill-being is causally related to his work activities.

As to the issue of notice, the Arbitrator notes that at the time of arbitration, Petitioner testified that on December 4, 2015 when he saw Dr. Miller he had a discussion with him about his shoulder and that it was on this date that he had a feeling that his condition of ill-being in the right shoulder may have been

caused by his work duties. Based on the foregoing, the Arbitrator finds that timely notice of the accident was given by Petitioner to Respondent.

In so concluding that Petitioner's right shoulder condition of ill-being is related to his work activities, the Arbitrator finds Petitioner to be a credible witness on his own behalf. The Arbitrator notes that Petitioner's description of his job duties was consistent with the videos that were entered into evidence at the time of arbitration, even with Petitioner's admission that the machine depicted in Petitioner's Exhibit 8 was larger than the machine that he used while working for Respondent. (PX8; RX7). Having reviewed and considered the evidence as a whole, the Arbitrator finds Dr. Ramirez's causation opinion to be persuasive and further finds that Petitioner's testimony at the time of arbitration was consistent with the hypothetical job duties as posed to Dr. Ramirez upon which his causation opinion was based. (PX 1). As a result thereof, the Arbitrator finds that Petitioner's job duties at or above shoulder-level are sufficiently repetitive or cumulative to support a finding of causation for the right shoulder condition.

Based upon the foregoing and the record as a whole, the Arbitrator concludes that Petitioner has met his burden of proving that he sustained accidental injuries that arose out of and in the course of his employment with Respondent on December 4, 2015, that timely notice of the accident was given to Respondent and that his current condition of ill-being is causally related to his work activities.

With respect to disputed issue (J) pertaining to necessary medical services, in light of the Arbitrator's aforementioned conclusions, the Arbitrator finds that Petitioner's care and treatment to his right shoulder was reasonable, necessary, and causally related to his work accident of December 4, 2015. As a result, the Arbitrator finds that Respondent shall pay all reasonable and necessary medical services as set forth in Petitioner's Exhibit 6, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit for all medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

With respect to disputed issue (K) pertaining to temporary total disability benefits, the Arbitrator notes that Petitioner seeks temporary total disability benefits for the timeframe of February 5, 2016 through June 30, 2016. (AX1). Related thereto, the Arbitrator notes that the parties agreed at the time of Dr. Ramirez's deposition that Petitioner was off work beginning on February 5, 2016 and that he returned to work on July 1, 2016. (PX1). As a result thereof, the Arbitrator finds that Respondent shall pay temporary total disability benefits for a period of 20 5/7 weeks, addressing the timeframe of February 5, 2016 through June 30, 2016, given the Arbitrator's findings with respect to disputed issues (C), (E) and (F).

With respect to disputed issue (L) pertaining to the nature and extent of Petitioner's injury, and consistent with 820 ILCS 305/8.1b, permanent partial disability shall be established using the following criteria: (i) the reported level of impairment pursuant to subsection (a) of Section 8.1b of the Act; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. 820 ILCS 305/8.1b. No single enumerated factor shall be the sole determinant of disability. *Id.*

With respect to Subsection (i) of Section 8.1b(b), the Arbitrator notes that no AMA rating was offered by either party in this matter. As a result thereof, the Arbitrator gives no weight to this factor.

With respect to Subsection (ii) of Section 8.1b(b), the Arbitrator notes that Petitioner continues to work for Respondent. The Arbitrator finds that the nature and demands of his position will likely have some affect on his permanent partial disability and, as such, the Arbitrator places greater weight on this factor when making the permanency determination.

With respect to Subsection (iii) of Section 8.1b(b), Petitioner was 52 years old on his date of accident. Given the age of Petitioner and the fact that his treating physician, Dr. Ramirez, gave him a full duty/no restriction release, the Arbitrator places lesser weight on this factor when making the permanency determination.

With respect to Subsection (iv) of Section 8.1b(b), the Arbitrator notes that Petitioner continues to work for Respondent and was given a full duty release by his treating physician, Dr. Ramirez. There was no evidence proffered at arbitration to demonstrate that this work accident has impaired or otherwise affected his future earnings capacity. The Arbitrator places no weight on this factor when making the permanency determination.

With respect to Subsection (v) of Section 8.1b(b), the Arbitrator notes that Petitioner testified that he was able to continue bowling, but that his team had fallen apart. Petitioner testified that he was returned to work full duty on June 30, 2016 and that he came back to all of his regular job duties without any problems. Petitioner testified that he no longer takes any prescription medications for his shoulder. At his final office visit with Dr. Ramirez on June 30, 2016, it was noted that Petitioner was five months status post rotator cuff repair and was back to doing all activities of daily living without any problems. It was noted that Petitioner had no complaints. Petitioner was released to activities as tolerated and was instructed to return on an as-needed basis. (PX2). The Arbitrator concludes that Petitioner's evidence of disability at the time of arbitration was corroborated by his treating records at the conclusion of his treatment with Dr. Ramirez. The Arbitrator accordingly places greater weight on this factor in determining permanency.

The Arbitrator notes that the determination of permanent partial disability benefits is not simply a calculation, but an evaluation of all of the factors as stated in the Act in which consideration is not given to any single factor as the sole determinant. Based on the above factors and the record in its entirety, the Arbitrator concludes that Petitioner sustained permanent partial disability to the extent of 10% loss of use of the person-as-a-whole under Section 8(d)2 of the Act.

SOIACC023

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

Todd D Ehlers,

Petitioner,

20IWCC0054

vs.

NO: 16 WC 39092

State of IL/Department of Juvenile Justice,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, prospective medical 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 11, 2019, 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

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

SQ1KC0008

20 IWCC0054

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

Pursuant to §19(f)(1) of the Act, claims against the State of Illinois are not subject to judicial review. Therefore, no appeal bond is set in this case.

DATED: JAN 24 2020
o1/9/20
DLS/rm
046

Deborah L. Simpson

Barbara N. Flores

Marc Parker

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

20IWCC0054

EHLERS, TODD D
Employee/Petitioner

Case# **16WC039092**

ST OF IL/DEPARTMENT OF JUVENILE JUSTICE
Employer/Respondent

On 7/11/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.07% 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:

4075 FISHER KERHOVER COFFEY ET AL
JASON COFFEY
600 STATE ST
CHESTER, IL 62233

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

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

1350 CENTRAL MANAGEMENT SERVICES
BUREAU OF RISK MANAGEMENT
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

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

JUL 11 2019

Brendan O'Rourke, Assistant Secretary
Illinois Workers' Compensation Commission

20IWCC0054

20IWCC0054

STATE OF ILLINOIS)
)SS.
COUNTY OF Williamson)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Todd D. Ehlers,
Employee/Petitioner

v.

State of Illinois/Department of Juvenile Justice,
Employer/Respondent

Case # **16** WC **39092**

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 **Robert M. Harris**, Arbitrator of the Commission, in the city of **Herrin**, on **June 12, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **December 16, 2016**, Respondent ***was*** operating under and subject 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 $**52,852.00**; the average weekly wage was $**1,054.85**.

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

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

Respondent shall be given a credit for all TTD paid to date.

Respondent is entitled to a credit for all medical benefits paid to date through their group health insurance plan pursuant to Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical services as provided in Petitioner's Group Exhibit #6, 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 to date, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall authorize and pay for the surgery currently recommended by Dr. Matthew Gornet, Petitioner's 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.

ADOOSVIOS

Robert M. Harris

20IWCC0054

Signature of Arbitrator Robert M. Harris

July 11, 2019
Date

JUL 11 2019

20IWCC0054

STATE OF ILLINOIS)
)SS.
COUNTY OF Williamson)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Todd D. Ehlers,
Employee/Petitioner

v.

State of Illinois/Department of Juvenile Justice,

Case # **16** WC **39092**

Consolidated cases: **None**

FINDINGS OF FACT

The parties presented for arbitration on June 12, 2019 pursuant to Section 19(b) of the Act. Petitioner alleges he suffered a work-related back injury on December 16, 2016 leading to the current recommendation for low back surgery. Respondent disputed Petitioner's current condition and need for surgery is causally related to the work injury. Respondent is also disputing liability for some of the medical bills incurred based solely upon their dispute as to causal connection. Respondent did not dispute the reasonableness of the medical bills as contained in Petitioner's Group Exhibit #6.

Petitioner testified at arbitration. Todd Ehlers is a forty-one-year-old educator currently employed by the Illinois Department of Corrections (T15-16). On December 16, 2016, Petitioner was employed by the State of Illinois Department of Juvenile Justice as a Juvenile Justice Specialist, a correctional officer in a juvenile facility (T16-17). There were two youths involved in an altercation on December 16, 2016, and Petitioner and a co-worker were attempting to break up the altercation when one of the youths fell to the ground on top of Petitioner injuring Petitioner (T17-18). Petitioner reported his injury to his employer and several witnesses wrote written reports of the injury as well (T18) (Rx. 1.)

Petitioner went to the emergency room at Chester Memorial Hospital later that same evening arriving around 11:59 a.m. (T19)(Px. 1, pg. 3)). At the emergency room, Petitioner stated he was breaking up a fist fight at work and hit the floor and a youth fell on him (Px. 1, pg. 3). Petitioner complained of burning pain in his low back

that gets sharp with movement (Px. 1 pg. 3). Petitioner underwent x-ray examination at the emergency room which indicated mild degenerative disc disease at the L5-S1 level of the spine (Px. 1, pg. 11).

Petitioner followed-up with his primary-care physician (T19). Petitioner was seen at the Chester Clinic on December 19, 2016 documenting his work injury (Px. 2, pg. 4). Petitioner's physician referred him to physical therapy (Px. 2, pg. 4). On December 27, 2016, Petitioner presented again for re-evaluation and noted he was not feeling much better having difficulty sitting or driving for any extended period of time, and further noting physical therapy had not contacted him yet to establish care (Px. 2, pg. 7). By January 3, 2017, physical therapy still had not been initiated, and Petitioner noted his back pain does seem to get more intense when he is sitting erect (Px. 2, pg. 10). On January 17, 2017, Petitioner was reporting his pain would reach 8 or 9 out of ten at times in spite of starting physical therapy so Petitioner was referred for MRI examination and to continue physical therapy (Px. 2, pgs. 12-13). Following MRI examination, Petitioner was referred to a neurosurgeon, Dr. Franklin Hayward (T20) (Px. 2, pg. 16).

Petitioner was seen by Dr. Franklin Hayward at Heartland Spine Institute on February 20, 2017 (Px. 3, pg. 2). Petitioner provided the same history of injury and complained of low back pain as well as numbness in his bilateral feet (Px. 3, pg. 2). Dr. Hayward reviewed Petitioner's MRI as disc dessication at L5/S1 with a diffused disc bulge at L5/S1 which was causing foraminal narrowing right greater than left at L5/S1 (Px. 3, pg. 3). There was also disc dessication and diffused bulge with mild foraminal stenosis on the right at L4/5 as well (Px. 3, pg. 3). Dr. Hayward ordered further diagnostic examinations including x-ray and CT scans, as well as nerve conduction studies with Dr. Sawar (Px. 3, pg. 4).

On March 28, 2017, Petitioner followed-up with Dr. Hayward noting continuing low back pain and left foot numbness (Px. 3, pg. 5). Dr. Hayward noted the nerve conduction study failed to demonstrate radiculopathy, but the CT scan did demonstrate rather significant foraminal stenosis at L5/S1 which was affecting the L5 nerve root (Px. 3, pg. 5, 24-27). Dr. Hayward referred the Petitioner to Dr. Zhu for pain management (Px. 3, pg. 5). Petitioner underwent injections by Dr. Zhu which provided only twelve hours of relief to his back pain and foot numbness (T21)(Px. 3, pg. 7). Physical therapy did not permanently alleviate his low back pain and numbness either (T21). Dr. Hayward wanted Petitioner to see Dr. Zhu again to discuss radiofrequency ablations (Px. 3, pg. 7).

On June 12, 2017, Dr. Hayward noted Petitioner had neural foraminal stenosis bilaterally and felt the condition was responsible for Petitioner's intermittent leg pain (Px. 3, pg. 9). Dr. Hayward felt Petitioner's pain was

significant enough to warrant surgical intervention (Px. 3, pg. 10). Dr. Hayward recommended a complete facetectomy at L5/S1 on the left followed by placement of bone graft material with the disc space, as well as a spacer and pedicle screw instrumentation, otherwise known as a trans-lumbar interbody fusion (Px. 3, pg. 10). On September 1, 2017, Petitioner followed-up with Dr. Hayward noting he was awaiting workers' compensation to approve the procedure and indicating Petitioner was still awaiting his IME which wasn't scheduled until October (Px. 3, pg. 11).

Petitioner sought a second opinion with Dr. Matthew Gornet on February 24, 2018 and has continued to treat with Dr. Gornet ever since (T20). Petitioner provided a consistent history of injury to Dr. Gornet and reviewed his prior histories of medical treatment since December 16, 2016 (Px. 4, pg. 102). Petitioner had previously undergone a relatively benign lumbar discogram with Dr. Zhu which Dr. Gornet found to be unreliable (Px. 4, pg. 104). Dr. Gornet felt given the intravenous sedation administered to Petitioner at the time of the discogram, as well as the opening pressures applied during the discogram, the examination was insufficient (Px. 4, pg. 104). Dr. Gornet reviewed the MRI and CT scan and recommended a L5-S1 fusion and L4/5 disc replacement (Px. 4, pg. 104).

Petitioner has been able to work full duty since a couple of weeks after his surgery (T22). He took a new position as an educator with the Illinois Department of Corrections teaching math and English (T22). The educator position allows Petitioner more flexibility with movement to deal with his pain allowing him to stand, sit, and stretch if his low back pain increases (T22). However, Petitioner's overall back pain and foot numbness has not subsided (T23). Petitioner still has sharp back pain in the lower back, constant discomfort, and numbness in the left foot (T23). Petitioner is choosing to undergo back surgery at this time as recommended by Dr. Gornet due to the constant discomfort and pain (T23). Petitioner did not want to undergo the fusion recommended by Dr. Hayward because he has been advised by all of his treating physicians that he would suffer from issues at the level above the fusion in future years (T24). The surgery recommended by Dr. Gornet involves a disc replacement at the level above the fusion which would allow the adjacent discs to be less susceptible to future issues (T25). Dr. Hayward does not even offer disc replacement surgery at this time (T25).

Petitioner is currently working thirty-seven and one-half hours per week with the Illinois Department of Corrections teaching two regularly scheduled classes per day (T29). The work schedule is considered full duty employment (T29). Petitioner will also work periodically as a part-time police officer in the Villages of Ellis Grove, Ruma, and Smithton, all in Illinois (T30). Petitioner will work a maximum of ten hours per week

policing in Ruma, Illinois (T30). Petitioner will work approximately five hours per week in Ellis Grove, Illinois, and he has one eight-hour shift per month in Smithton, Illinois (T30-31). Petitioner wears a ballistics vest and uniform when he is working as a police officer (T33). The vest weighs approximately four pounds (T34). Petitioner has been trained in policing regarding how to restrain combative people, but he did not utilize his training during the altercation causing his work injury because the regulations of the Department of Juvenile Justice will not allow for him to perform the same techniques as in the policing arena (T36). Petitioner is restricted by the Villages in the police duties he can perform at this time (T39). Petitioner conducts patrol stops and performs investigations but any further escalation beyond those two simple duties he is to call for backup (T39-40). The Villages Petitioner is doing police work in have populations of approximately 300 people so there are many times Petitioner goes a whole shift without getting a single call (T40).

Petitioner does lift free weights and performs cardio exercise two to three times per work at this time (T37). He does not perform any squats or dead lifts but does engage in light bench press (T37-38). Petitioner does not run but does walk for cardio (T38). Petitioner does not ride a bicycle (T38). Petitioner does hunt birds and deer with a revolver (T 38-39). He does not bow hunt (T38).

Petitioner's treating physician, Dr. Matthew Gornet, testified via evidence deposition on February 15, 2019, and the transcript of said deposition was admitted into evidence at arbitration. Dr. Gornet is a board-certified orthopedic surgeon devoted to spine surgery for over the last twenty years (Px. 4, pg. 4). Dr. Gornet focuses his practice on spine surgery treating approximately 120 patients per week and performing 5-10 surgeries per week (Px. 4, pg. 5). Dr. Gornet testified Petitioner presented to him on February 24, 2018 with low back pain to both sides, both buttocks, and both hips with intermittent leg tingling and persistent tingling in his left foot (Px. 4, pg. 7). Dr. Gornet reviewed Petitioner's mechanism of injury and medical history following his work injury and felt the Petitioner's symptoms were causally connected to his work injury (Px. 4, pg. 8). Dr. Gornet noted Petitioner was recommended for radiofrequency ablations by Dr. Hayward, but Petitioner heard about disc replacement surgery and wanted a referral to him (Px. 4, pg. 8).

Dr. Gornet performed a physical examination on Petitioner and found he had decreased sensation in the S1 dermatome on the left which correlated to the Petitioner's subjective complaints (Px. 4, pg. 9). Petitioner's strength and reflexes were essentially normal (Px. 4, pg. 10). Dr. Gornet also reviewed the diagnostic examination films and found obvious central herniation/annular tear at both L4/5 and L5/S1 best visualized on image 7 of 17 of the T2 weighted sagittals and STIR sequences of the MRI of January 26, 2017 (Px. 4, pg. 10).

Dr. Gornet's review of the CT scan of January 12, 2018 showed an obvious annular tear centrally at L4-5 and an extravastation and tear in the disc at L5/S1 (Px. 4, pg. 10). Dr. Gornet printed out the films and marked on them to show the herniations and annular tears present, and these films were attached to the deposition transcript and directly viewed by the Arbitrator herein. (Px. 4, pg. 11).

Dr. Gornet testified the films, the results on physical examination, and Petitioner's subjective complaints correlated (Px. 4, pg. 12). Accordingly, Dr. Gornet stated he would disagree with the Section 12 evaluator when he found no disc herniation and/or annular tears (Px. 4, pg. 12).

Dr. Gornet diagnosed Petitioner with disc injury at L4/5 and L5/S1 with some aggravation of preexisting disc degeneration at L5/S1 (Px. 4, pg. 16). Dr. Gornet opineed Petitioner had exhausted all conservative care without symptom relief so he is recommending either two disc replacements or a disc replacement at L4/5 and fusion at L5/S1 (Px. Pg. 16). Dr. Gornet based his recommendation on patients he has treated with like conditions with good to excellent results and the medical literature and peer-reviewed process which validates this form of surgical treatment (Px. 4, pgs. 16-17).

Dr. Gornet did not believe radiofrequency ablations would provide significant benefit with Petitioner because the patient does not have significant facet arthropathy (Px. 4, pg. 17). Dr. Gornet testified Petitioner was in a holding pattern at this time until the surgery would be approved (Px. 4, pg. 18). Dr. Gornet testified he opined Petitioner's current condition and need for surgery was causally connected to his work injury and the treatment he has recommended is both reasonable and necessary (Px. 4, pg. 18).

On cross-examination, Dr. Gornet testified he had seen Petitioner a total of three times (Px. 4, pg. 22). Petitioner's pain scale rating at the first visit with Dr. Gornet was a 3 out of 10 (Px. 4, pg. 22). Dr. Gornet did not ask Petitioner to rate his pain on the pain scale at any other visit, and Petitioner's complaints remained identical for all three visits (Px. 4, pg. 23). Dr. Gornet remembered Petitioner stating his complaints affected his quality of life but did not have specific activities listed in the medical notes (Px. 4, pg. 24).

Dr. Michael Chabot, Respondent's Section 12 evaluator, testified via evidence deposition on October 26, 2018, and the transcript of said deposition was admitted into evidence at arbitration. Dr. Chabot is a board-certified orthopedic surgeon who is fellowship trained in spine surgery (Rx. 3, pg. 4). Dr. Chabot usually performs surgery two days per week (Rx. 3, pg. 5). Dr. Chabot also performs independent medical evaluations in the legal

field about six times per week (Rx. 3, pg. 5). The majority of the independent medical evaluations are for the employer or employer's representative (Rx. 3, pg. 6). Dr. Chabot reviewed medical records, performed a physical examination and authored a report regarding the Petitioner (Rx. 3, pg. 7). Dr. Chabot's physical examination revealed decreased sensation in Petitioner's left lateral calf and left first webspace (Rx. 3, pg. 8). Petitioner completed a questionnaire on the date of the evaluation and rated his pain on the pain scale of about 1.5 out of 10 (Rx. 3, pg. 8).

Dr. Chabot reviewed x-rays and an MRI film from January 26, 2017 and found diminished disc space height of L5/S1 of about sixty percent and, to a lesser extent, at L4/5 as well (Rx. 3, pg. 9). There was significant disc space collapse and degermation at the L5/S1 level and evidence of mild facet degeneration and mild bilateral foraminal narrowing at L4/5 (Rx. 3, pg. 9). Dr. Chabot did not appreciate any disc herniation in Petitioner's low back (Rx. 3, pg. 9). Dr. Chabot diagnosed the Petitioner with back strain, back pain, and disc degeneration (Rx. 3, pg. 10). Dr. Chabot testified Petitioner's diagnosis was causally related to his reported work injury (Rx. 3, pg. 11). At the time of the deposition, Dr. Chabot was not aware Petitioner was treating with Dr. Gornet and did not have any opportunity to review his medical records (Rx. 3, pg. 11).

Dr. Chabot opined Petitioner was not a candidate to undergo a surgical procedure as it would not guarantee a satisfactory outcome (Rx. 3, pg. 15). Dr. Chabot opined Petitioner had pain propagators coming from his facet joints which could not be addressed with a one or two level fusion (Rx. 3, pgs. 15-16). Dr. Chabot recommended aggressive core strengthening program and the use of over-the-counter medications (Rx. 3, pg. 16).

On cross-examination, Dr. Chabot admitted he did not review the actual discogram films but just Dr. Zhu's report of the procedure (Rx. 3, pg. 19). Dr. Chabot did not appreciate any annular tearing on review of the MRI (Rx. 3, pg. 19). Dr. Chabot did opine the findings he made on physical examination could indicate radicular symptoms in the Petitioner (Rx. 3, pg. 20). Dr. Chabot also felt Petitioner was credible while discussing his injury and pain (Rx. 3, pg. 23).

Dr. Chabot felt Petitioner's low pain responses during the discogram were significant relative to his opinion but did admit the intravenous sedation during the procedure could affect the Petitioner's pain responses (Rx. 3, pg. 22). Dr. Chabot also admitted that the pain scale, in general, is subjective in nature (Rx. 3, pg. 22). Dr. Chabot did not recommend radiofrequency ablations for Petitioner (Rx. 3, pg. 27).

Dr. David Robson performed a Chart Review dated March 19, 2019 and Petitioner admitted the report into evidence at arbitration. Dr. Robson reviewed medical records spanning December 17, 2016 to April 23, 2019 including records from Dr. Gornet, Dr. Hayward, Frontenac Surgery Center, Dr. Michael Chabot, Apex Physical Therapy, as well as the diagnostic films from Chester Memorial Hospital, MRI Partners of Chesterfield, and St. Luke's CDI (Px. 7, pgs. 1-2). Dr. Robson summarized and concluded that "all physicians agree that the incident as described on 12/16/16 was the causative factor in the development of his symptoms and treatment to date" (Px. 7, pg. 2). Dr. Robson indicated Petitioner's pain scores were low and the Petitioner was working without restriction which would indicate the Petitioner should just accept his condition as is. However, if things had changed, the Petitioner would certainly be a candidate for a fusion from L4-S1, or a disc replacement at L4/5 and fusion at L5/S1 which Dr. Robson believed to be equivalent operations and would be related to Petitioner's initial work injury (Px. 7, pg. 2).

CONCLUSIONS OF LAW

The Arbitrator adopts and incorporates the Statement of Facts above into the Conclusions of Law sections below. Disputed issues:

F. ☒ Is Petitioner's current condition of ill-being causally related to the injury? Based on a review of the record, the Arbitrator finds and concludes as follows:

Petitioner has sustained his burden of proof regarding causal connection herein. Essentially, every treating physician stated Petitioner's current condition of ill-being is causally related to his work injury. Dr. Gornet and Dr. Chabot testified Petitioner's condition was causally related to his work injury. Dr. Robson's record review stated the same. The only dispute is whether Petitioner needs surgery as a result of his work 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? Based on a review of the record, the Arbitrator finds and concludes as follows:

Respondent disputed liability for the incurred medical bills based upon causal connection. Respondent did not dispute whether the medical bills were reasonable and necessary. As stated, every physician testified Petitioner's current condition was causally related to his work injury. Accordingly, Respondent shall pay for the incurred medical bills as detailed in Petitioner's Group Exhibit #6. Respondent shall be given a credit for

medical benefits that have been paid to date, 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? Based on a review of the record, the Arbitrator finds and concludes as follows:

Petitioner is entitled to prospective medical care including the surgical procedure as recommended by Dr. Matthew Gornet, Petitioner's treating physician. Dr. Hayward believed Petitioner needed surgery. Dr. Gornet testified Petitioner needed surgery. Dr. Robson felt Petitioner would require surgery if his pain was getting worse since he last saw Dr. Gornet. **Only Dr. Chabot, Respondent's Section 12 evaluator, believed surgery was not reasonable and necessary.** Dr. Chabot found on physical exam Petitioner was suffering from possible radiculopathy, appreciated no disc herniation or annular tearing on MRI, and had not reviewed any of Dr. Gornet's records. The MRI films were entered into evidence with Dr. Gornet specifying precisely the location of Petitioner's disc herniations and annular tears. Accordingly, Dr. Gornet's testimony is more persuasive than that of Dr. Chabot. Dr. Hayward believed surgery was necessary, and Dr. Robson thought the Petitioner would be a candidate if the Petitioner's condition had worsened. Petitioner's testimony was credible. Petitioner has provided a consistent history of injury. Petitioner testified that his low back condition was affecting his life and he is ready and willing to undergo the procedure recommended by Dr. Gornet. Dr. Chabot conceded during testimony his belief Petitioner was credible. If Petitioner is determined to be credible, and he states his low back pain is affecting his quality of life, then it seems reasonable to conclude prospective medical treatment is necessary and Respondent shall approve and authorize the same.

It is the Commission's function, to choose between conflicting medical opinions. *International Vermiculite Co. v. Industrial Comm'n*, 77 Ill.2d 1, 4, 31 Ill.Dec. 789, 394 N.E.2d 1166, 1168 (1979); *ARA Services, Inc. v. Industrial Comm'n*, 226 Ill. App. 3d 225, 232, 168 Ill. Dec. 756, 590 N.E. 2d 78, 82 (1992). Not only may the Commission decide which medical view is to be accepted, it may attach greater weight to the opinion of the treating physician. *International Vermiculite Co. v. Industrial Comm'n*, 77 Ill.2d 1, 4, 31 Ill.Dec. 789, 394 N.E.2d 1166, 1168 (1979); *ARA Services, Inc. v. Industrial Comm'n*, 226 Ill. App. 3d 225, 232, 168 Ill. Dec. 756, 590 N.E. 2d 78, 82 (1992). Accordingly, the Arbitrator places greater weight, reliance and credibility on the opinions of Petitioner's treating physician Dr. Gornet over those of Respondent's expert examiner Dr. Chabot.

Robert M. Harris

Robert M. Harris, Arbitrator
Dated: July 11, 2019

STATE OF ILLINOIS)
) SS.
COUNTY OF)
CHAMPAIGN

☐ Affirm and adopt (no changes)	☒ Injured Workers' Benefit Fund (§4(d))
☒ Affirm with explanation	☐ 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

ADLAI MILLER,

Petitioner,

20IWCC0055

vs.

NO: 12 WC 26579

LAMBRIGHT DISTRIBUTORS, HAROLD LAMBRIGHT, HAROLD LAMBRIGHT D/B/A LAMBRIGHT DISTRIBUTORS, VERNON LAMBRIGHT (DECEASED), ELSIE LAMBRIGHT, ELSIE LAMBRIGHT D/B/A LAMBRIGHT DISTRIBUTORS, TRAILER REFRIGERATION, INC., ELSIE LAMBRIGHT D/B/A TRAILER REFRIGERATION, INC., VERNON LAMBRIGHT D/B/A LAMBRIGHT DISTRIBUTORS, & IL STATE TREASURER AND EX-OFFICIO CUSTODIAN OF THE INJURED WORKERS' BENEFIT FUND,

Respondents.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondents herein and notice given to all parties, the Commission, after considering the issues of jurisdiction, statute of limitations, employment relationship, accident, causation, notice, average weekly wage/benefit rate, temporary total disability, permanent partial disability, medical expenses both current and prospective, penalties and fees, and evidentiary rulings, and being advised of the facts and law, affirms the Decision of the Arbitrator with explanation, as stated below, and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

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The Arbitrator found that Petitioner was an employee of Lambright Distributors, which was owned purportedly by Vernon Lambright. On June 29, 2012, Petitioner was injured while unloading a truck with a forklift. It was established at arbitration that Lambright Distributors did not have workers' compensation insurance at the time of the accident. The accident eventually resulted in the amputation of Petitioner's right leg below the knee. During the pendency of Petitioner's claim, Vernon Lambright died on June 1, 2015. After his death, Vernon's widowed wife, Elsie Lambright, incorporated Lambright Distributors with the same name, same location, and same assets. Elsie acknowledged at arbitration that she was the owner of the new Lambright Distributors but both she and her son, Harold, denied that she had any ownership interest in the prior incarnation of Lambright Distributors.

Despite her assertion of non-ownership of the original Lambright Distributors, on July 18, 2017, Elsie Lambright executed Payment Contract 16 INC 00011 (settlement contract) with the Commission's Insurance Compliance Unit. She signed the contract on behalf of her deceased husband and herself, individually, and each as owner of Trailer Refrigeration (which was found not liable) and each as owner of Lambright Distributors. Elsie paid $8,500 for an acknowledged failure to carry workers' compensation insurance. An addendum to the contract specifically refers to Adlai V. Miller's pending claim in this matter. She also agreed to pay all benefits due to any employee injured during the period of insurance noncompliance. However, the settlement also specifies that the document did not constitute any admission of liability for any particular workers' compensation claim, including that of Petitioner, and that she specifically denied liability for Petitioner's injury. The settlement also affords Elsie the right to assert any and all legal and factual defenses allowed under the Workers' Compensation Act.

The Arbitrator found that Lambright Distributors, and Elsie Lambright individually, were liable for Petitioner's claim and assessed penalties and fees as well. The Arbitrator relied upon the settlement contract to establish that Lambright Distributors was not a sole proprietorship, but an ongoing business entity in which Elsie had an ownership interest. The Commission agrees with the determination of the Arbitrator and finds that the settlement contract cited above is dispositive on the issues of ownership and whether the statute of limitations was waived.

Elsie has denied being the employer in this case and also asserted an affirmative defense of statute of limitations because she was not a named respondent until the statute of limitations had run. However, by accepting potential liability for "...the pending claim of Adlai V. Miller in case number 12-WC-026579...." on behalf of "Vernon Lambright (deceased) and Elsie Lambright, individually and as owner of Trailer Refrigeration, Inc. and as owner of Lambright Distributors," Elsie effectively waived these arguments on behalf of herself and her deceased husband, individually, or as an owner of Lambright Distributors.

The premise of Elsie's argument that she was not always an owner of Lambright Distributors is that the business was a sole proprietorship owned by the late Vernon Lambright (per her testimony and that of her son, Harold Lambright) which ceased to exist upon his death.

Statutes

Elsie maintains the fact that she carried on the same sort of business under the same name merely indicates she created a new sole proprietorship which does not assume the liabilities of Vernon's sole proprietorship. See *Vernon v. Schuster*, 179 Ill. 2d 338, 348 (1997). Elsie similarly argues that a dead person is a nonexistent entity and cannot be a party to a suit. See *Relf v. Shatayeva*, 2013 IL 114925, ¶ 22. She further contends she and Vernon could not be named as Respondents after the running of the statute of limitations because: (a) the original application was filed against a nullity; and (b) Elsie (even d/b/a Lambright Distributors) is a distinct legal entity from Vernon. See *Vaughn v. Speaker*, 126 Ill. 2d 150, 158-59 (1988).

All of these arguments presuppose that Lambright Distributors was merely a pseudonym used by Vernon as a sole proprietor. However, Elsie specifically accepted potential liability for Petitioner's accident on June 29, 2012 and acknowledged ownership of Lambright Distributors in the execution of the settlement contract. A settlement agreement between two parties cannot be used as an admission of liability against one of them in a related suit. *Pientka v. Board of Fire Comm'rs*, 125 Ill. App. 3d 124, 131 (1984). It may, however, be admissible as some evidence of the status of one of the parties and its effect or the identity of the real party in interest. See *id.* at 129-31 (and cases discussed therein). Thus, the Commission finds that the evidence in this case establishes that Elsie Lambright was a proper Respondent individually and as an owner of Lambright Distributors at the time of Adlai V. Miller's accident.

Regarding Respondents' statute of limitations defense, section 6(d) of the Act provides:

> "In any case, other than one where the injury was caused by exposure to radiological materials or equipment or asbestos unless the application for compensation is filed with the Commission within 3 years after the date of the accident, where no compensation has been paid, or within 2 years after the date of the last payment of compensation, where any has been paid, whichever shall be later, the right to file such application shall be barred." 820 ILCS 305/6 (West 2018).

The time period for filing an application for compensation pursuant to section 6(d) of the Act is considered a statute of limitations that is subject to waiver and estoppel. *Baldock v. Industrial Comm'n,* 63 Ill. 2d 124, 126 (1976); *Pantle v. Industrial Comm'n,* 61 Ill. 2d 365, 367 (1975); *Railway Express Agency v. Industrial Comm'n,* 415 Ill. 294, 299 (1953). "The right to invoke a statute-of-limitations defense can be expressly waived or waived by conduct inconsistent with an intent to enforce that right." *Hassebrock v. Ceja Corp.*, 2015 IL App (5th) 140037, ¶38. "[W]hether there has been a waiver of limitations depends upon the particular facts of the case." *Baldock*, 63 Ill. 2d at 127. For example, where an employer and employee have entered into a settlement agreement after the limitations period has expired and the agreement is confirmed by the Commission, "the conclusion necessarily follows that they waived jurisdiction as to the time limitation with reference to voluntary payment, even though the agreement stated to the contrary." *Tribune Co. v. Industrial Comm'n*, 290 Ill. 402, 405 (1919).

aaaaaaaaa

In this case, Respondents Lambright Distributors, Elsie Lambright, and Elsie Lambright d/b/a Lambright Distributors entered into a settlement contract with the Commission rather than Petitioner, but the effect is the same. The language of the settlement contract, including the addendum, is key. "In interpreting a contract, it is presumed that all provisions were intended for a purpose, and conflicting provisions will be reconciled if possible so as to give effect to all of the contract's provisions." *Shorr Paper Products, Inc. v. Aurora Elevator, Inc.*, 198 Ill. App. 3d 9, 13 (1990). "A court will not interpret a contract in a manner that would nullify or render provisions meaningless, or in a way that is contrary to the plain and obvious meaning of the language used. [Citation.] Further, when parties agree to and insert language into a contract, it is presumed that it was done purposefully, so that the language employed is to be given effect. [Citation.]" *Thompson v. Gordon*, 241 Ill. 2d 428, 442 (2011).

The language of the addendum to the settlement contract obligates Respondents Lambright Distributors, Elsie Lambright, and Elsie Lambright d/b/a Lambright Distributors to pay all benefits due and owing to any petitioners who sustained compensable injuries during the period of noncompliance, while reserving factual and legal defenses. The addendum also specifically refers to Petitioner's claim, while denying actual liability and reserving these Respondents' defenses. The Commission does not interpret the settlement contract to allow these Respondents to deny that they were Petitioner's Employers, because doing so would render these provisions of the contract a nullity. *Id.*

The same reasoning applies to Respondents Lambright Distributors, Elsie Lambright, and Elsie Lambright d/b/a Lambright Distributors assertion of the statute of limitations defense. These Respondents signed the settlement contract on July 18, 2017, with all parties aware that more than three years had elapsed from the date of the accident in this case. Although these Respondents denied actual liability on Petitioner's claim, Respondents nevertheless acknowledged and accepted their potential liability for this claim. To interpret that language as merely the acknowledgement of a time-barred, stale claim would render that language a nullity. *Id.* In submitting to the Commission's jurisdiction regarding potential exposure regarding Petitioner's claim, Respondents Lambright Distributors, Elsie Lambright, and Elsie Lambright d/b/a Lambright Distributors agreed they were Petitioner's employers by the terms of the settlement contract and addendum and waived the limitations defense despite the language generally reserving their defenses to Petitioner's claim. See *Tribune Co.*, 290 Ill. at 405.

This conclusion is also entirely consistent with the purpose of statutes of limitation. As the Illinois Supreme Court has observed:

> "Statutes of limitation, like other statutes, must be construed in the light of their objectives. The basic policy of such statutes is to afford a defendant a fair opportunity to investigate the circumstances upon which liability against him is predicated while the facts are accessible. * * * As observed by Mr. Justice Holmes in *New York Central Railroad* v. *Kinney,* 260 U.S. 340, 342, 'Of course an argument can be made on the other side, but when a defendant

Sample Copy

> has had notice from the beginning that the plaintiff sets up and is trying to enforce a claim against it because of specified conduct, the reasons for the statute of limitations do not exist, and we are of opinion that a liberal rule should be applied.'" *Geneva Construction Co. v. Martin Transfer & Storage Co.*, 4 Ill. 2d 273, 289-290 (1954).

In this case, there is no suggestion that Respondents Lambright Distributors, Elsie Lambright, and Elsie Lambright d/b/a Lambright Distributors were unaware of Petitioner's claim, even prior to Vernon Lambright's death. Given the unique facts and circumstances presented in this case, there is no equitable concern weighing against application of the waiver of the statute of limitations in this case.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondents shall pay to the Petitioner the sum of $253.00 per week for a period of 74 and 2/7th weeks, that being the period of temporary total incapacity for work and/or need for maintenance under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondents pay the medical expenses as specified in the Order of the Arbitrator under §8(a) of the Act, subject to the applicable medical fee schedule in §8.2.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondents pay to Petitioner 253.00 for 100 weeks as provided in §8(d)2 because the injuries resulted in the loss of the use of 20% of the person-as-a-whole and $483.36 a week for an additional 215 weeks because the injuries also resulted in 100% loss of the use off the right leg through amputation.

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

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

IT IS FURTHER ORDERED BY THE COMMISSION that Respondents Lambright Distributors, Elsie Lambright, and Elsie Lambright d/b/a Lambright Distributors shall pay Petitioner penalties of $10,000.00 pursuant to Section 19(l), penalties of $75,221.09 pursuant to Section 19(k), and attorney fees of $15,044.22 pursuant to Section 16.

The Illinois State Treasurer, *ex officio* custodian of the Injured Workers' Benefit Fund, was named as a co-Respondent in this matter. The Treasurer was represented by the Attorney General. This award is entered against the Fund to the extent permitted and allowed under Section 4(d) of the Act. In the event Respondent's Elsie Lambright & Co. fail to pay the benefits awarded, the Injured Workers' Benefit Fund has the right to recover the benefits due and owing the Petitioner pursuant to Sections 5(b) and 4(d) of the Act. Respondents Lambright Distributors, Elsie

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Lambright, and Elsie Lambright d/b/a Lambright Distributors shall reimburse the Injured Workers' Benefit Fund for any compensation obligations of Respondents Lambright Distributors, Elsie Lambright, and Elsie Lambright d/b/a Lambright Distributors.

Bond for the removal of this cause to the Circuit Court by Respondents 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: JAN 24 2020

Deborah L. Simpson

Barbara N. Flores

Marc Parker

DLS/dw
O-12/5/19
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ABSTRACT

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

20IWCC0055

MILLER, ADLAI
Employee/Petitioner

Case# **12WC026579**

LAMBRIGHT DISTRIBUTORS LAMBRIGHT, HAROLD HAROLD LAWBRIGHT D/B/A LAMBRIGHT DISTRIBUTORS LAMBRIGHT, VERNON (DECEASED) LAMBRIGHT, ELSIE ELSIE LAMBRIGHT DISTRIBUTORS TRAILER REFRIGERATION ELSIE LAMBRIGHT D/B/A TRAILER REFRIGERATION & ILLINOIS STATE TREASURER
Employer/Respondent

On 5/21/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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STATE OF ILLINOIS)
)SS.
COUNTY OF CHAMPAIGN)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

ADLAI MILLER
Employee/Petitioner

v.

Case # **12** WC **26579**

Consolidated cases: _____

LAMBRIGHT DISTRIBUTORS, HAROLD LAMBRIGHT, HAROLD LAMBRIGHT D/B/A LAMBRIGHT DISTRIBUTORS, VERNON LAMBRIGHT (DECEASED), ELSIE LAMBRIGHT, ELSIE LAMBRIGHT D/B/A LAMBRIGHT DISTRIBUTORS, TRAILER REFRIGERATION, ELSIE LAMBRIGHT D/B/A TRAILER REFRIGERATION & IL STATE TREASURER AND EX-OFFICIO CUSTODIAN OF THE INJURED WORKERS' BENEFIT FUND
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Christina Hemenway**, Arbitrator of the Commission, in the city of **Urbana**, on **January 16, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☒ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☒ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☒ What was the date of the accident?
E. ☒ 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 **Motion to Dismiss; Liability to Pay Award; and Mutual Release.**

FINDINGS

On **June 29, 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 $**7,694.94**; the average weekly wage was $**334.56**.

On the date of accident, Petitioner was **69** 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 $**25,800.00** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**25,800.00**.

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

ORDER

As explained in the Arbitration Decision, Respondents Lambright Distributors, Elsie Lambright, and Elsie Lambright d/b/a Lambright Distributors ("Elsie Lambright & Co."), shall pay Petitioner **$16,824.50** for medical bills from Orthopedic Center of Illinois and pay Petitioner **$155,854.93** for medical bills from St. John's Hospital. Respondents Elsie Lambright & Co. shall pay **$33,681.41** directly to the U.S. Department of Veterans Affairs for medical bills incurred that were related to Petitioner's work accident. Total medical bills payable under this award are **$206,360.84**.

Respondents Elsie Lambright & Co. shall be given a credit of $63,054.66 for medical benefits previously paid to Carle Foundation Hospital and Carle Physician Group, shall owe nothing more to those providers, and shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit.

Respondents Elsie Lambright & Co. shall pay Petitioner temporary total disability benefits of **$253.00/week** for **64 weeks**, for the period of June 30, 2012, through September 20, 2013, **($16,192.00)**, and shall further pay Petitioner maintenance benefits of **$253.00/week** for **10 2/7 weeks** for the period of September 21, 2013, through December 1, 2013, **($2,602.29)**, for a total of **$18,794.29**.

Respondents Elsie Lambright & Co. shall pay Petitioner the sum of **$253.00/week** for a period of **100 weeks ($25,300.00)**, as provided in **Section 8(d)2** of the Act, because the injuries sustained caused a **20% loss of use of the body as a whole** (loss of occupation), and shall pay Petitioner the sum of **$483.36/week** for a further period of **215 weeks ($103,922.40)**, as provided in **Section 8(e)12** of the Act, because the injuries sustained caused a **100% loss of use/amputation of the right leg**, for a total of **$129,222.40**.

Respondents Elsie Lambright & Co. shall pay temporary benefits of $18,794.29 and permanent benefits of $129,222.40 for a total of $148,016.69, and shall receive credit in the amount **$25,800.00** for benefits previously paid, leaving a balance of **$122,216.69**.

Respondents Elsie Lambright & Co. shall pay to Petitioner penalties of **$10,000.00** pursuant to **Section 19(l),** penalties of **$75,221.09** pursuant to **Section 19(k),** and attorney fees of **$15,044.22** pursuant to **Section 16**, for a total of **$100,265.31**.

The Illinois State Treasurer, ex-officio custodian of the Injured Workers' Benefit Fund, was named as a co-Respondent in this matter. The Treasurer was represented by the Illinois Attorney General. This award is hereby entered against the Fund to the extent permitted and allowed under Section 4(d) of this Act. In the event Respondents Elsie Lambright & Co. fail to pay the benefits awarded, the Injured Workers' Benefit Fund has the right to recover the benefits paid due and owing the Petitioner pursuant to Section 5(b) and 4(d) of the Act. Respondents Elsie Lambright & Co. shall reimburse the Injured Workers' Benefit Fund for any compensation obligations of Respondents Lambright Distributors, Elsie Lambright, and Elsie Lambright d/b/a Lambright Distributors.

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

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

Signature of Arbitrator

May 20, 2019
Date

MAY 21 2019

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STATE OF ILLINOIS)
) SS
COUNTY OF CHAMPAIGN)

20IWCC0055

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

ADLAI MILLER
Employee/Petitioner

v. Case #: **12 WC 26579**

LAMBRIGHT DISTRIBUTORS, HAROLD LAMBRIGHT, HAROLD LAMBRIGHT D/B/A LAMBRIGHT DISTRIBUTORS, VERNON LAMBRIGHT (DECEASED), ELSIE LAMBRIGHT, ELSIE LAMBRIGHT D/B/A LAMBRIGHT DISTRIBUTORS, TRAILER REFRIGERATION, ELSIE LAMBRIGHT D/B/A TRAILER REFRIGERATION & IL STATE TREASURER AND EX-OFFICIO CUSTODIAN OF THE INJURED WORKERS' BENEFIT FUND
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

On July 30, 2012, Petitioner Adlai Miller filed an Application for Adjustment of Claim for date of accident June 29, 2012, seeking relief under the Illinois Workers' Compensation Act from Respondent-Employer, Lambright Distributors. PX1. It was thereafter discovered that Respondent-Employer failed to maintain workers' compensation insurance on Petitioner's date of accident, which was confirmed by Certification from the National Council on Compensation Insurance. PX2. Petitioner thus filed an Amended Application for Adjustment of Claim on March 3, 2015, seeking relief under the Act through the Illinois Injured Workers' Benefit Fund (hereinafter "IWBF"). PX1.

At the request(s) of the State and the Commission, and as new information came to light as to the identity and ownership of the uninsured Respondent-Employer, Petitioner filed:

1. Second Amended Application for Adjustment of Claim on February 6, 2018, adding Vernon M. Lambright and Vernon M. Lambright d/b/a Lambright Distributors.
2. Third Amended Application for Adjustment of Claim on July 9, 2018, adding Harold Lambright and Harold Lambright d/b/a Lambright Distributors.
3. Fourth Amended Application for Adjustment of Claim on November 15, 2018, adding Elsie Lambright, Elsie Lambright d/b/a Lambright Distributors, Trailer Refrigeration, Inc., and Elsie Lambright d/b/a Trailer Refrigeration; modifying to Vernon Lambright (deceased); and removing Vernon Lambright d/b/a Lambright Distributors. PX1.

After proper notice to the parties as to the date, time, and location of hearing, this matter proceeded to arbitration in Urbana on January 16, 2019.

Pursuant to the Act, and given the IWBF is a named party in this case, all issues are in dispute with the exception of Petitioner's age, marital status, and number of dependents.

Testimony of Petitioner and Medical Records

On the date of accident, June 29, 2012, Petitioner was 69 years old, married, and had no dependent children. He is currently 76 years old. Petitioner testified that he had been working for Lambright Distributors (hereinafter "Respondent-Employer") for approximately six months on the date of accident. He testified that he began working for Respondent-Employer in January of 2012, and that he was hired by then-owner Mr. Vernon Lambright (hereinafter "Vernon"). Regarding the specific circumstances under which Petitioner was hired, he testified that Vernon solicited him to begin driving trucks for Respondent-Employer. Petitioner testified that Vernon could not or would not drive automobiles himself because, as a member of the Amish community, driving was against his personal beliefs. Petitioner testified that the entire time he worked for Respondent-Employer, Vernon was his direct supervisor.

Petitioner testified that his work duties included driving trucks, as well as a variety of mechanic-type and warehouse duties, including but not limited to: operating gasoline-powered vacuum pumps; flushing, cleaning, and refurbishing refrigeration units; changing valves; loading and unloading trucks; and operating "SkyTraks" and forklifts. He testified that many of his work duties required the use of hand tools such as wrenches. He testified that Respondent-Employer determined the time, place, and manner of his work, and that Respondent-Employer supplied all tools and equipment used in the performance of his work duties.

Paystubs documenting compensation Respondent-Employer paid to Petitioner for work performed were admitted into evidence. Petitioner received weekly paychecks and was paid at a rate of $9.00 per hour. Respondent-Employer withheld federal and state income taxes from Petitioner's paychecks. On his paystubs, Petitioner was listed as "Employee." The paychecks were paid specifically by Respondent-Employer, "LAMBRIGHT DISTRIBUTORS." Further listed on Petitioner's paystubs was the address and then-owner of Respondent-Employer, "Lambright Distributors, 35E CR 200N, Arthur, IL 61911, VERNON LAMBRIGHT." PX30.

Petitioner testified that the last day he worked for Respondent-Employer was on the date of accident, June 29, 2012. He testified that he did not have any right leg conditions or symptoms prior to the accident.

Petitioner testified that immediately prior to the accident on June 29, 2012, he was operating a forklift to unload a delivery of refrigeration units from the back of a truck. The area where he was unloading units was just inside the entrance to Respondent-Employer's premises, which more generally is located at 35 East County Road 200 North, Arthur, Illinois. PX32. He testified that he used the forklift to raise a refrigeration unit from the truck bed, and as he backed the forklift away from the truck, he encountered "loose rock" and that "the ground became unstable" beneath the forklift. He testified that given the weight of the refrigeration unit and the instability of the ground beneath the forklift, the forklift tipped over onto its right side.

Petitioner testified that as the forklift tipped to the right side, he held on to it and braced his right leg on the ditch bank located between East County Road 200 North and the unloading area on Respondent-Employer's premises. *See* PX32A-C. Petitioner testified that he then attempted to exit the forklift and in so doing, removed his left foot from a steel plate inside the forklift. He testified that the steel plate was where his feet would rest when operating the forklift. Since the forklift was tipped to the right side, once he removed his left foot, the steel plate slid off the forklift and chopped his right leg, which was still braced against the ditch bank. Specifically, the plate hit his right ankle. Petitioner testified that the steel plate was approximately 30 inches long, 12 inches wide, and 3/8-inch thick.

Petitioner testified that after the steel plate hit his right leg, he laid on the ground and waited for the ambulance to arrive. He did not know who called the ambulance. He testified that Vernon Lambright was present on Respondent-Employer's premises at the time of the accident, and though he did not witness the accident occur, he became aware of the accident shortly thereafter. Petitioner testified that following the accident, once he got home from the hospital, he and Vernon Lambright discussed the accident on one occasion.

Petitioner was transported by ambulance to Carle Foundation Hospital. Upon arrival, he had pain and numbness in his right ankle, and a scalp laceration on the back of his head. He underwent X-rays of his right foot, ankle, and knee, as well as CT scans of his right ankle, brain and cervical spine. Imaging studies of his right lower extremity revealed a severely comminuted fracture of the distal tibia and fibula, with fractures extending into the medial malleolus and posterior calcaneus. Imaging studies of his brain and spine were negative for acute findings. The laceration on his head was stapled. Petitioner was admitted to the hospital overnight. He was ultimately diagnosed with a right distal tibia-fibula fracture with intra-articular extension. Open reduction and internal fixation surgery was planned, but Petitioner had significant soft tissue swelling in his right ankle, precluding surgical intervention at that time. His right leg and ankle were placed in a splint. On June 30, 2012, Petitioner was discharged with instructions for further treatment and possible surgery once inflammation in his right leg diminished. PX6.

On July 3, 2012, Petitioner presented for re-evaluation of his right ankle fracture at the Department of Veteran's Affairs medical clinic located in Mattoon, Illinois. Dr. Shantha Monippallil obtained Petitioner's medical records from Carle Foundation Hospital and, upon review, referred Petitioner to the Emergency Department at V.A. Illiana in Danville, Illinois. Petitioner's wife transported him to V.A. Illiana the same day. He was evaluated by Dr. Joyce Brunt at V.A. Illiana, who noted his right distal leg was swollen with several blisters. Dr. Brunt reviewed Petitioner's x-rays and referred him for further orthopedic evaluation at Carle Foundation Hospital. PX7, PX20.

On July 6, 2012, Petitioner presented to Carle Foundation Hospital for reevaluation of his right leg injuries. His splint was removed, revealing the development of serous and bloody fracture blisters on his right leg. He was diagnosed with a right distal tibia-fibula fracture with horrendous soft tissue compromise. His right leg and ankle blisters were "deroofed," the wounds were dressed, and his right leg was reoutfitted with a compression splint. Petitioner underwent a pre-operative consultation at Carle Foundation Hospital the same day, and was instructed to return on July 10, 2012. PX8.

From July 10, 2012, through July 12, 2012, Petitioner received inpatient treatment at Carle Foundation Hospital. PX8, PX9. On July 10, 2012, Dr. Mark Palermo performed an open reduction and internal fixation surgery of Petitioner's right distal tibia and fibula. Following the procedure, antimicrobial treatment was given for 24 hours and then he was fit in a PRAFO boot on his right leg. At discharge, he was ordered to remain non-weightbearing with the right lower extremity, prescribed medications for pain and for DVT prophylaxis, and instructed to follow up in two weeks. PX9.

On July 17, 2012, Petitioner presented to the Emergency Department at Carle Foundation Hospital. He reported that since being discharged following surgery, he suffered fevers and drainage from the surgical area, as well as increased pain and swelling in his right lower extremity. He underwent blood culture and swab tests, which revealed postoperative infection and sepsis. He was admitted for further evaluation and treatment and remained an inpatient at Carle Foundation Hospital from July 17, 2012, until July 23, 2012. On July 19, 2012, he underwent a surgical procedure performed by Dr. Mark Palermo involving irrigation and excisional debridement of the right leg including skin, muscle, and fascia. At discharge, Petitioner was transferred to St. John's Hospital in Springfield, Illinois. PX10.

Upon arrival to St. John's Hospital on July 23, 2012, Petitioner was diagnosed with a nonhealing osteomyelitis ulcer in his right tibia. PX11. He was admitted and remained in inpatient care from July 23, 2012, until August 13, 2012. During that time period, Petitioner underwent numerous diagnostic and surgical procedures, the foremost of which include:

July 23, 2012: Right leg X-rays;
July 24, 2012: Surgery including right tibia and fibula hardware removal, excisional debridement of right tibia and fibula to the level of bone, closed reduction and application of external fixator, and right distal tibia exostectomy (Dr. Osaretin Idusuyi);
July 26, 2012: Right lower extremity angiography (Dr. Colleen Moore); Surgery including excisional debridement of right tibia and fibula to the level of bone, and application of VAC dressing (Dr. Idusuyi);
July 27, 2012: Washout operation of right lower extremity wound with negative pressure wound therapy application (Dr. Nada Berry);
July 31, 2012: Surgery including transfer of left-sided free fasciocutaneous anterolateral thigh flap to right lower extremity (Dr. Berry);
August 2, 2012: Chest X-rays;
August 7, 2012: Split-thickness skin graft to right lower extremity (Dr. Berry). PX11.

On August 13, 2012, Petitioner was discharged home. PX11. On August 29, 2012, he followed up with Dr. Idusuyi at Orthopedic Center of Illinois. He underwent x-rays and physical examination, which revealed his right ankle wounds were healing slowly. He followed up on September 24, 2012, at which time his imaging studies and physical examination revealed soft tissue defects in his right tibia. Dr. Idusuyi recommended a corrective tibiocalcaneal arthrodesis with a blade plate and iliac crest bone graft. PX12.

In anticipation of the recommended surgery, Dr. Idusuyi referred Petitioner for a cardiovascular consult. On October 2, 2012, Petitioner underwent a transthoracic

echocardiogram at St. John's Hospital. He followed up at Prairie Cardiovascular the same day to review his results. PX12.

On October 11, 2012, Petitioner underwent surgery at St. John's Hospital by Dr. Idusuyi. Procedures included removal of the external fixator on his right leg; debridement of the ankle to the level of the bone; repair of distal tibia fracture nonunion; application of autogenous bone graft to the nonunion site; right ankle arthrodesis; and placement of an electrical bone stimulator. He remained in St. John's Hospital overnight and was discharged on October 12, 2012. PX13.

On October 17, 2012, Petitioner followed up with Dr. Idusuyi. His intraoperative imaging studies showed a rare coagulase which was sensitive to antibiotics. Dr. Idusuyi referred him to an infectious disease specialist for an antibiotic treatment recommendation. He also referred Petitioner to Dr. Berry for a plastic surgery consultation. Petitioner's right leg was placed in a splint and he was instructed to follow up in one week. On October 29, 2012, Petitioner followed up with Dr. Idusuyi. His dressings and splint were replaced; however, his right lower extremity reconstruction had become infected. PX14, PX15.

October 29, 2012, Petitioner was readmitted to St. John's Hospital "after his wound dehisced and he had exposure of plate and bone in his right lower extremity wound". He was diagnosed with a nonhealing wound in his right lower extremity. On October 30, 2012, he underwent right lower extremity wound debridement surgery followed by VAC placement. On November 1, 2012, he underwent an additional right ankle debridement surgery. Petitioner's postoperative diagnosis remained an abscess with chronic osteomyelitis in his right ankle, and his options were discussed including a repeat debridement with attempts for osteosynthesis versus a right below-knee amputation. On November 3, 2012, he underwent a right below the knee amputation at St. John's Hospital. The procedure also included myodesis of the posterior musculature, and was performed by Dr. Idusuyi. Petitioner remained an inpatient at St. John's Hospital until being discharged on November 6, 2012. PX16.

On November 12, 2012, Petitioner followed up with Dr. Idusuyi, at which time a compression posterior splint was placed around the surgical site and what remained of his right leg. He returned on November 12, 2012, and was evaluated for a right below the knee prosthetic. He returned on November 16, 2012. His staples were removed, and it was recommended that he be fitted for a prosthetic. PX17.

On March 23, 2013, Petitioner presented to Dr. Idusuyi for a postoperative evaluation. His postoperative stump had no signs of infection and his prosthesis was functioning well. He returned on July 8, 2013, for an 8-month post-operative evaluation. He reported he was walking full weight-bearing using his prosthesis, but had suffered pain in his right leg amputation incision site for approximately two months. His pain was aggravated by walking and activities using his prosthesis and was alleviated by rest. He reported that the pain interfered with his walking and daily activities. On examination, Dr. Idusuyi noted that the muscle in the post-operative stump appeared slipped posteriorly off the tibia. He recommended that Petitioner undergo an amputation revision surgery. PX17.

On August 2, 2013, Petitioner presented to St. John's Hospital for surgery by Dr. Idusuyi. Preoperative diagnosis was a failed right below knee amputation. He underwent a revision surgery and his postoperative stump was placed in a posterior splint. PX18.

On August 7, 2013, Petitioner followed up with Dr. Idusuyi, who noted he was healing as planned and instructed him to follow up on one week. Petitioner returned on August 14, 2013. He was scheduled to have his sutures removed at that time, but Dr. Idusuyi decided not to remove them, due to increased swelling around the surgical site. Petitioner was instructed to return in one to two weeks to have them removed. PX19.

On September 4, 2013, Petitioner presented to VA Illiana with a chief complaint that his prosthesis fit poorly. It was noted that he had residual swelling in his post-operative stump. A replacement socket with locking suspension was ordered for him. On September 20, 2013, he followed up at VA Illiana Mattoon Clinic for an evaluation of his post-operative stump. Upon examination, there were two small lesions in areas where sutures had been removed. PX20.

Petitioner testified consistent with the medical records submitted into evidence. He testified that since September 2013, any follow up care he received related to injuries sustained in the accident was rendered by VA Illiana.

Petitioner testified that prior to the accident on June 29, 2012, he did not have any problems with his right leg. At present, he can only ambulate with use of a prosthesis as a result of injuries sustained in the accident. He testified that he cannot walk as fast as he could prior to the accident, and he has difficulty traversing stairs, uneven surfaces, unstable ground, and inclines. He testified that when walking, especially on stairs or over long distances, he must be very careful and watch where he steps with his right leg to avoid losing his balance and falling. He further testified that he has decreased balance and increased fatigue, and that the end of his postoperative stump gets painful and sore when walking too long. He testified that to manage his ongoing symptoms, he must put a salve on the stump, which he obtains on an ongoing basis from the Department of Veteran's Affairs.

Petitioner testified that he is no longer able to climb ladders as he did prior to the accident, such as to go up in a hay loft. He struggles to lift and especially to carry heavy weights or other objects, such as those he needed to maneuver when working for Respondent-Employer. Petitioner testified that after being released from medical care, he performed a job search in the geographic area in which he lives, namely rural Arthur, Illinois. He testified that he searched for a job for "a little over two months", but was unable to gain employment at such places as MasterBrand and several cabinet shops. He further testified that the reason he was not hired was because the potential employers did not have work "for somebody with a prosthetic [leg]."

Petitioner testified that following his failed job search, he began working independently as a taxi cab driver for members of the Amish community, and that his independent taxi cab service has been his sole employment since the accident. He testified that even despite his sole vocation now being taxi cab driving, injuries to his right leg sustained in the accident make driving more difficult for him to perform. He works at his taxi business approximately 10 to 12 hours a day and estimated that he earns $300 a week. He noted, however, that he has expenses

associated with the self-employment, including gas, tires, fuel, and maintenance of the van. He testified that he is not really making money, but it gives him something to do.

Petitioner testified on cross-examination and on re-direct that his understanding was that he worked for both Vernon and Elsie Lambright. He stated, "I did not know any different. I just thought she owned—they had it joint together, but I don't know."

Petitioner testified that he paid $16,824.50 out-of-pocket for medical bills for treatment resulting from his work accident. He further testified that some of his medical bills were paid by and through Trinity Medical Aid, after leaders of his Mennonite church and members of Vernon Lambright's Amish church induced him to sign an agreement entitled "Mutual Release." RX5. Specifically, those present when Petitioner was instructed to sign the agreement were Wilbur Gingerich, the Bishop of his Mennonite church, in addition to Mennonite ministers Ernie Gingerich and Kenny Yoder. Others present included Darrell Herschberger, a Mennonite that "took care of medical bills," two Amish people Petitioner knew by name, Marlin Plank and L.V. Miller, as well as several members of Vernon Lambright's Amish church.

Petitioner testified that his understanding of the agreement was that he had to sign it and all of his medical bills would be paid by Trinity Medical Aid. He testified that, instead, only a percentage of his medical bills were paid by Trinity Medical Aid, despite leaders of the Mennonite and Amish churches telling him all his bills would be paid when they instructed him to sign. Petitioner testified that "he didn't have much choice" when the church leaders confronted him to sign. Specifically, he testified that he thought he had no option but to sign the document because he thought his medical bills would be paid and that the bills would not be paid if he did not sign the document.

Petitioner testified that Vernon Lambright was not present at the time he signed the agreement, and that he did not know who else—such as Vernon and Elsie Lambright—would later sign the agreement. He testified that he was never given any copy of the agreement, and that he had not seen a copy since the day he signed until the day of his arbitration hearing, when it was presented by Respondent-Employer.

Petitioner testified that when he was working for Lambright Distributors, he understood that he also worked for Elsie Lambright, and that Lambright sons Lester and Joseph also worked with him. He testified on cross-examination that Elsie Lambright operated a gospel bookstore on the property.

Testimony of Harold Lambright

Respondent Harold Lambright testified that he lived at 40 E 200 N, Arthur, IL and that he was born on April 9, 1996. Petitioner is the son of Vernon and Elsie Lambright and he has eight brothers and sisters. Mr. Lambright was 16 years old on June 29, 2012 when Petitioner's accident occurred. He acknowledged on cross-examination that he worked for Lambright Distributors at that time, but testified he did not get a paycheck and was "just helping out dad".

Mr. Lambright testified that to the best of his knowledge his dad was the sole owner of Lambright Distributors. He testified that his father passed away on June 1, 2015, and that an

estate was never opened for his father. He testified that he did not have an ownership interest in Lambright Distributors. He testified that he formed a limited liability company by the same name on March 20, 2018, and that Lambright Distributors LLC does not conduct any business and does not have any assets or property. He testified that he formed the LLC, "In hopes to some day have my own company."

Mr. Lambright testified that his understanding was that his mother started a business also called Lambright Distributer after his father's death and that she was the sole owner. It was his understanding that the business that his mother owned and the business his father owned had different tax identification numbers, different employer identification numbers, and different resale tax identification numbers. He testified that he is the manager of the Lambright Distributors owned by his mother, that he manages eight employees, and that prior to him managing the company, his father managed it.

On cross-examination, Mr. Lambright testified that the business manufactured refrigeration units, freezers, and coolers for sale. The employees of the business are Lester Lee, David Schrock, Lucas Kaufman, Darrell Schrock, Daniel Schrock, Lester Lambright, Joseph Lambright, Herbert Miller, and Rachael Lambright. He further testified that since his father's death in 2015, when he became the manager, Lambright Distributors had some changes, which included "different manufacturing, different freezers, coolers, different designs." However, it has the same employees and conducts the same type of business as prior to 2015.

Mr. Lambright testified that once the refrigeration units are manufactured, the units get shipped by LTL Freight Company. He testified that he is also the manager of Trailer Refrigeration, and that Trailer Refrigeration was owned by his mother, had no employees and moved refrigeration units on the property. Trailer Refrigeration is a corporation.

Mr. Lambright testified that after his father's death, his mother started the new business and "we went on from there." He acknowledged that the "new" business has the same name as the old business—Lambright Distributors. It likewise has the same mailing address, is on the same premises, utilizes the same trucks and equipment, conducts the same basic business operations, and has by and large the same employees.

When asked why he set up Lambright Distributors LLC, Mr. Lambright testified, "Well, in hopes of some day having my own business, but it would be relevantly [sic] the same as the current Lambright Distributors."

The Arbitrator found Harold Lambright to be both evasive and calculated in his answers, calling into question the veracity of his testimony.

Testimony of Elsie Lambright

Elsie Lambright testified that she is the owner of Lambright Distributors with 11 employees and Trailer Refrigeration with no employees. She testified that after her husband died, she took over the ownership of Lambright Distributors and obtained new tax ID numbers for the business. She further testified that she does not take any responsibility for her husband's

debts. She testified since assuming control of Lambright Distributors after Vernon died, business operations have continued on in the same manner as before his death, on the same property, with nearly the same equipment. She testified that prior to his death, her husband owned the property upon which all of the businesses sit. Since his death, she owns the property. She acknowledged that that was no estate set up after his death. She testified that in 2012 her role in Lambright Distributors was to "help where needed", including doing the books.

Mrs. Lambright acknowledged that she entered into an agreement with the Workers' Compensation Commission Insurance Compliance Department and signed a Payment Contract, identified as Petitioner's Exhibit 31.

The Payment Contract she signed was in the case of *Illinois Workers' Compensation Commission v. Lambright Distributors, Vernon Lambright and Elsie Lambright individually and as owner of Trailer Refrigeration, Inc. and as owner of Lambright Distributors,* Case no. 16 INC 00011. The Payment Contract is a voluntary and binding agreement which Elsie Lambright entered into with the State of Illinois, Illinois Workers' Compensation Commission as owner/operator/officer of "Employer." "Employer" is defined in the Payment Contract as "Vernon Lambright (Deceased), and Elsie Lambright, individually and as owner of Trailer Refrigeration, Inc. and as owner of Lambright Distributors". Under the Payment Contract, Elsie Lambright agreed to pay a sum of money to resolve an unknown amount of insurance noncompliance penalties. A key term under the Payment Contract, which Elsie Lambright agreed to when she signed the agreement, states: "Employer further agrees to pay all benefits due and owing to any petitioner(s) who has/have sustained compensable injuries during the period(s) of non-compliance." PX31.

The Arbitrator found Elsie Lambright to be both evasive and calculated in her answers, calling into question the veracity of her testimony.

Petitioner's Exhibit 2 is a Certification from the National Council on Compensation Insurance, which indicates that Respondent-Employer Lambright Distributors did not have workers' compensation insurance coverage on the date of Petitioner's accident of June 29, 2012.

CONCLUSIONS OF LAW

The Arbitrator hereby incorporates by reference the above Findings of Fact, and the Arbitrator's and parties' exhibits are made a part of the Commission's file. After review of the evidence and due deliberations, the Arbitrator finds on the issues presented at trial as follows.

In support of the Arbitrator's decision relating to issue (A), whether Respondent was operating under and subject to the Illinois Workers' Compensation Act, the Arbitrator finds the following:

The Act provides for automatic application of its provisions to any business deemed to be hazardous under Section 3. 805 ILCS 305/3. Specific to this case, Sections 3(8) and 3(15) provide for application of the Act to any business engaged in the use of (8) sharp edged cutting tools, grinders, or implements; and to any business engaged in the use of (15) electric, gasoline, or other power-driven equipment.

It is undisputed that Petitioner was employed as a driver and mechanic at Lambright Distributors on the date of his accident. Petitioner testified that his position required him to perform various tasks, including driving trucks to and from Indianapolis, loading and unloading trucks on Respondent-Employer's premises, as well as cleaning, repairing, and refurbishing refrigeration units. His job duties required him to use numerous tools, equipment, and vehicles which were fueled by gasoline or diesel engines, including vacuum pumps, automobiles, fork-lifts, and SkyTraks.

The Arbitrator finds that, based on Petitioner's operation of such tools, equipment, and vehicles, the nature of Respondent Lambright Distributors' business falls within the definition of "hazardous", as defined in Section 3 of the Act. As such, the Arbitrator finds that Respondent Lambright Distributors was therefore operating under and subject to the Illinois Workers' Compensation Act.

The Arbitrator makes no finding on this issue as to Trailer Refrigeration, given the Arbitrator's decision as to employer-employee relationship, detailed below.

In support of the Arbitrator's decision relating to issue (B), whether there was an employer-employee relationship, the Arbitrator finds the following:

The existence of an employment relationship is a prerequisite for any award under the Act. There is no specific litmus test for determining whether an employer-employee relationship exists. Instead, there are multiple factors to consider when assessing the nature of the relationship between the parties. *Ware v. Industrial Comm'n.*, 318 Ill.App.3d 1117, 1122 (1st Dist. 2000). Among these are: (1) whether the employer may control the manner in which the person performs the work; (2) whether the employer dictates the person's schedule; (3) whether the employer pays the person hourly; (4) whether the employer withholds income and social security taxes from the person's compensation; (5) whether the employer may discharge the person at will; (6) whether the employer supplies the person with materials and equipment; and (7) whether the employer's general business encompasses the person's work. *Roberson v. Industrial Comm'n.*, 866 N.E.2d 191, 200 (Ill. 2007). Other relevant factors include the label the parties place on their relationship, and whether the parties' relationship was "long, continuous, and exclusive." *Ware,* 318 Ill.App.3d at 1122, 1126. No single factor is determinative and such determination of the employer-employee relationship rests on the totality of the circumstances. *Roberson*, 866 N.E.2d at 200.

In this case, Petitioner offered credible, unrebutted testimony and provided relevant supporting documentation, all of which clearly evidences the fact that he was employed by Lambright Distributors as a driver and mechanic on June 29, 2012. He further testified that he had been employed by Lambright Distributors for approximately six months at the time of his work accident. Petitioner testified that all aspects of his work schedule, including where and when he would work, as well as his specific duties, were all dictated by Vernon Lambright, then-owner of Respondent-Employer, Lambright Distributors. He further testified that all of the tools, equipment, and vehicles which he used and operated in the furtherance of his job duties were owned and provided by Lambright Distributors.

Petitioner's unrebutted testimony, paystubs, and W-2 forms all show that he was indeed an employee and that Lambright Distributors was in fact his employer. His paystubs and testimony show he was paid for his work by check on a weekly basis. His paystubs and W-2 form reveal that federal and state taxes were withheld from his weekly paychecks by Respondent-Employer. Finally, his paystubs clearly list him as an employee, and clearly identify the source of payment as his employer, Lambright Distributors.

When applying the facts of this case to the factors articulated above, the Arbitrator finds that the facts overwhelmingly evidence an employer-employee relationship between Petitioner and Respondent-Employer Lambright Distributors on the date of his accident, June 29, 2012.

The Arbitrator further finds that Petitioner failed to prove by a preponderance of the evidence that an employer-employee relationship existed between himself and Harold Lambright. There was no evidence presented to show that Harold Lambright had any ownership rights or obligations in Lambright Distributors on June 29, 2012, nor that he subsequently assumed any such rights or obligations. The Arbitrator is mindful of the undisputed existence of "Lambright Distributors, LLC", and that Harold Lambright is the Manager thereof. However, the record shows that the LLC was formed on March 20, 2018, nearly six years after Petitioner's work accident of June 29, 2012. Further, that entity was not named as a Respondent. In addition, the Arbitrator notes that at the time of Petitioner's accident, Harold Lambright was merely 16 years old.

The Arbitrator further finds that Petitioner failed to prove by a preponderance of the evidence that an employer-employee relationship existed between himself and Trailer Refrigeration. In fact, there was no evidence presented to show that Petitioner worked for Trailer Refrigeration.

Liability as to the remaining named Respondents is addressed under issue (O) below.

In support of the Arbitrator's decision relating to issue (C), whether Petitioner sustained an accidental injury that arose out of and in the course of his employment, the Arbitrator finds the following:

To obtain compensation under the Illinois Workers' Compensation Act, a claimant must show by a preponderance of the evidence that he suffered a disabling injury arising out of and in the course of his employment. 805 ILCS 305/2; *Metropolitan Water Reclamation District of Greater Chicago v. Illinois Workers' Compensation Comm'n*, 407 Ill.App.3d 1010, 1013 (1st Dist. 2011).

"Arising out of" the employment refers to the origin or cause of the claimant's injury *Sisbro, Inc. v. Industrial Comm'n,* 207 Ill.2d 193, 203 (2003). An accident arises out of one's employment if its origin is in some risk connected with or incidental to the employment so as to create a causal connection between the employment and the accidental injury. *Caterpillar Tractor Co. v. Industrial Comm'n,* 129 Ill.2d 52, 58 (1989). Typically, 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. *Id.* A risk is incidental to the employment where it belongs to or is connected with what an employee has to do in fulfilling his duties. *Id.* Finally, an injury generally arises "in the course of employment" when it occurs "within the time and space boundaries of the employment." *Sisbro,* 207 Ill.2d 193 at 203.

Petitioner offered credible and unrebutted testimony that on June 29, 2012, he was instructed to unload refrigeration units from trucks on Respondent-Employer's premises at Lambright Distributors, 35 East County Road 200 North, Arthur, Illinois. Petitioner testified that as he unloaded refrigeration units from the back of a truck with a forklift, the forklift tipped over to the right side. As he attempted to exit the forklift, a steel plate fell and crushed his right leg. His testimony was unrebutted and was corroborated by the medical records.

The Arbitrator found Petitioner to be exceedingly credible and forthright in all aspects of his testimony. The Arbitrator finds that Petitioner was performing acts he was instructed to perform by his employer, that the risk was incidental to his employment as a mechanic and driver, and that the accident occurred within the time and space boundaries of the employment. As such, the Arbitrator finds that Petitioner sustained an accident that arose out of and in the course of his employment on June 29, 2012.

In support of the Arbitrator's decision relating to issue (D), what is the date of accident, the Arbitrator finds the following:

Petitioner testified that the accident occurred on June 29, 2012. His testimony is supported by the medical records, and there was no evidence presented to the contrary. The Arbitrator finds that the date of accident was June 29, 2012.

In support of the Arbitrator's decision relating to issue (E), whether timely notice of the accident was given to Respondent, the Arbitrator finds the following:

Petitioner credibly testified that the accident occurred on Respondent-Employer's premises at Lambright Distributors, 35 E CR 200 N, Arthur, Illinois. He testified that at the time of the accident then-owner Vernon Lambright was on the premises, and that an ambulance transported him from the premises to the hospital. He testified that he and Vernon Lambright discussed the accident on one occasion following the accident, after he returned from the hospital. Petitioner's testimony was unrebutted. The evidence in the record further shows that some medical bills were paid by Lambright Distributors, and that Vernon Lambright entered into a Mutual Release to which Elsie Lambright was a witness.

Based on the foregoing and the record in its entirety, the Arbitrator finds that Respondent was given notice of the accident within the time limits stated in the Act.

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:

Petitioner's credible testimony and the supporting medical records plainly show that his right leg was intact prior to suffering a work accident on June 29, 2012. Petitioner further

testified that he had no problems with his right leg prior to the accident, and that he maintained the ability to walk, traverse uneven surfaces or stairs, climb ladders, pick up and carry heavy items, and work long, physically demanding hours as a mechanic. His testimony was unrebutted and is substantiated by the medical records. Thus, the Arbitrator finds that Petitioner's current condition of ill-being, which is status-post revision amputation of his right leg, is causally related to the injury sustained in the work accident of June 29, 2012.

In support of the Arbitrator's decision relating to issue (G), what were Petitioner's earnings, the Arbitrator finds the following:

Petitioner's credible testimony and corroborating paystubs show he began working for Respondent-Employer sometime during the second week of January 2012, and worked there continuously until the date of accident, June 29, 2012. Petitioner was able to locate paystubs from only seven weekly pay periods during the time he worked for Respondent-Employer, all of which were submitted into evidence. PX30. Petitioner's earnings over the seven relevant weeks total $2,862.90, yielding an average weekly wage of $408.98.

Petitioner's Form W-2 Wage and Tax Statement (hereinafter "W-2") shows his total earnings in 2012 were $7,694.94. RX3. Given Petitioner began working for Respondent-Employer in 2012, and he never returned to work following the accident, his W-2 presumably does accurately depict his total earnings for work on behalf of Respondent-Employer during the year prior to the accident. The Arbitrator notes, however, that Petitioner's W-2 is not helpful in determining how many *complete pay periods* should be included in Petitioner's average weekly wage calculation.

The Arbitrator further notices that as of the pay period ending June 2, 2012, the last paystub Petitioner submitted into evidence, his year-to-date gross earnings totaled $7,111.89, not including mileage. PX30. Given that Petitioner's accident occurred on Friday, June 29, 2012, some four weeks after the pay period ending June 2, 2012, the Arbitrator finds it curious that Petitioner's 2012 earnings totaled just $7,694.94 according to his W-2. PX30, RX3. If Petitioner's Form W-2 is taken at face value, he would only have earned a total of $583.05 over four additional pay periods between June 3, 2012, and the date of accident. The same would yield average earnings of just $145.76 per week, which at Petitioner's rate of $9.00/hour, equates to only 16.2 hours worked per week during the four weeks preceding the accident. Given the information contained in the paystubs submitted, the same is simply incongruent with an assumption that Petitioner's W-2 is an aggregate of continuous, complete pay periods, thus making it exceedingly difficult to determine his average weekly wage.

The Arbitrator notes that Petitioner's exact start date and the total number of complete pay periods is unclear from the evidence in the record, and that it was Petitioner's burden to prove same. However, what is clear is that Respondent-Employer reported earnings of $7,694.94 for Petitioner in 2012, and that Petitioner worked from January 22, 2012, through June 29, 2012, a period of 23 weeks.

Without further information and evidence from Petitioner, the Arbitrator finds that Petitioner's earnings in the year prior to the accident were $7,694.94 and that he worked 23

weeks, yielding an average weekly wage of $334.56. The Arbitrator notes that this figure is very close to the weekly gross pay shown on most of the paychecks submitted by Petitioner.

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 paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds the following:

Under Section 8(a) of the Act, a claimant is entitled to recover reasonable medical expenses, the incurrence of which are causally related to an accident arising out of and in the course of employment and which are necessary to diagnose, relieve, or cure the effects of the claimant's injury. *Absolute Cleaning/SVMBL v. Illinois Workers' Compensation Comm'n*, 409 Ill.App.3d 463, 470 (4th Dist. 2011).

In light of the Arbitrator's findings with respect to issues (C) and (F), the Arbitrator finds that medical services rendered to date with regard to Petitioner's injuries were reasonable and necessary in his care and treatment relative to his accident on June 29, 2012. No evidence was presented by Respondent-Employer or co-respondent, the IWBF, to the contrary. The Arbitrator further finds that the medical services, including numerous surgeries to reconstruct and combat infection in Petitioner's right leg, amputation and revision amputation surgeries, physical therapy, prosthetic treatment, and follow-ups, all appear to have been warranted.

The Arbitrator finds that Respondent is liable for the following medical bills, as set forth in Petitioner's Exhibits 22, 23, 24, 25, and 26, subject to the medical fee schedule as provided in Sections 8(a) and 8.2 of the Act, with the exception of the specific VA bills itemized below.

1.	Orthopedic Center of Illinois, 6/24/12-8/1/13	$ 30,046.00
2.	St. John's Hospital, 7/23/12-8/1/13	$296,635.20
3.	Carle Hospital, 6/29/12-7/23/12	$112,046.98
4.	Carle Physician Group, 6/29/12-7/23/12	$ 20,492.00
5.	U.S. Department of Veterans Affairs Lien	$ 33,681.41
	TOTAL	**$492,901.59**

The Arbitrator ***declines*** to award the following medical bills from the U.S. Department of Veteran's Affairs, as the Arbitrator finds that the treatment rendered in conjunction with such bills is unrelated to Petitioner's work accident of June 29, 2012.

Date of Service	Provider Name	Primary Diagnosis	Billed Charges
11/6/14	Edward Chen MD	Keratoderma	$ 177.84
11/6/14	Edward Chen MD	Keratoderma	$ 58.12
12/8/14	Edward Chen MD	Keratoderma	$ 177.84
12/8/14	Edward Chen MD	Keratoderma	$ 58.12
3/26/14	Edward Chen MD	Keratoderma	$ 318.54
3/26/14	Edward Chen MD	Keratoderma	$ 125.68
9/24/15	Edward Chen MD	"700"	$ 246.00
9/24/15	Edward Chen MD	"700"	$ 61.51
10/7/15	John Kalec MD	Candidiasis	$ 125.68
10/7/15	John Kalec MD	Candidiasis	$ 318.54
9/17/18	Todd Garner DO	Pain in left foot	$1,701.16

9/17/18	Edward Chen MD	Pain in left foot	$ 539.00
		TOTAL	$3,908.03

The right to credits, which operates as an exception to liability created under the Act, is narrowly construed. *World Color Press v. Industrial Comm'n*, 125 Ill.App.3d 469, 471 (1984). Further, it is the burden of the employer to establish its entitlement to a credit under Section 8(j) of the Act. *Hill Freight Lines, Inc. v. Industrial Comm'n*, 36 Ill.2d 419, 424 (1967).

The Arbitrator notes that bills from Orthopedic Center of Illinois, St. John's Hospital, Carle Foundation Hospital, and Carle Physician Group all reflect discounts and payments, and further reflect a zero balance on the accounts. The extent to which Respondent-Employer shall receive a credit, however, is difficult to ascertain. The Arbitrator notes that Respondent-Employer did not proffer any documentation as to payments it made to any of the above providers pursuant to Sections 8(a) and 8.2 of the Act. Further, Respondent-Employer did not claim a credit under 8(j) on the Request for Hearing form, but rather only wrote, "Respondents state that medical bills have -0- balances." (The IWBF specifically marked it had paid nothing.)

It is unclear whether any bills were ultimately paid directly by or on behalf of Respondent-Employer, or through any group health plan which it may have contributed to. No evidence was offered showing Respondent-Employer's relationship with any group health plan, whether it paid into a group health plan, if any such plan paid medical bills in this case, or whether payments under such a plan qualified for 8(j) credit. Likewise, review of Petitioner's paystubs shows no deductions for any group health insurance plan. Even if Lambright Distributors paid employee benefits in full, there is no evidence of same.

There is further no evidence that "Trinity Medical Aid" ever made a single payment in this case and there is no reference to that entity outside the "Mutual Release." RX5. If indeed Trinity Medical Aid made payments, there is no evidence Respondent-Employer had a relationship with Trinity Medical Aid, and no evidence Respondent-Employer contributed to any program in whole or in part such that it might qualify for 8(j) credit. Based on the evidence in the record, it appears more likely that any bills paid by Trinity Medical Aid were connected to Petitioner's Mennonite faith, as his church is also called Trinity, and not to a group health or other insurance plan contributed to by Respondent-Employer.

The Arbitrator finds it necessary to address each of the medical providers separately with regard to any possible credit.

Orthopedic Center of Illinois—There is no reference whatsoever to Respondent-Employer on these bills, and the account is listed as "Self Pay—No Ins". The bill shows a "courtesy adjustment" on each charge, and reflects payments made by Petitioner for each charge. Petitioner testified that he paid all bills to this provider, totaling $16,824.50. The Arbitrator finds that Respondent is liable for reimbursement to Petitioner in the amount of **$16,824.50**.

St. John's Hospital—The heading of the bills from St. John's notes "Lambright Distribution", which the Arbitrator interprets to mean that the provider has simply listed the employer, albeit a slight misnomer of same. There is no reference to a Guarantor. All of the bills reflect two items: (1) "Adj Amish Community Discount"; and (2) "Pmt Retail LB Check".

There is no explanation on the bills as to either item, and Respondent-Employer did not proffer any such explanation or documentation as to payments. While the discount for the Amish Community is rather self-explanatory, the payment information is not. In that Respondent-Employer did not meet its burden with respect to credit under Section 8(a), 8.2, or 8(j), no such credit shall be given. The Arbitrator acknowledges the "Amish Community Discount" applied by St. John's Hospital, however, and allows such credit. The Arbitrator finds Respondent is liable for payment of the St. John's Hospital bills in the amount of **$155,854.93**.

Carle Foundation Hospital—These bills list Lambright Distributors as Guarantor, and further list payments and/or discounts titled "Generic Work Comp". Although Respondent-Employer again did not proffer documentation as to payments, the Arbitrator finds that the bills nevertheless sufficiently explain such payments, given the listing of Lambright Distributors as Guarantor. The Arbitrator finds that Respondent-Employer has met its obligations under the Act with regard to these bills, is entitled to credit for payments shown on the bills totaling $52,749.38, and is not liable for further payment to this provider.

Carle Physician Group—These bills list Lambright Distributors as the Account owner. All of the bills reflect two items: (1) "Insurance Payment (Insurance)"; and (2) "Contractual Write-Off (Insurance)". Although Respondent-Employer again did not proffer documentation as to payments, the Arbitrator finds that the bills nevertheless sufficiently explain such payments, given the listing of Lambright Distributors as the Account owner. The Arbitrator finds that Respondent-Employer has met its obligations under the Act with regard to these bills, is entitled to credit for payments shown on the bills totaling $10,305.28, and is not liable for further payment to this provider.

To summarize, the Arbitrator finds that Respondent is liable for payment of medical bills as follows.

1. Payable to Petitioner as part of this award	
a. Orthopedic Center of Illinois/reimbursement	$ 16,824.50
b. St. John's Hospital	$155,854.93
2. Payable to U.S. Department of Veterans Affairs	$ 33,681.41
TOTAL	**$206,360.84**

The Arbitrator notes that the IWBF asserted that the Veterans Affairs lien should be awarded only as against the Lambright Respondents, and not against the Illinois State Treasurer as Ex Officio Custodian of the Injured Workers' Benefit Fund. However, the IWBF cited no controlling authority on the issue, and the Arbitrator declines to so limit the award.

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 order to be eligible for temporary total disability benefits, a claimant must prove not only that he did not work, but also that he was unable to work. *City of Granite City v. Industrial Comm'n*, 279 Ill.App.3d 1087, 1090 (5th Dist. 1996). 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. *Gallantine v. Industrial Comm'n*, 201 Ill.App.3d 880, 887 (2nd Dist. 1990).

Petitioner claims entitlement to temporary total disability benefits from June 29, 2012, through September 20, 2013, a period of 64 weeks. Petitioner further claims entitlement to maintenance benefits from September 20, 2013, through December 1, 2013, a period of 10 2/7 week. At the outset, the Arbitrator notes the overlap of September 20 in both periods alleged, and addresses same below. Respondent-Employer claimed credit for prior payments under Section 8(j) and stated on the Request for Hearing form, "$25,800 was paid on behalf of Vernon Lambright to Petitioner in TTD." Petitioner agreed with such claim of payment and credit.

In light of the Arbitrator's findings as to issues (C) and (F), the Arbitrator finds that Petitioner was temporarily and totally disabled from June 30, 2012, through September 20, 2013, that being the last medical treatment in the record, a period of 64 weeks. The Arbitrator further finds that Petitioner remained disabled with work restrictions and entitled to maintenance benefits from September 21, 2013, through December 1, 2013, a period of 10 2/7 weeks.

In so concluding, the Arbitrator finds significant Petitioner's credible, unrebutted testimony and the corroborating medical records, all of which establish that he was medically unable to work, actively seeking medical treatment, and not yet at maximum medical improvement until September 20, 2013. He is thus entitled to temporary total disability for that period of time. Furthermore, even after seemingly being released from medical treatment, Petitioner had ongoing work restrictions. The Arbitrator finds that Petitioner performed a diligent job search and was unsuccessful in finding employment. He ultimately began working independently for himself as a taxi cab driver. The record does not provide a specific date that he began this endeavor. However, the Arbitrator notes Petitioner's testimony that he looked for employment for "a little over two months", and notes his assertion that maintenance benefits should end on December 1, 2013. As such, the Arbitrator finds that he is entitled to maintenance benefits from September 21, 2013, through December 1, 2013.

Having previously found Petitioner's average weekly wage to be $334.56, the Arbitrator finds that his temporary total disability rate is $253.00, the statutory minimum rate in effect on his date of accident for a married individual with no dependent children.

The Arbitrator finds that Respondent is liable for temporary total disability benefits of $16,192.00, from June 30, 2012, through September 20, 2013, a period of 64 weeks. The Arbitrator further finds that Respondent is liable for maintenance benefits of $2,602.29, from September 21, 2013, through December 1, 2013, a period of 10 2/7 weeks. Respondent is liable for a total $18,794.29 in benefits, subject to the stipulated prior payments of $25,800.00.

In support of the Arbitrator's decision relating to issue (L), the nature and extent of Petitioner's injury the Arbitrator finds the following:

With regard to the nature and extent of disability, for accidents occurring on or after September 1, 2911, pursuant to Section 8.1b of the Act, in determining the level of permanent partial disability the Arbitrator must look at the following five factors.

In regard to factor **(i) the reported level of impairment pursuant to Subsection (a)**, although this accident was after the effective date of Section 8.1b of the Act, none of the parties

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offered into evidence a reported level of impairment pursuant to Subsection (a). As such, the Arbitrator places no weight on this factor.

In regard to factor **(ii) the occupation of the injured employee**, the record reveals Petitioner was employed as a truck driver and mechanic at the time of the accident and that he was not able to return to his former occupation as a result of said injuries. The Arbitrator notes that Petitioner's job duties involved climbing ladders and stairs, picking up and carrying heavy objects, traversing uneven surfaces, and operating assorted warehouse-type equipment and vehicles. Petitioner credibly testified that due to decreased balance, dexterity, and mobility as a result of his injuries, he is either unable to perform or has significant difficulty performing such activities. Because of the nature and physical requirements of Petitioner's former occupation, and noting Petitioner indeed lost his occupation as a result of his injuries, the Arbitrator places significant weight on this factor.

In regard to factor **(iii) the age of the employee at the time of the injury**, Petitioner was 69 years old at the time of the accident. The Arbitrator notes that Petitioner's relatively older age reduces the number of years he otherwise could be expected to continue working in a position that involves walking, standing, traversing uneven surfaces, and operating machinery, all of which are difficult for Petitioner to now perform. Conversely, the Arbitrator notes Petitioner's age, in conjunction with his serious and permanent injuries, significantly hinders his ability to obtain alternative employment. The Arbitrator places greater weight on this factor.

In regard to factor **(iv) the employee's future earning capacity**, the Arbitrator notes Petitioner has only been able to return to work as an independent taxi cab driver. His taxi work is confined to a limited scope and geographic area specifically tied to the Amish community in Arthur, Illinois. The Arbitrator finds Petitioner credibly testified that his expenses of operating his independent taxi service counteract much of his revenue. Given Petitioner's actual and prospective earning capacity has been greatly diminished by his injuries and related functional limitations, the Arbitrator places significant weight on this factor.

In regard to factor **(v) evidence of disability corroborated by treating medical records**, the Arbitrator notes that Petitioner sustained a crushing injury to his right lower leg with multiple fractures. He underwent multiple surgeries, including skin grafts and flaps, followed by a below the knee amputation on November 3, 2012, and a revision amputation on August 2, 2013. In all, Petitioner underwent no less than 12 surgeries. He currently must utilize a prosthetic leg on a permanent basis. Petitioner testified that he is unable to ambulate as fast or as far as he could prior to the accident. Likewise, he suffers permanent functional limitations restricting his ability to climb ladders or stairs, pick up or carry heavy objects, and traverse uneven or unstable surfaces. The medical records fully corroborate Petitioner's credible testimony and support that Petitioner never fully recovered, given that he suffered the complete and total loss of his right leg below the knee. As a result of these injuries, Petitioner was unable to return to his former occupation. The Arbitrator places significant weight on this factor.

The Arbitrator notes that consideration of the factors enumerated in Section 8.1b does not simply require a calculation, but rather a measured evaluation of all five factors, of which no single factor is the sole determinant on the issue of permanency. Taking the above five factors into consideration, and based on the record in its entirety, the Arbitrator finds that as a result of

his accident of June 29, 2012, and subsequent loss of occupation, Petitioner sustained a 20% loss of use of the body as a whole (100 weeks) pursuant to Section 8(d)2 of the Act.

Having previously found Petitioner's average weekly wage to be $334.56, the Arbitrator finds that his permanent partial disability rate is $253.00, the statutory minimum in effect on his date of accident for a married individual with no dependent children. The Arbitrator finds that Respondent is liable for permanent partial disability benefits of $25,300.00.

Further, the Arbitrator finds that as a result of his accident of June 29, 2012, and subsequent below the knee amputation, Petitioner sustained a 100% loss of his right leg (215 weeks) pursuant to Section 8(e)12.

Pursuant to section 8(b)4.1 of the Act, the minimum permanent partial disability rate for cases involving the amputation of a member is equal to 50% of the statewide average weekly wage ("SAWW") for the date of accident. The published SAWW for the time period January 15, 2012, to July 14, 2012, was $966.72. Accordingly, the statutory amputation minimum PPD rate applicable here is 50% of $966.72, or $483.36. The Arbitrator finds that Respondent is liable for statutory amputation/permanent partial disability benefits of $103,922.40

In support of the Arbitrator's decision relating to issue (M), whether penalties or fees should be imposed upon Respondent, the Arbitrator finds the following:

Section 19(l) Penalties

Section 19(l) of the Act states, in part,

> *In case the employer or his or her insurance carrier shall without good and just cause fail, neglect, refuse, or unreasonably delay the payment of benefits under Section 8(a) or Section 8(b), the Arbitrator or the Commission shall allow to the employee additional compensation in the sum of $30 per day for each day that the benefits under Section 8(a) or Section 8(b) have been so withheld or refused, not to exceed $10,000. A delay in payment of 14 days or more shall create a rebuttable presumption of unreasonable delay.* 805 ILCS 305/19(l).

In this case, Respondent-Employer failed to pay medical bills to Orthopedic Center of Illinois and to the U.S. Department of Veteran's Affairs, and whether other bills were paid by Respondent-Employer directly or on its behalf is unclear. Respondent-Employer likewise failed to pay immediate statutory loss benefits and temporary total disability benefits. The Arbitrator notes that while there is proof Petitioner eventually received some payments from "Accident Aid Plan," there is no proof whether those payments were made on behalf of Respondent-Employer or whether any relationship existed between Respondent-Employer and Accident Aid Plan. Even assuming that the payments were indeed on behalf of Respondent Employer, they did not commence until at least February 28, 2013, the date of the first check in evidence, and the last payment was August 14, 2015. RX6.

Having found Petitioner was entitled to temporary total disability beginning on June 30, 2012, 34 6/7 weeks of benefits ($8,818.86) had accrued as of February 28, 2013, the date Accident Aid Plan began sending Petitioner money.

Having found Petitioner was entitled to immediate statutory loss benefits following his right leg amputation on November 3, 2012, 16 full weeks of benefits ($7,733.76) had accrued as of February 28, 2013, the date Accident Aid Plan began sending Petitioner money.

Accordingly, even when Accident Aid Plan began making monthly payments of $800.00, or an average of $200.00 per week, Petitioner had already accrued benefits of $16,552.62, and continued to accrue additional benefits which far outweighed the amounts received from Accident Aid Plan. Thus, even assuming that Accident Aid Plan acted on behalf of Respondent-Employer, despite the fact that there is no evidence of same, Respondent-Employer would have carried a balance forward despite actively making monthly payments, and its ongoing delay in payment of compensation was not remedied.

No evidence of a good or just cause for delay was offered by Respondent-Employer. The Arbitrator notes that Vernon Lambright, former owner of Lambright Distributors, was alive for nearly 18 months of the ongoing delay, as he did not pass away until June 1, 2015. RX4. The Arbitrator further notes that persistent delay by Elsie Lambright, current owner of Lambright Distributors, was frivolous and simply to avoid payment. Ms. Lambright blatantly testified that upon assuming control of Lambright Distributors after her husband Vernon's death, she obtained new tax identification and business registration numbers and that she considered Petitioner's compensation as "not her responsibility."

Based upon the foregoing and the record in its entirety, the Arbitrator finds that Respondent unreasonably failed to pay medical bills, temporary total disability benefits, and immediate statutory amputation loss in a timely manner and/or in the proper amount and is liable for payment to Petitioner in the amount of $10,000.00 pursuant to Section 19(l).

Section 19(k) Penalties

Section 19(k) of the Act states, in part,

> *In case where there has been any unreasonable or vexatious delay of payment 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. Failure to pay compensation in accordance with the provisions of Section 8, paragraph (b) of this Act, shall be considered unreasonable delay.* 805 ILCS 305/19(k).

Unpaid Medical Bills

The record shows that Respondent-Employer failed to pay Orthopedic Center of Illinois/Petitioner medical bills in the amount of $16,824.50. Respondent-Employer also failed to pay related U.S. Department of Veteran's Affairs medical bills in the amount of $33,681.41. The Arbitrator is mindful of the preceding award to Petitioner in the amount of $155,854.93 for the bill from St. John's Hospital. However, for the purpose of determining Section 19(k)

penalties, that bill is not included. Rather, the Arbitrator finds that Respondent-Employer failed to pay medical bills totaling $50,505.91.

Unpaid Immediate Statutory Loss and Temporary Total Disability Benefits

Section 8(e) of the Act provides for immediate payment of statutory amputation benefits. 820 ILCS 305/8(e). In *Greene Welding and Hardware v. Illinois Workers' Compensation Commission*, the Appellate Court upheld section 19(k) penalties for unpaid immediate statutory amputation benefits which had accrued prior to arbitration. *Greene Welding & Hardware v. Illinois Workers' Comp. Comm'n*, 396 Ill.App.3d 754, 758 (4th Dist. 2009). The court in *Greene* also upheld section 19(k) penalties for unpaid temporary total disability and unpaid medical bills. *Id.* The court's analysis with regard to the award of penalties for unpaid immediate statutory loss benefits is particularly instructive here:

> We find that the legislature intended that individuals who receive amputations should be *immediately* compensated when no dispute exists as to whether the injury arose out of and in the course of employment. Such result is consistent with the legislature's intent because *prompt* payment alleviates the possibility that an employee will be faced with unnecessary financial burdens. Requiring *immediate* payment is not unfair to the employer because statutorily it would have to pay the amount owed at some point in time. It is consistent with the purpose of the Act to require the amount owed to be paid *promptly*. The employer can pay the amount owed immediately since section 8(e) clearly sets forth the compensation an employer is obligated to pay. *Greene Welding*, 396 Ill.App.3d 754, 758 (2009), *citing Lester v. Industrial Comm'n,* 256 Ill.App.3d 520 (1993).

Here, the issue of accident was only disputed at arbitration because Respondent-Employer failed to maintain workers' compensation insurance, and dispute of all issues is mandated for cases involving the Injured Workers' Benefit Fund. The Arbitrator finds no real dispute exists as to whether the injury arose out of and in the course of Petitioner's employment. Respondent-Employer's acquiescence to pay some medical benefits, while not all, long before this matter proceeded to hearing is evidence of there being no real dispute on the issue of accident. Pursuant to section 8(e) of the Act, Respondent-Employer was thus required to immediately commence payments following Petitioner's right leg amputation on November 3, 2012. Having found Petitioner was entitled to immediate statutory loss benefits of $483.36 per week for a total of 215 weeks, the Arbitrator finds unpaid benefits of $103,922.40 must be included in the determination of 19(k) penalties.

Having found Petitioner was entitled to temporary total disability benefits of $18,794.29, and immediate statutory loss benefits of $103,922.40, Respondent-Employer was required to pay benefits totaling $122,716.69. The Arbitrator further finds that Petitioner received money from "Accident Aid Plan," totaling $25,800.00. RX6. Although there was no evidence proffered that any of these payments were made on behalf of Respondent-Employer, or that any relationship between Accident Aid Plan and Respondent-employer indeed existed, Petitioner testified that the payments were for "part of" his wages. Further, Petitioner agreed and stipulated on the Request for Hearing that the payments were for TTD. As such, the Arbitrator finds Respondent-Employer is entitled to credit in the amount of $25,800.

The Arbitrator finds Respondent-Employer failed to pay immediate statutory loss and temporary total disability benefits totaling $122,716.69, less credit of $25,800.00, leaving a balance of $96,916.69.

Respondent-Employer's failure to pay $50,505.47 in medical bills and $96,916.69 in immediate statutory loss and temporary total disability benefits was unreasonable and vexatious. The Arbitrator awards Petitioner section 19(k) penalties of $25,252.74 for the unpaid medical bills ($50,505.47 x 0.5 = $25,252.74), and $48,458.35 for the unpaid immediate statutory loss and temporary total disability benefits ($99,916.69 x 0.5 = $49,968.35).

Section 16 Fees

Pursuant to Section 16 of the Act, Petitioner is further entitled to attorney's fees of $5,050.55 for the unpaid medical bills ($25,252.74 x 0.2 = $5,050.55). Likewise, Petitioner is entitled to attorney's fees of $9,993.67 for the unpaid immediate statutory loss and temporary total disability benefits ($49,968.35 x 0.2 = $9,993.67).

Summary

Based upon the foregoing and the record in its entirety, the Arbitrator finds that Respondent-Employer is liable for payment to Petitioner of penalties and fees as follows:

1. Section 19(l) penalties of $10,000.00
2. Section 19(k) penalties totaling $75,221.09
3. Section 16 attorney's fees totaling $15,044.22

In support of the Arbitrator's decision relating to issue (O)(1), the Motion to Dismiss by party Respondents Harold Lambright, Elsie Lambright, and Trailer Refrigeration, the Arbitrator finds the following:

Respondents Harold Lambright, Harold Lambright d/b/a Lambright Distributors, Elsie Lambright, Elsie Lambright d/b/a Lambright Distributors, Trailer Refrigeration, and Elsie Lambright d/b/a Trailer Refrigeration (hereinafter "Named Respondents") filed a Motion to Dismiss, citing Section 6(d) of the Act. In their Motion to Dismiss, Named Respondents assert that Section 6(d) Act provides that a Petitioner must file his Application against the *named Respondent* within three years after the date of the accident or within two years after the date of the last payment of compensation. . . ." Named Respondents further assert that since Harold Lambright, Elsie Lambright, and Trailer Refrigeration were not named until November 15, 2018, the claim against them is barred. RX1, *emphasis added.* The Arbitrator disagrees and hereby denies the Motion to Dismiss.

In so concluding, the Arbitrator notes that Section 6(d) does not require that the Application be "against the named Respondent". The relevant portion of Section 6(d) of the Act which Named Respondents seemingly refer to states:

> *In any case, other than one where the injury was caused by exposure to radiological materials or equipment or asbestos unless the application for compensation is filed with the Commission within 3 years after the date of the accident, where no*

compensation has been paid, or within 2 years after the date of the last payment of compensation, where any has been paid, whichever shall be later, the right to file such application shall be barred. 820 ILCS 305/6(d).

In essence, Section 6(d) formally sets out the time period in which a claimant has a right to file an application before their claim is barred. It does not, however, indicate any time limit under which additional parties may be added to an Application.

Petitioner's accident occurred on June 29, 2012. The Application for Adjustment of Claim was filed about one month later, on July 30, 2012. Shortly thereafter, the matter was assigned case number 12 WC 26579, which has remained the case number for the duration of its pendency within the IWCC system, more than seven years. Due to the complicated nature of this case and the fact that Respondent-Employer/Named Respondents failed to maintain workers' compensation insurance at the time of the accident, Petitioner was burdened with repeatedly amending his Application and serving notice on all Respondents so that the matter could eventually move forward.

Named Respondents offered no legal basis for their Motion to Dismiss outside of Section 6(d) of the Act, and the Arbitrator finds that Section 6(d) does not stand for the proposition being asserted by Named Respondents as the basis for dismissal.

Further, the Arbitrator is guided by the Appellate Court in *Illinois Institute of Technology Research Institute v. Industrial Commission*, 314 Ill.App.3d 149 (1st Dist. 2000) (hereinafter "*Illinois Institute*"). In that case, a widow initially filed an Application in her own name, on behalf of her deceased husband, and was allowed to correct or amend her Application at arbitration. Respondent argued that the statute of limitations had passed, which was one of the issues on appeal.

The Court noted that the Code of Civil Procedure (hereinafter "the Code") does not generally apply to workers' compensation proceedings, to the extent that the procedure in question is regulated by the Workers' Compensation Act. However, where the Act or Commission Rules do not regulate a topic, civil provisions have been applied to workers' compensation actions. *Id.* at 154.

Specifically, the Court noted that the Act does not address the issue of amendment. It further noted that while 50 Ill. Admin. Code section 7020.20(e) (now 9020.20) provides for amendment to an Application, it does not detail under what circumstances amendments may be had, stating only that the Application may be amended any time before a hearing on the merits. *Id.* at 155. [The Arbitrator notes that this rule was amended, effective November 9, 2016, and the following language was added: "It shall be within the discretion of the Commission whether to allow any amendments to the Application after the commencement of a hearing on the merits."]

The Court went on to apply the misnomer (Section 2-401) and relation back (Section 2-616) provisions of the Code, noting the policy considerations underlying the Workers' Compensation Act of providing for summary and informal proceedings which was intended to avoid technical and cumbersome pleading rules to expedite matters. *Id.* at 155. The Arbitrator finds that the relation back provision of Section 2-616 of the Code applies to the instant case.

Under Section 2-616(a), amendments are allowed at any time before final judgment "on just and reasonable terms", introducing any party who ought to have been joined, changing or adding new causes of action or defenses, and "in any matter, either of form or substance" which may enable the plaintiff to sustain the claim for which it was intended to be brought or the defendant to make a defense. 735 ILCS 5/2-616(a).

Applying Section 2-616(a) to the instant case, the Arbitrator finds that Petitioner properly amended the Applications and that the statute of limitations in Section 6(d) of the Workers' Compensation Act did not bar same.

Under Section 2-616(b), an amended pleading relates back to the original pleading when two elements are met: (1) the original complaint was timely filed, and (2) the cause of action asserted in the amended complaint grew out of the same transaction or occurrence. 735 ILCS 5/2-616(b). The provision is to be liberally construed to allow a decision on the merits rather than dismissal on technicalities. *Illinois Institute*, at 158.

In the instant case, it is undisputed that the initial Application was timely filed within the statute of limitations set out in Section 6(d) of the Act. It is further undisputed that each Amended Application thereafter asserted a cause of action that grew out of the same occurrence, namely Petitioner's injury of June 29, 2012. Elsie Lambright testified that she was aware of the accident and aware of the claim. She also signed the Mutual Release on February 26, 2013, that specifically related to the accident and to the worker's compensation claim that arose out of the accident. It is also further evidence that she was aware of the claim and understood it to be against the business Lambright Distributors.

The Arbitrator finds that the Amended Applications for Adjustment of Claim were proper, that such amendments relate back to the date of filing of the initial Application, and that Petitioner's claim is not barred by the statute of limitations as to each of the Named Respondents and the Injured Workers' Benefit Fund. As such, the Arbitrator denies the Motion to Dismiss.

In light of the Arbitrator's findings above with respect to issue (B), that no employer-employee relationship existed between Petitioner and Harold Lambright or between Petitioner and Trailer Refrigeration, the Motion to Dismiss as to those party Respondents is moot.

In support of the Arbitrator's decision relating to issue (O)(2), whether any party Respondents are liable, the Arbitrator finds the following:

The Arbitrator finds Lambright Distributors, Elsie Lambright, and Elsie Lambright d/b/a Lambright Distributors (hereinafter "Elsie Lambright & Co.") liable for payment of this award under the Act. The circumstances behind Petitioner filing against Elsie Lambright & Co. is laid out in the Findings of Fact.

The record is clear that Petitioner worked for Lambright Distributors at the time of his accident. It is likewise clear that Lambright Distributors was owned by Vernon Lambright at the time of the accident. Elsie Lambright & Co. argues that because Vernon passed away prior to arbitration, it is not responsible to make any payments related to Petitioner's accident on June 29,

2012. The Arbitrator disagrees and finds that the facts in evidence, the legislative intent of the IWBF, and Illinois principles of contract law dictate that Elsie Lambright & Co. be held liable to pay Petitioner.

The Arbitrator finds Elsie is not just the widow of former owner of Lambright Distributors, Vernon Lambright. To this day, Elsie Lambright owns and operates the same business with the same name as prior to Vernon's passing—Lambright Distributors. The address for Lambright Distributors, both on the date of accident and at present, is identical—35 East County Road 200 North, Arthur, Illinois. Elsie Lambright continues to maintain that address as both a business and a residential address.

The evidence in the record clearly shows Elsie Lambright, both as an individual and as owner and operator of Lambright Distributors, owns the same real property and most of the same equipment and vehicles as on the date of Petitioner's accident. She continues to employ most of the very same employees, and continues business operations that are indistinguishable from those on the date of Petitioner's accident.

Furthermore, Elsie Lambright entered into a binding settlement agreement with the Illinois Workers' Compensation Commission Insurance Compliance Department when she signed the Payment Contract on June 13, 2017. The contract states, "***[E]mployer further agrees to pay all benefits due and owing to any petitioner(s) who has/have sustained compensable injuries during the period(s) of non-compliance***". "Employer" is defined by the agreement as "Vernon Lambright (deceased) and Elsie Lambright, individually and as owner of Trailer Refrigeration, Inc. and as owner of Lambright Distributors." Elsie Lambright not only signed the agreement on behalf of Lambright Distributors, but she also explicitly stated that she *individually* agreed to pay all benefits due to any petitioner who sustained compensable injuries.

It is no secret Elsie Lambright & Co. entered into the Payment Contract to resolve serious civil and criminal noncompliance penalties for failure to maintain workers' compensation insurance, and that the non-compliance action was initiated as a result of Petitioner's accident. In fact, the Contract specifically references Petitioner by name. Regardless, a key term of that Contract was the agreement by Elsie Lambright & Co. to pay for petitioner(s) injuries which occurred during noncompliance, should the same be found compensable under the Act.

Finally, although the Arbitrator finds Elsie Lambright & Co. liable to pay this award, the IWBF is secondarily liable. The legislative intent of the IWBF is to act as a safety net for injured employees who encounter an employer's failure to protect against or pay for compensable injuries. Section 4(d) of the Act clearly states that "[m]oneys in the Injured Workers' Benefit Fund shall be used only for payment of workers' compensation benefits for injured employees when the employer has failed to provide coverage as determined under this paragraph (d) *and* has failed to pay the benefits due to the injured employee." 820 ILCS 305/4(d) (emphasis added). Thus, the IWBF is only to be used as a last resort source of recovery, and is secondarily liable, should Elsie Lambright & Co. fail to pay the benefits due to Petitioner in accordance with this award.

The Arbitrator finds that Elsie Lambright entered into a binding contract with the Illinois Workers' Compensation Insurance Compliance Department, individually and as owner of

Lambright Distributors and Trailer Refrigeration, and on behalf of Vernon Lambright (deceased), to be liable for benefits due and owing. Having found that Petitioner proved he sustained compensable injuries while working at Lambright Distributors during the period of noncompliance, the Arbitrator now finds that Lambright Distributors, Elsie Lambright, and Elsie Lambright d/b/a Lambright Distributors is liable to pay this award. Further, having already found Petitioner successfully proved all issues in dispute, the Arbitrator finds the IWBF to be secondarily liable.

In support of the Arbitrator's decision relating to issue (O)(3), whether the Mutual Release terminated Petitioner's claim and absolved Respondents from further liability, the Arbitrator finds the following:

Section 23 of the Act provides, in part:

No employee...shall have power to waive any of the provisions of this Act in regard to the amount of compensation which may be payable to such employee...except after approval by the Commission, and any employer...who shall enter into any payment purporting to compromise or settle the compensation rights of an employee...without first obtaining the approval of the Illinois Workers' Compensation Commission...shall be barred from raising the defense of limitation in any proceedings subsequently brought by such employee. 820 ILCS 305/23; *see also Maxit, Inc. v. Van Cleve*, 231 Ill.2d 229 (2008).

Accordingly, the Arbitrator finds the Mutual Release was not approved by the Commission and it did not terminate Petitioner's claim. Respondents are not absolved from liability by virtue of it being signed by Petitioner.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MICHAEL STOUT,
Petitioner,

20IWCC0056

vs.

NO: 17 WC 37794

GERRESHEIMER GLASS,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causation, temporary total disability, permanent partial disability, and medical expenses both current and prospective, and being advised of the facts and law, reverses the Decision of the Arbitrator and finds that Petitioner sustained his burden of proving a repetitive trauma accident which caused a condition of ill-being of his right shoulder manifesting itself on November 17, 2017. Furthermore, the Commission remands this case to the Arbitrator for further proceedings for a determination of an additional amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill.2d 327 (1980).

I. FINDINGS OF FACT

A. Petitioner's Testimony

Petitioner testified he worked as a millwright since 1991. Petitioner explained that a millwright has to do the job of carpenters, pipe fitters, and boiler makers. They "have to do everything." He was showed a description of the millwright job, which he thought was very accurate. It indicated that he uses hand and power tools, operates hoisting/lifting devices, jacks and tractors, maintains transmissions, vacuums, and hydraulic/pneumatic systems. These are mostly manual instruments. He estimated that about 90% of his work is at or above shoulder level. On average, Petitioner testified that during the first 15 years about 80% of his work was

above shoulder level and it then reduced. Petitioner explained that he has had an apprentice over the last three years and his work is still at least 60% above shoulder level.

According to the aforementioned job description, a millwright's job includes among other things: to install, align, take apart, and move stationary machinery and industrial equipment using hand and power tools; operate hoisting and lifting devices to position machinery and parts during installation and setup and repair of equipment; inspect and examine machinery and equipment, install, troubleshoot, and maintain power transmission, vacuum, hydraulic/pneumatic systems, and programmable logic controls; adjust machinery and repair/replace defective parts; overhaul or maintain, and set-up machinery; clean, lubricate, and maintain machinery; construct foundations for machinery; and assemble machinery and equipment prior to installation by using hand tools, power tools, and welding equipment.

Petitioner identified photos of him working which he testified showed him tearing apart an old compressor room with pipe wrenches, greasing a crane trolley system, and greasing a "zerk" fitting. Most of the bearings he has to grease are above chest level. He has to hold his hands straight out in front of him. There are like 100 zerk fittings, "so you have to pump three pumps into each of them" with a grease gun which he does using his right hand. Some of them have to be greased daily and some weekly. He estimated that he greased above his head at least three hours a day. He has to use ladders that are straight vertical ranging between 30, 50, and 150 feet. He has to climb these ladders daily.

Petitioner testified that in 1996 he suffered a dislocated right shoulder while working as a millwright for another company. He had two surgeries after that dislocation; one to repair the injury and insert clips and the second to remove the clips. In 2002 he had another injury to his right shoulder while working for Respondent. Respondent had him fill out an accident report and sent him to the clinic for one visit "but there was no therapy or anything of that nature." He did not file a workers' compensation claim or hire an attorney for that accident. He had another injury to his right shoulder in 2011 and completed another accident report. He had eight weeks of physical therapy for that injury. He did not file a claim or hire an attorney for that injury either.

Petitioner acknowledged he reported right-shoulder pain to his primary care physician, Dr. Davison, on September 1, 2017 and had an MRI on September 18, 2017. He referred Petitioner to Dr. Pomponi, an orthopedic surgeon, who evaluated him on November 1, 2017 and placed him off work. To this point, Petitioner had not reported an accident at work related to his right shoulder. Dr. Pomponi performed arthroscopic surgery on November 16, 2017.

Petitioner testified that, after the surgery, he had a conversation with Dr. Pomponi in which he told him about his work activities. Petitioner explained that he "asked [Dr. Pomponi] what was all going on with it [to which Dr. Pomponi replied,] you know, your shoulder is totally messed up. It is full of arthritis. He had to shave it all down. I said, how did I acquire this in my right shoulder? It is odd." Petitioner testified that Dr. Pomponi explained to him that "it was

like carpal tunnel. You continue to use it. It builds up. He said it is from working with your right shoulder all the time. Overhead and the heavy work that you do created the issue in [your] shoulder."

Petitioner testified that he had the opportunity to tell Dr. Pomponi about his work for Respondent that day. It was Petitioner's belief after this conversation with Dr. Pomponi that his right shoulder condition was related to his duties at work whereas prior to this conversation he did not know that the condition was work-related. Petitioner explained that he "had gone to the doctor a couple of times. He gave me the steroid pack and everything is good. And I just went back to work."

Petitioner had physical therapy after the surgery with Dr. Pomponi. Then, on January 12, 2018, Dr. Pomponi recommended an additional surgery. Petitioner saw Dr. Chudik for a second opinion. Thereafter, he began treating with Dr. Chudik and on February 20, 2018, Dr. Chudik performed a total right-shoulder replacement surgery. Petitioner followed with Dr. Chudik post-operatively and underwent physical therapy. He was released to return to work, working no more than 40 hours per week, effective September 4, 2018. Petitioner was then released to return to work without restrictions on October 5, 2018.

Petitioner testified that he had the opportunity during his treatment with Dr. Chudik to tell him about his duties at work as a millwright, including everything he previously described during his testimony. Specifically, that the majority of his work was overhead and that he had to climb up towers, grease, weld, pipe fit, etc.

In the interim, Petitioner was evaluated by Dr. Karlsson at Respondent's request on April 27, 2018. He testified that he was with Dr. Karlsson for about three to five minutes. Petitioner testified that Dr. Karlsson "asked me what I did. I started telling him. He's like, that's good enough. I'm like, okay." Petitioner did not feel that Dr. Karlsson gave him the opportunity to explain the complete work that he did for Respondent. He attempted to talk to Dr. Karlsson about the all of the overhead work that he did, but "[h]e just told me that was enough. I just raised my arm, raised my arm, put my arms up, put my arms down. He said, what do you do? I said, well, I am a millwright by trade and started discussing it. He said, okay, that's good. The meeting was over."

Prior to the end of the year, Petitioner reported[1] the accident and that he wished to file a workers' compensation claim. He did so verbally and via text message to Ariann Lawhorn, in Respondent's human resources department at the time. The text messages include Petitioner's specific request to file a claim for his arthritic shoulder due to repetitive use as of November 16, 2017. Ms. Lawhorn responded "Ok, would have been better to file at the beginning, especially since you already claimed short term and filled a claim saying it wasn't work related." She also asked for his doctor's information. Petitioner responded that he "[w]asn't aware until surgery what exactly the problem was… As you know until one educates themselves. 'Talks to someone

[1] The parties do not dispute whether Petitioner gave proper notice.

who knows more than me.' That repetitive action injury are workmans comp related. Which I didn't know and surgery was done so fast." Ms. Lawhorn replied, "I understand, it just gets complic-ated now because of the std claim and bills already being paid by bcbs." She further inquired about the amount of Petitioner's years working for Respondent "14 years at gx, lots of heavy work, and I think you said u had a prior work injury to that shoulder[?]" Petitioner responded, "16 plus years. Surgery in 1996 on that shoulder. 2006 injured at GX. Over head and heavy work yes[.]"

On cross examination, Petitioner acknowledged that this was not his first workers' compensation claim against Respondent. In 2006 he had a claim for a back injury and in 2008 he had a claim for a finger injury. He previously filed accident reports, six of which he identified. Petitioner was aware of accident reporting procedures and that all injuries are to be reported immediately, no matter how minor the injury. He was also aware that Respondent had a clinic to which it sent injured employees. Petitioner did not go to that clinic for his current shoulder injury. He asked for an accident report but did not complete one. He agreed that he attended more than 10 safety meetings during his employment with Respondent. Petitioner attended such a meeting in March 2017.

Petitioner was shown, a short-term disability form. He acknowledged that he signed the form and it indicated that his disability was not work-related. Dr. Pomponi signed the form as well, but that was before surgery. Petitioner received short-term disability benefits for six months. He was also shown the FMLA form, dated December 7, 2017. He was told he had to go on FMLA leave, he knew he was put on FMLA, but he never saw the document or signed it. Petitioner agreed that he did not file an Application for Adjustment of Claim until December 27, 2017. He disagreed that his job did not involve lifting "weight at distance" or repetitive activity. He considered his job highly repetitive.

On redirect examination, Petitioner testified he was never disciplined by Respondent regarding his reporting the accident/injury. He was not aware of any accusations that he violated safety rules. He did not refuse to treat with the company clinic. At the time he signed the short-term disability form, he did not think his condition was work-related. He only thought that it was related after surgery, after he and Dr. Pomponi talked, and after Dr. Pomponi actually saw the inside of his shoulder. He explained that "carrying weight at distance" meant "with arms extended right out."

B. Richard Armellino

Mr. Richard Armellino was called to testify by Petitioner. He was currently employed by Respondent and had been for 41 and a half years. He was a millwright, but he was also a mechanical crew leader and, in that capacity, supervised Petitioner. Mr. Armellino agreed that the job description was fairly accurate. He estimated that he worked at or above shoulder-level about 50% of the time. As crew leader, he would have to work over shoulder less than Petitioner. He did not perform lubrication duties.

20IWCC0056

On cross examination, Mr. Armellino testified he had similar shoulder problems as Petitioner. He did not file a workers' compensation claim and went through group insurance because he did not report the condition within 24 hours. He had rotator cuff repair surgery and was off work for four and a half months. Respondent did not have safety meetings very often anymore. He attended one in March of 2017.

On redirect examination, Mr. Armellino testified he now believed his left-shoulder condition was work-related because he felt something pull while he was working but did not think much of it at the time.

C. Dr. Chudik – Deposition Testimony

Petitioner called Dr. Chudik as a witness and he testified by deposition on September 10, 2018. Dr. Chudik is board certified in orthopedics and orthopedic sports medicine and specializes in shoulders. He performs 600 to 700 shoulder/knee surgical procedures annually. He has treated patients with jobs that involve heavy physical demand, such as Petitioner's.

Dr. Chudik testified that simply reaching repetitively, especially away from one's body, creates as much compressive force on the shoulder joint as equivalent to one's body weight. Adding weight and vibration, the compressive forces to keep the ball centered in the socket of the joint are extremely high. With movement, there is also a lot of shear and wear at the shoulder joint.

Dr. Chudik explained that he does a lot of biomechanics and shoulder mechanism-of-injury research, and has also done tribology work, which is the study of surface wear. He noted that he was seeing arthritis in younger and younger individuals, particularly those participating in sports and laborious occupations. In addition, if someone had a prior injury, Dr. Chudik explained that the degeneration is going to accelerate if the patient continues to put high demands on their shoulder.

Dr. Chudik noted that Petitioner had a significant past medical history including two prior injuries and surgeries. People with shoulder arthritis who continue to put stress on the joint causes the condition to get progressively worse. Typically, patients with post-traumatic arthritis who are engaging in strenuous labor would experience gradual worsening of arthritis symptoms which becomes less tolerable eventually prompting treatment; "it's not always one episode." Dr. Chudik has seen both patients who aggravated arthritis by a single event and some patients whose symptoms became intolerable after years of strenuous work.

Regarding Petitioner's medical treatment, Dr. Chudik testified that he first saw Petitioner on January 24, 2018. At the time he already had arthroscopic shoulder surgeries in 1997 and 2017. The more recent surgery reduced Petitioner's pain, but he still had weakness and tightness. The surgeon recommended a shoulder replacement, but Petitioner thought he was a

20 IWCC0056

little young for that (52). Petitioner came to him for a second opinion regarding the proposed surgery.

Dr. Chudik ultimately performed a total shoulder replacement for Petitioner. His intra-operative diagnosis was significant glenohumeral arthritis; the cartilage surfaces were gone. In his opinion, several factors contributed to Petitioner's arthritic condition: his injury at a younger age and need for surgery, his occupation, and working in his position since 2001. Dr. Chudik added that Petitioner's "work is a very significant causal factor that had he not been continuing to do – as I explained before, every injury has some risk for developing arthritis, but it's really the rate of acceleration of the arthritis and its needs [sic] for treatment is more dependent on your continued activities." He explained that Petitioner's laborious job with a lot of repetitive reaching, work with tools, hoisting/lifting, and climbing ladders put a lot of repetitive, continuous stress five out of seven days a week for many hours a day all of which accelerated his arthritis and the need for treatment. Dr. Chudik testified that the arthritis accelerated at such a pace that shoulder replacement was needed at the age of 52, and the biceps instability/partial rupture and adhesive capsulitis were concomitant of the arthritis.

On cross examination, Dr. Chudik testified that he may have reviewed Petitioner's prior medical records, but he did not recall. He did review Dr. Karlsson's Section 12 report and the written description of Petitioner's job activities. In looking at the job description, he concluded that Petitioner did a lot of repetitive work with his arms in reaching, lifting, carrying, pulling, working overhead, and "climbing ladders he did once a week with some significance." He noted that Dr. Karlsson, who opined that his condition was the natural result of his disease, was a knowledgeable general orthopedist whereas he, Dr. Chudik, had a "special niche in shoulder replacement." However, Dr. Chudik agreed with Dr. Karlsson that Petitioner's prior dislocation and subsequent surgery put him at risk for developing arthritis, but he stressed that so did his job activities. He again noted Petitioner's developing such extensive arthritis at the age of 52. Also because of his age, he would likely need some revision surgery in the future.

D. Dr. Karlsson – Section 12 Examination Report and Deposition Testimony

Respondent called Dr. Karlsson as a witness and he testified by deposition on September 17, 2018. He is a board-certified orthopedic surgeon and performs all orthopedic surgeries except spine surgery, mostly on knees, shoulders, and hips. At Respondent's request, Dr. Karlsson examined Petitioner on April 27, 2018 and issued a report dated May 21, 2018. Dr. Karlsson had a very minimal independent recollection of Petitioner and referred primarily to his report.

Petitioner reported right shoulder problems that he related to his work as a millwright since 1991 and "had osteoarthritis in his right shoulder from years of use and work overhead." "Much of what he felt his shoulder problems were from greasing where he had to do a hundred different bearings and pumping a grease gun to grease the bearings." He also reported that he was performing these duties in different areas of the plant and had to go through a series of

towers and ladders that he would climb partway to grease something and go up to a different level and grease something else. He performed those activities once a week and, answering Dr. Karlsson's inquiry, Petitioner estimated that he climbed a total height of about 200 feet per week.

Petitioner also reported prior treatment for his shoulder. His primary care physician, Dr. Davidson, prescribed medication, which Petitioner thought were Prednisone packs. Petitioner was then referred to Dr. Pomponi who performed arthroscopic surgery. Dr. Pomponi found Petitioner had arthritis but no tears. After he did not improve postop, Dr. Pomponi recommended a partial shoulder replacement. Petitioner went to Dr. Chudik for a second opinion. He reported that his original pain did not improve with the surgery performed by Dr. Pomponi. Dr. Chudik ordered an MRI and advised Petitioner he needed a full shoulder replacement, which he performed on February 20, 2018. That was about nine weeks before Dr. Karlsson saw him.

Petitioner also reported he had a right-shoulder dislocation in 1996 when he fell backwards while at work. He had surgery to "tighten up the shoulder." He then had to have a second surgery a couple of weeks later to remove a clip that became dislodged. Then, in 2006 he had an injury to his right shoulder pulling a rope up over a railing. He had six weeks of physical therapy for that injury. Petitioner reported he did pretty well thereafter and needed no additional treatment until recently, which Petitioner attributed to repetitive and overhead activities.

Dr. Karlsson opined that Petitioner's right-shoulder condition and need for arthroplasty were not related to his working overhead, using a grease gun, or climbing ladders. Rather, he opined that ~~the~~ it was most likely related to his prior dislocation which required reconstruction surgery. He noted that the pathology he saw was chronic, severe, and involved deformity of the humeral head which was no longer in a ball shape. These are all long-standing conditions and did not develop over the past few years. He indicated that the dislocation was the "only true injury" Petitioner sustained. He explained that dislocation requiring surgery is a significant change in the structure of the joint and resulted in the gradual worsening of his shoulder over time. In addition, the description of Petitioner's work duties did not involve "prolonged activity at one level or prolonged stress to the shoulder." Although Dr. Karlsson did not believe the condition was related to Petitioner's work activities, the treatment he received was appropriate. He would be able to return to work at full duty within three to six months after surgery.

On cross examination, Dr. Karlsson agreed it was possible that "depending on the level of repetitive overuse," "people who do repetitive lifting or overhead injuries are at risk for accelerating or exacerbating their underlying shoulder arthritis." Dr. Karlsson agreed with an excerpt from an American Academy of Orthopaedic Surgeons publication stating that "risk factors for shoulder injuries are people who do repetitive lifting or overhead activities…" stating that it was similar to his statement and "certainly a possibility." He also testified that activity change can be a treatment for such a condition.

20IWCC0056

E. Additional Information

Regarding his current condition of ill-being, Petitioner testified that he continues to work for Respondent in a full duty capacity. He explained that he gets help with heavy lifting and heavy pulling, unlike before his accident. He also can climb the short ladder, but has his apprentice go up when there is a need to climb the 50-foot ladder. Petitioner also explained that he cannot pull his body weight when climbing a ladder and now has to "back hook" with his right arm to climb or descend the ladder. Due to the lack of strength on the right, Petitioner primarily uses his left arm and his legs.

II. CONCLUSIONS OF LAW

A. Accident/Causation

The Commission finds that Petitioner has established that he sustained a compensable accident and a causal connection between that accident and his condition of ill-being. Thus, the Commission reverses the arbitration decision.

"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. Industrial Comm'n*, 207 Ill. 2d 193, 205 (2003). In a repetitive injury case, the facts must be closely examined to ensure a fair result for both the faithful employee and the employer. *Durand v. Industrial Comm'n*, 224 Ill. 2d 53, 71 (2006). The supreme court has stated that the purpose behind the Illinois Workers' Compensation Act is best served by allowing compensation where an injury is 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 court went on to state:

> "Requiring complete collapse in a case like the instant one would not be beneficial to the employee or the employer because it might force employees needing the protection of the Act to push their bodies to a precise moment of collapse. Simply because an employee's work-related injury is gradual, rather than sudden and completely disabling, should not preclude protection and benefits. *** 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."

Id. (quoting *Peoria County*, 115 Ill. 2d at 529-30).

In finding that Petitioner did not sustain his burden of proving accident and/or causation, the Arbitrator noted that the job description did not show repetitive activities and did not specify the weights he had to lift on a continued or repetitive basis. He also noted that Dr. Pomponi never opined that there was any correlation between Petitioner's condition and his work

activities despite Petitioner's testimony to the contrary, and that he actually attested that Petitioner's condition was unrelated to his work activities in the short-term disability request. The Arbitrator also noted that Petitioner never filed an accident report. Finally, the Arbitrator found the opinion testimony of Dr. Karlsson more persuasive than that of Dr. Chudik. He found particularly persuasive Dr. Karlsson's explanation of the effect of the surgically repaired shoulder dislocation in 1996. He also found Dr. Chudik's opinion unpersuasive because he did not consider the deformity in Petitioner's humeral head in adopting his opinions.

In this case, Petitioner's testimony establishes that most of his work was performed above shoulder-level over many years. Petitioner's detailed explanation of his work duties is not only uncontroverted but corroborated by the testimony of Mr. Armellino specifying the functions listed in Respondent's job description that required Petitioner to work repetitively above shoulder level. That Respondent's written job description does not specify that Petitioner would be expected to work repetitively above shoulder level in the repair and maintenance of large industrial machinery does not undercut the evidence that Petitioner did, in fact, do so at least 60% of the time for decades. The limitations of the written job description do, however, explain what Dr. Karlsson did not know about Petitioner's work activities as well as an imprecise understanding which led, in part, to his opinions.

Ultimately, Dr. Karlsson opined that Petitioner's shoulder condition was chronic, long-standing, and wholly attributable to nonoccupational degeneration. However, Dr. Karlsson's determination that Petitioner's shoulder condition was chronic does not undermine the conclusion that it was also attributable, in part, to repetitive, strenuous, overhead work activities done over many years as a millwright. Petitioner testified that Dr. Karlsson did not allow him to explain the details of his job, in contrast to Dr. Chudik to whom he was able to fully explain his physical duties. Petitioner's testimony to this effect is corroborated by the information contained in Dr. Karlsson's report and his deposition testimony: Dr. Karlsson did not know, or believe, that Petitioner's work included "prolonged activity at one level or prolonged stress to the shoulder." The evidence establishes otherwise. Dr. Karlsson also acknowledged the possibility that, depending on the level of repetitive use, lifting or overhead work a person was at risk for accelerating or exacerbating underlying shoulder arthritis.

In contrast, Dr. Chudik opined that there was a causal connection between Petitioner's work activities and his shoulder condition. In so concluding, he testified about his understanding of the physical activities involved in Petitioner's work as a millwright. Dr. Chudik understood Petitioner's work to be inclusive of a lot of repetitive reaching, work with tools, hoisting/lifting, and climbing ladders: this is consistent with the testimony of both Petitioner and Mr. Armellino, and more detailed than the understanding of Respondent's Section 12 examiner, Dr. Karlsson. Dr. Chudik ultimately opined that Petitioner's work was repetitive and placed continuous stress on his shoulder, all of which accelerated his arthritis and the need for a shoulder replacement at the relatively young age of 52. Moreover, in the context of his specialized training in the shoulder Dr. Chudik persuasively explained that such activities create compressive force on the

20 IWCC0056

shoulder joint as equivalent to one's body weight and, adding weight, vibration, and movement, the compressive forces are extremely high with additional wear at the joint.

In consideration of the record as a whole, the Commission finds the opinions of Dr. Chudik to be based on a more complete understanding of the physical activities involved in Petitioner's work and, thus, to be more persuasive than those of Dr. Karlsson. The evidence establishes that Petitioner's condition deteriorated to the point of needing a shoulder replacement, in part, because of the constant compressive forces placed on his shoulder resulting from primarily above-shoulder level work for Respondent.

Moreover, the Commission relies on the opinions of Dr. Chudik in determining that Petitioner sustained an injury with a gradual onset that is linked to his work manifesting on November 16, 2017 as claimed. The date of the accident from which notice must be given is the date when the injury "manifests itself." *Peoria County*, 115 Ill. 2d at 531. The phrase "manifests itself" signifies "the date on which both the fact of the injury and the causal relationship of the injury to the claimant's employment would have become plainly apparent to a reasonable person." *Id.* In this case, Petitioner testified that he was unaware of the connection between his work activities and shoulder until a conversation he had with Dr. Pomponi after his arthroscopic surgery. On the issue of Petitioner's alleged conversation with Dr. Pomponi, the Commission notes that Petitioner's testimony about that conversation was not rebutted. Additionally, the text messages exchanged between Petitioner and Ms. Lawhorn express Petitioner's understanding. Thus, the Commission does not find Petitioner's initial failure to report the accident or injury to be inimical to his claim.

B. Causal Connection

The Commission next considers whether Petitioner's current condition of ill-being is causally related to the accident. As explained above, the Commission finds the opinions of Dr. Chudik to be persuasive and relies on his opinions herein. Dr. Chudik opined with a reasonable degree of medical certainty that Petitioner's shoulder condition is causally related to his work activities. Thus, the Commission concludes that Petitioner's current condition is causally connected to the accident.

C. Temporary Total Disability

Petitioner claims entitlement to temporary total disability benefits in the amount of $753.16 per week for 43&5/7 weeks period from November 2, 2017 to September 3, 2018, pursuant to §8(b) of the Act. The parties stipulated in the Request for Hearing that Petitioner's average weekly wage, calculated pursuant to section 10 of the Act, was $1,129.74. Having found Petitioner's accident compensable, the Commission awards Petitioner the claimed temporary total disability benefits.

20IWCC0056

D. Prospective Medical Treatment

Petitioner further seeks an annual follow up appointment with Dr. Chudik, as was recommended by Dr. Chudik. The Commission finds this recommended follow up appointment to be reasonable, awards that visit, and directs Respondent to authorize and pay for such visit.

E. Medical Expenses

Petitioner claims Respondent should pay outstanding reasonable and necessary medical expenses of $121,606.53 pursuant to §8(a), subject to the applicable medical fee schedule in §8.2 of the Act. Petitioner also acknowledges Respondent should be given a credit of $26,158.97 for medical benefits paid by its group medical carrier. Respondent shall hold Petitioner harmless for any claims for which it receives credit, pursuant to §8(j) of the Act. Respondent again disputed this claim by denying the accident arose out of the course of Petitioner's employment. Having found Petitioner's accident arose out of his employment, the Commission awards Petitioner the claimed medical expenses, and awards Respondent the credit under §8(j) of the Act as stipulated by the parties in the Request for Hearing.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator dated April 30, 2019 is reversed and the Commission finds that Petitioner sustained his burden of proving a repetitive trauma accident which caused a condition of ill-being in his right shoulder manifesting itself on November 16, 2017.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $753.16 per week for a period of 43 and 5/7th weeks November 2, 2017 to September 3, 2018, 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 the medical expenses submitted into evidence, as well as prospective follow up visits as recommended by Dr. Chudik under §8(a) of the Act, subject to the applicable medical fee schedule in §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.

20IWCC0056

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is entitled to $26,158.97 for medical bills paid under §8(j) of the Act and Respondent shall hold Petitioner harmless for such expenses.

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: JAN 24 2020

Barbara N. Flores

BNF-MP/dw
O-12/19/19
46

Marc Parker

Dissent

I respectfully dissent from the decision of the majority. I would have affirmed the Decision of the Arbitrator in which he found that Petitioner did not sustain his burden of proving repetitive trauma accident, did not prove that the current condition of ill-being of his right shoulder was causally related to his work activities, and denied compensation.

In finding that Petitioner did not sustain his burden of proving accident/causation, the Arbitrator noted that the job description did not show repetitive activities and did not specify the weights he had to lift on a continued or repetitive basis. He also noted that despite Petitioner's testimony to the contrary, Dr. Pomponi never opined that there was any correlation between Petitioner's condition and his work activities, and that he actually attested that Petitioner's condition was unrelated to his work activities in the short-term disability request. The Arbitrator also noted that Petitioner never filed an accident report. Finally, the Arbitrator found the opinion testimony of Dr. Karlsson more persuasive that that of Dr. Chudik. He found particularly persuasive Dr. Karlsson's explanation of the effect of the surgically repaired shoulder dislocation in 1996. He also found Dr. Chudik's opinion unpersuasive because he did not consider the deformity in Petitioner's humeral head in adopting his opinions. I concur with the reasoning of the Arbitrator.

20IWCC0056

The Arbitrator is correct that the job description does not specify the weight Petitioner had to repetitively lift and/or the amount of time he had to engage in various activities. In addition, I believe that Dr. Karlsson's explanation regarding the importance of Petitioner's prior dislocation and subsequent shoulder reconstruction surgery was persuasive. Perhaps the most salient evidence was the lack of any statement by Dr. Pomponi relating Petitioner's condition and subsequent need for surgery to his work activities in contradiction to Petitioner's testimony. He actually attested that the condition was not work related in the short-term disability form. In addition, in my opinion Petitioner did not specify how the work activities directly affected him rather than simply arguing the general demands of the job as millwright. Therefore, I am concerned that based on the reasoning of the majority, every millwright who sustains any condition of ill-being of their shoulders would have a compensable injury. I do not believe such a result is tenable.

For the reasons stated above, I would have affirmed the Decision of the Arbitrator in which he found that Petitioner did not sustain his burden of proving repetitive trauma accident, did not prove that the current condition of ill-being of his right shoulder was causally related to his work activities, and denied compensation. Therefore, I respectfully dissent from the decision of the majority.

Deborah L. Simpson

DLS/dw
O-12/19/19

Deborah L. Simpson

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Kathryn Korak,
Petitioner,

vs. No: 17 WC 09711

20IWCC0057

State of Illinois,
University of Illinois
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, nature and extent of permanent partial disability, medical expenses and Section 8(j) credit on 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 4, 2018 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.

SOIACC0025

20IWCC0057

Pursuant to §19(f)(1) of the Act, claims against the State of Illinois are not subject to judicial review. Therefore, no appeal bond is set in this case.

DATED: JAN 28 2020

Marc Parker

Barbara N. Flores

Deborah L. Simpson

mp-wj
o-01/07/20
68

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

KORAK, KATHRYN
Employee/Petitioner

Case# **17WC009711**

20IWCC0057

UNIVERSITY OF ILLINOIS
Employer/Respondent

On 9/4/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.21% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4128 RUBENS AND KRESS
ROBERT B PAWLOWSKI
134 N LASALLE ST SUITE 444
CHICAGO, IL 60602

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

2593 GANAN & SHAPIRO PC
TIMOTHY STEIL
411 HAMILTON BLVD SUITE 1006
PEORIA, IL 61602

1073 UNIVERSITY OF ILLINOIS
OFFICE OF CLAIMS MANAGEMENT
100 TRADE CENTER DR SUITE 103
CHAMPAIGN, IL 61820

0904 STATE UNIVERSITY RETIREMT SYS
PO BOX 2710 STATION A
CHAMPAIGN, IL 61825

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

SEP 4 - 2018

Illinois Workers' Compensation Commission

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Kathryn Korak
Employee/Petitioner

v.

University of Illinois
Employer/Respondent

Case # **17** WC **9711**

Consolidated cases: **N/A**

20IWCC0057

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Michael Nowak**, Arbitrator of the Commission, in the city of **Urbana**, on **3/16/18**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ 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 **11/12/14**, 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*** 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 **23** years of age, ***single*** with **no** dependent children.

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

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

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

Respondent is entitled to a credit of $**30,594.77** under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical services of $**6,537.83 plus $165.00 in out of pocket expenses paid to Petitioner**, the agreed to amount of outstanding medical expenses, 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.

Based on the factors enumerated in §8.1b of the Act, which the Arbitrator addressed in the attached findings of fact and conclusions of law, and the record taken as a whole, Respondent shall pay Petitioner the sum of $**220**/week for **51** weeks, as provided in Section **8(e) and 8(d)2** of the Act, because the injuries sustained caused **20% loss of the left hand (41 weeks), and 2% loss of use of the person as a whole (10 weeks).**

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

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

Michael K. Nowak, Arbitrator

8/28/18
Date

ICArbDec p. 2

SEP 4 - 2018

FINDINGS OF FACT

This claim involves an undisputed accident which caused injuries to Petitioner's left hand as well as psychological issues. Respondent does not dispute the causal connection between the accident and the left hand injuries nor do they dispute liability for medical expenses related to the hand (any charges incurred on or before 5/19/15). Respondent does, however dispute the causal connection between Petitioner's psychological condition of ill-being and the accident as well as the charges of Samaritan Counseling Center relative to psychological counseling. The parties further stipulated and agreed that at the time of Arbitration $6,537.53 in medical bills and $165.00 in out of pocket payments by Petitioner remained outstanding, some of which charges are related to treatment of the left hand.

Petitioner in this matter worked as a shop assistant for the Respondent in the theater department. Petitioner testified that her job duties were theatrical set buildout, which mostly consisted of cutting wood, bending steel, welding, and various other tasks needed to build and construct stage scenery for plays. she began work with the Respondent in the fall of 2013, when she started graduate school at the University of Illinois.

On November 12, 2014, Petitioner was assigned to build a theatrical wall with an arch for the Respondent. In order to make the arch, Petitioner was required to use a machine to bend a piece of steel. When Petitioner placed the steel into the machine, her left hand was crushed by the machine. Petitioner testified that after her hand was crushed, she felt intense pain and sought medical treatment immediately.

On November 12, 2014 the Petitioner was taken via ambulance to the Carle Foundation emergency room (Pet Ex. 3, P. 7). The records state that Petitioner was working at the Krannet Center of Performing Arts and got her left hand stuck in a steel wheel (Pet Ex. 3, P.7). Petitioner was diagnosed with traumatic finger amputation and open finger fracture (Pet Ex. 3, P. 10). Due to the severity of Petitioner's left-hand injury, Petitioner was transported to Memorial Hospital to be under the care of Dr. Robert Russell (Pet Ex. 3, P. 10).

Upon arrival at Memorial Hospital, Petitioner underwent immediate surgery to repair her extensor tendon of her left index finger and percutaneous pinning of her index and long finger fractures (Pet Ex. 1, P 30). Following the surgery, Petitioner was admitted to the plastic surgical floor (Pet Ex. 1, P. 30). The following day, Petitioner began leech therapy to help alleviate venous congestion (Pet Ex. 1, P. 30). On post-operative day 3, all of Petitioner's dressings were changed and cleaned, and Petitioner was deemed fit for discharge with instructions to follow up in 2 weeks. (Pet Ex. 1, P 31).

On November 18, 2014, Petitioner had a follow up evaluation with Dr. Russell at the Heartland Plastic Surgery Center (Pet Ex. 2, P. 17). The record indicates that Petitioner recently underwent an open reduction and internal fixation of the left ring finger distal phalanx fracture with nail bed repair and left index finger extensor tendon repair, as well as left index finger open reduction and internal fixation of middle phalanx fracture (Pet Ex. 2, P. 17). Dr. Russell ordered a PIP-based extension splint to the left index finger to keep her tendon repair static and ordered her to follow up in a week (Pet Ex. 2, P. 17).

Petitioner returned to Heartland Plastic Surgery Center on November 25, 2014 (Pet. Ex 2, P. 16). At this visit, Petitioner's left hand was improving, but Petitioner had some blistering required attention (Pet Ex. 2, P. 16). Following the cleaning, Petitioner was ordered to return to the office in two weeks (Pet Ex. 2, P. 16).

On December 9, 2014, Petitioner again returned to Heartland Plastic Surgery Center (Pet Ex. 2, P. 15). At this visit, it was noted that Petitioner had some dark ecchymosis on her index finger (Pet Ex. 2, P. 15). Petitioner was ordered to follow up in 2 weeks at which time the pins would probably be removed (Pet Ex. 2, P. 12).

Petitioner returned to Heartland Plastic Surgery Center on December 26, 2014 (Pet Ex. 2, P. 14). At this visit, Dr. Russell reviewed recent x-rays which showed good healing. In addition, Dr. Russell removed two pins from Petitioner's left index finger and one from her long finger (Pet Ex. 2, P. 14). Petitioner was instructed to begin active and passive range of motion exercises (Pet Ex. 2, P. 14).

On January 8, 2015, Petitioner began a regimen of physical therapy at the Carle Foundation (Pet Ex. 3, P. 39). Petitioner underwent forty-three sessions of physical therapy to her left hand from January 8, 2015 through May 15, 2015. (Pet. Ex. 3, P. 39-137)

During Petitioner's therapy, Petitioner continued to treat with Dr. Russell. Petitioner had subsequent monthly follow-up appointments on January 13, 2015, February 3, 2015, March 3, 2015, and April 7, 2015. At each of these visits, Petitioner's left hand was revaluated and Petitioner was instructed to continue with physical therapy (Pet Ex. 2, P. 13-10)

On May 19, 2015, Petitioner again returned to Heartland Plastic Surgery Center (Pet Ex. 2, P. 9). At this visit, Dr. Russell noted that Petitioner had been doing well from her mutilating injury, but that her index fingernail never grew back (Pet EX. 2, P 9). Dr. Russell noted that Petitioner did have decreased range of motion in her left hand, but that overall Petitioner was at maximum medical improvement (Pet Ex. 2, P. 9).

Upon her release by Dr. Russell Petitioner left school and moved home to the Chicagoland area.

Petitioner testified that after she completed treatment with Dr. Russell of the Heartland Plastic Surgery Center, she was still having emotional issues dealing with the traumatic injury of almost losing her hand. Petitioner testified that her emotions were disproportionate to what was happening around her. Petitioner testified that she would start uncontrollably crying at completely trivial events. In addition, Petitioner testified her emotions fluctuate, such that she is quicker to get angry and frustrated with situations.

As a result of Petitioner's emotional issues, she sought the treatment of Sarah Greene, LCPC of Samaritan Counseling (Pet Ex. 4). During her intake clinical assessment which was completed on October 21, 2015 it was noted that Petitioner presented due to "lack of direction for school and work and symptoms of anxiety and depression; All also related to accidentally slicing off her finger and having reattached Nov 2014." *Id.*, at 34. The personal history reflects "Ct reported going to college for theatre stage building, realizing it wasn't for her after her finger accident. Ct dropped out and is now living with her parents." *Id.*, at 35. The clinical formulation indicates "CT appears to have symptoms of anxiety and depression resulting from dropping out of college and not feeling it was a good fit as well as lack of direction for job/carrer and school…" *Id.*, at 36

Petitioner underwent 18 sessions from September 30, 2015 through July 20, 2016 (Pet Ex. 4). During these sessions, Petitioner would work on coping methods to deal with the anxiety and depression she was having as a result of an injury she sustained while working in the theater department at her school (Pet Ex. 4, P.

2). Petitioner also testified about the usefulness of the coping techniques gained in the counseling sessions, but that she still occasionally has emotional breakdowns. Petitioner testified that as a result of her emotional issues, she now tries to avoid situations in which she knows will trigger emotional breakdowns. Lastly, Petitioner testified that had it not been for her November 12, 2014 traumatic injury, Petitioner would not have sought the treatment at Samaritan Counseling.

At the time of hearing Petitioner complained of nerve pain running along the scar tissue in her hand. She testified that her finger can be controlled, but it does not feel like it is part of her. She described the pain as starting in her fingers and running into her hand. The left index finger will not fully extend.

Petitioner testified that prior to the accident she played piano, but can no longer do so. She has also had to give up rock climbing which she did before the accident. She has difficulty typing. She cannot perform fine manipulations with her index finger, and has to think about how she uses her hand.

CONCLUSIONS

Issue (F): Is Petitioner's current condition of ill-being causally related to the injury?
Issue (J): Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?

As indicated above, the parties stipulated that the condition of ill-being of Petitioner's left hand and all medical expenses related thereto have been or will be paid by Respondent according to the fee schedule. Although the parties agreed that Respondent has paid $30,594.77 in medical expenses as of the time of hearing for which they are entitled to credit, they further agreed that $6,537.83 in medical expenses remain outstanding and Petitioner paid an additional $165.00 out of pocket.

Petitioner not only sustained a left-hand injury, but also a psychological injury as a result of her November 12, 2014 accident. Petitioner credibility testified that she suffered extreme emotional distress as a result of almost losing her left hand. This testimony is supported by the Samaritan Counseling records.

The counseling records mention many factors in Petitioner's life which precipitated her anxiety and depression. However, the trauma of her work accident is certainly one of the factors. Further, the traumatic injury set into motion many of the other factors listed as disturbing points in the counseling notes. For example, the notes clearly indicate that it was the traumatic event which caused Petitioner to re-think her course of study and career path resulting in her decision to drop out of college and return home and the current uncertainty regarding her future job/career.

Based upon the foregoing, and the record taken as a whole, the Arbitrator finds Petitioner has met her burden of establishing that her current psychological condition of ill-being is causally related to the undisputed accident. The Arbitrator further finds that the stipulated $6,537.83 in outstanding medical expenses and the additional $165.00 which Petitioner paid out of pocket are reasonable necessary and related to the accident.

Respondent shall pay reasonable and necessary medical services of $6,537.83, the agreed to amount of outstanding medical expenses, as provided in Sections 8(a) and 8.2 of the Act, plus $165.00 in out of pocket expenses to be paid to Petitioner. 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.

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

Pursuant to §8.1b of the Act, permanent partial disability from injuries that occur after September 1, 2011 is to be established using the following criteria: (i) the reported level of impairment pursuant to subsection (a) of §8.1b of the Act; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. 820 ILCS 305/8.1b. The Act provides that, "No single enumerated factor shall be the sole determinant of disability." 820 ILCS 305/8.1b(b)(v).

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that neither party submitted an impairment rating. The Arbitrator therefore gives *no* weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that Petitioner was employed as a shop assistant. Following the completion of treatment of her hand injury Petitioner re thought her educational and career path, dropped out of graduate school and returned home. She remains unemployed. The Arbitrator therefore gives *greater* weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 23 years old at the time of the accident. Petitioner will have to deal with the residual symptoms of her injuries than would an older worker. The Arbitrator therefore gives *some* weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes there is no direct evidence of reduced earning capacity contained in the record. The Arbitrator therefore gives *no* weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes the Petitioner was a credible witness. Petitioner continues to experience significant pain in all aspects of her life, specifically Petitioner has significant numbness in her left hand, occasionally has blood pool up at the tip of her finger, has an obvious deformity to her index finger, has a hard time completing chores around the house, difficulty with grasping and closing her left hand, can no longer play the piano, has difficulty typing, and has difficulty with anything that requires fine motor skills. As to Petitioner's emotional state, Petitioner's emotions are still disproportionate to her surroundings, she suffers from uncontrollable crying, emotional breakdowns, has to avoid triggering events due to her fragile state, and has to employ emotional coping methods gained in counseling to go about her daily activities. Because the medical records and evidence taken as a whole corroborate the Petitioner's complaints of pain, weakness and loss of function in her hands, the Arbitrator therefore gives *greater* weight to this factor.

It is evident from the medical records and Petitioner's testimony that Petitioner's injury is not solely to her left index and middle fingers, but rather to her entire left hand. Petitioner testified that her pain starts in her fingers, but then encompasses her entire left hand. Petitioner also testified that as a result of the injury she has difficulty grasping items with her left hand. Petitioner testified she gets nerve pain in her hand, and that at

times, it mentally feels as if her two fingers are no longer attached to her hand. In addition, the Petitioner testified that she gets extreme chills in her left hand, so much so, that she wears a cut off glove every time the weather gets colder than 60 degrees.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 20% loss of use of the hand pursuant to §8(e) of the Act, and 2% loss of use of the person as a whole pursuant to §8(d)2 of the Act with regard to her psychological condition.

Respondent shall pay Petitioner the sum of $220/week for 51 weeks, as provided in Section 8(e) and 8(d)2 of the Act, because the injuries sustained caused 20% loss of the left hand (41 weeks), and 2% loss of use of the person as a whole (10 weeks).

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Steven Pratt,
Petitioner,

vs. No. 14 WC 27058

Lake Pointe Grill.
Respondent.

20IWCC0058

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 causal connection and nature and extent of Petitioner's temporary total disability and permanent partial disability, 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.

IT IS THEREFORE ORDERED BY THE COMMISSION that, the Decision of the Arbitrator filed August 20, 2018, is hereby affirmed and adopted.

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

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

SOINCOOPR

20IWCC0058

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $8,100.00. 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: JAN 28 2020

Marc Parker

mp/wj
01/09/20
68

Deborah L. Simpson

Barbara N. Flores

50IMCC0028

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

PRATT, STEVEN
Employee/Petitioner

Case# **14WC027058**

LAKE POINTE GRILL
Employer/Respondent

20IWCC0058

On 8/20/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.18% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in 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
RYAN A MELKAMP
3100 N KNOXVILLE AVE
PEORIA, IL 61603

3174 KOEPKE & HILTABRAND
LORI HILTABRAND
2341 W WHITE OAKS DR
SPRINGFIELD, IL 62704

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Steven Pratt,
Employee/Petitioner

v.

Lake Pointe Grill,
Employer/Respondent

Case # **14** WC **27058**

20IWCC0058 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 **7/23/18**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ 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 **6/27/14**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

Petitioner's current condition of ill-being ***is*** causally related to the accident through 3/16/15.

In the year preceding the injury, Petitioner earned $**15,702.96**; the average weekly wage was $**301.98**.

On the date of accident, Petitioner was **40** years of age, ***single*** with **2** dependent children.

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

Respondent ***has or will*** pay all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of $**327.00** for TTD, $**00.00** for TPD, $**00.00** for maintenance, and $**00.00** for other benefits, for a total credit of $**327.00**.

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

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $286.00/week for 5.4825 weeks, because the injuries sustained caused the 2.55% loss of the right leg, as provided in Section 8(e) of the Act. This loss of use is in addition to the 28.45% loss of use of the right leg petitioner received pursuant to a Settlement Contract for case 06 WC 30456.

Respondent shall pay Petitioner temporary total disability benefits of $286.00/week for 2-1/7 weeks, commencing 7/8/14 through 7/10/14, and 7/17/14 through 7/28/14, as provided in Section 8(b) of the Act. Respondent shall receive credit for the $327.00 respondent has already paid in temporary total disability benefits.

Petitioner's claim for maintenance benefits is denied given that the claim for maintenance benefits is for a period of time after 3/16/15.

Respondent shall pay reasonable and necessary medical services for petitioner's right knee through 3/16/15, 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

8/10/18
Date

AUG 20 2018

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 40 year old dishwasher, sustained an injury to his right knee that arose out of and in the course of his employment by respondent when he slipped and fell on a wet floor while carrying a hot skillet on 6/27/14.

Petitioner sustained a prior injury to his right knee while working for another employer on 6/8/06 when he slipped on a wet floor, fell, and twisted his right leg, landing on his right knee (06 WC 30456). An MRI showed an intact cruciate and menisci. When his symptomatology did not improve Dr. Ludwig performed a right knee arthroscopy with excision of parapatellar plica. Dr. Ludwig's post operative diagnosis was right knee medial parapatellar plica on 5/15/07. Petitioner testified that he continued to have pain in the front of his right knee, but had full range of motion and a good gait. On 8/20/07 petitioner reported that he returned to work on 8/3/07 and started having some pain similar to what it was preoperatively, but not as intense. Petitioner reported that he was taking aspirin for his pain. His examination was normal except for some tenderness along the medial aspect of the patella over the retinaculum, where there was a little crepitation. Dr. Ludwig released petitioner from his care and to regular duty work. Petitioner settled this claim for 28.45% loss of use of the right leg.

Petitioner first testified that on 6/27/14 while coming around the corner while holding a hot skillet he slipped and fell on some water. He testified that when he fell his feet went above his head and he landed with his right foot twisted underneath him. Petitioner testified that he continued to work, but did not complete his shift.

Then on cross examination petitioner testified that when he slipped and fell on 6/27/14 he landed on his hands and knees and his right leg twisted inward at the ankle. He testified that he caught himself with his hands when he fell, and then hit both his right and left knees together on the ground.

Petitioner left work and presented to the emergency room at Memorial Medical Center. Petitioner reported that he fell on a wet floor at work and smashed his right knee on the concrete floor. He complained of severe right knee pain below the knee cap with any movement. He rated his pain at a 9/10. A physical examination of the right knee was negative for all testing. Petitioner's range of motion was normal. X-rays revealed no acute osseous abnormalities. He was assessed with a contusion of the lower extremity. Petitioner was discharged to home in stable condition. He was given a prescription for Norco and ibuprofen. He was instructed to follow-up with Dr. Bussing in 5-7 days.

Following his discharge from the hospital petitioner followed-up with his primary care physician Dr. Bussing on 7/8/14. Petitioner complained of right leg pain. He stated that he worked as a dishwasher on Friday.

Went to ER and x-rays were okay. He stated that he returned to work on Saturday and barely made it through the day. He noted that on Sunday and yesterday his brother worked his shift for him. He reported that the only way he made it through work was taking pain pills every 8 hours. He stated that he takes ibuprofen every 8 hours and Norco at night. He gave a history of a scope on his right knee about 7 years ago, after which he wore a brace for awhile. He complained of a pinching sensation in the inside of his knee. Petitioner was examined and assessed with right knee pain. Dr. Bussing referred petitioner to orthopedics. He instructed petitioner to elevate his leg and ice as needed. Petitioner was instructed to follow-up in a month. Dr. Bussing took petitioner off work through 7/10/14.

On 7/17/14 petitioner presented to Dr. Ludwig at Orthopedic Center of Illinois with complaints of right knee pain that was medial, lateral and anterior. Petitioner gave a history of slipping on a wet floor at work on 6/27/14 and injuring his right knee. Petitioner reported popping and stiffness, but no swelling, locking or giving way. Petitioner's walk was limited. He described his pain as stabbing and burning, but not achy, sharp or shooting. He rated his pain at 6/10. Dr. Ludwig noted that he had done a prior right knee arthroscopy on 5/15/07, and petitioner had a brace after that. Petitioner noted that his aggravating factors were walking, stair climbing, running, squatting and twisting. Petitioner was examined and assessed with acute pain of the right knee, and contusion of the right knee. Dr. Ludwig told petitioner that he believed petitioner had sustained a contusion to his right knee and to take ibuprofen for an additional 3 weeks to see what happens. He believed petitioner's issues would resolve with time. He released petitioner to work on 7/28/14. He also told petitioner that if his right knee was not better in the next 3-4 weeks he could call and an MRI would be ordered.

On 8/6/14 petitioner underwent an MRI of the right knee without contrast. The impression was no evidence of internal derangement. The menisci, cruciate, and collateral ligaments were intact. Edema was noted in the suprapatellar fat pad that could possibly reflect impingement.

On 8/11/14 petitioner filed his Application for Adjustment of Claim. He alleged an injury to his right knee after falling on a wet floor. Although petitioner signed this Application for Adjustment of Claim, it is unknown when he signed it because the date he signed it was left blank.

On 8/18/14 petitioner followed-up with Dr. Ludwig. Petitioner was ambulating with a limp. An examination revealed no swelling and the alignment of his right knee was neutral. Tenderness was noted along the medial and lateral joint line. No effusion was noted. Range of motion was 0-135 degrees, strength was 5/5, and a ligament exam revealed a positive patellofemoral compression, and patellofemoral crepitation of 1+. Dr. Ludwig reviewed the MRI and noted that all the structural elements were intact including the menisci, cruciate, and collateral ligaments. He noted that there was a very mild amount of edema in the suprapatellar fat-pad; no

sign of any cartilage loss in any of the articular surfaces; and, no significant bone marrow edema in the patella. Dr. Ludwig assessed a contusion of the right knee and chondromalacia of the right knee. He was of the opinion that petitioner did not need any surgery. Dr. Ludwig talked with petitioner about a cortisone shot or formal therapy. Petitioner declined an injection because they had not worked in the past. Dr. Ludwig noted that petitioner stated that he would sit tight for now. Dr. Ludwig was of the opinion that petitioner bruised the back of his kneecap when he fell and had some posttraumatic chondromalacia. He released petitioner on an as needed basis.

On 8/19/14 petitioner called Dr. Ludwig requesting prescription pain medication. Petitioner was told that Dr. Ludwig does not manage chronic pain. Petitioner was instructed to continue with anti-inflammatory medications, and if he needs narcotics he should see his primary care physician.

On 12/29/14 petitioner returned to Dr. Ludwig with right medial knee pain. No history of an injury was noted. Petitioner complained of locking, giving way, popping and stiffness, but no swelling. Petitioner described his pain as sharp and burning, but not achy, stabbing or shooting. Petitioner rated his pain as a 5/10. He reported that his aggravating factors were walking, stair climbing, squatting and twisting. Dr. Ludwig told petitioner that he has some chondromalacia or inflammation under his patella, and this is not generally a surgical problem. Dr. Ludwig referred petitioner to physical therapy for a chondromalacia program.

On 1/8/15 petitioner called Dr. Ludwig's office asking for work restrictions. He stated that his employer was requiring him to work 2 hours before taking a break. He stated that he could only walk 20 feet before he had to sit down. Dr. Ludwig was of the opinion that petitioner did not qualify for work restrictions and would not be getting any.

On 1/29/15 petitioner began a course of physical therapy at Memorial Rehab Services on the referral of Dr. Ludwig. He was to be evaluated and treated with quad and IT band stretching, strengthening, and modalities. The date of onset of petitioner's right knee pain was identified as 12/29/14. Petitioner reported that he had a right knee surgery in 2007 after which he healed and was doing fine until he slipped on a wet floor at work and re-injured his right knee. He complained of pain on either side of the patellar tendon and sharp pains over the inside of the knee. He stated that walking and driving makes the pain worse. He also reported that his right knee pops and swells. Petitioner stated that he was working part time. Petitioner was assessed and therapy was recommended 2 times a week for 4 weeks.

On 2/24/15 petitioner reported to the therapist that he fell and landed on his right knee on Saturday (three days prior) and that seemed to make his right knee worse. On 2/27/15 petitioner was discharged from physical

therapy. It was noted that petitioner attended 8 of 9 appointments and had made little to no progress. As a result, the therapist was of the opinion that continuing therapy was not justified. Petitioner met only 1 of 5 goals. That goal was to be independent at home.

On 3/16/15 petitioner returned to Dr. Ludwig. He reported medial and posterior right knee pain. There was a history of an injury. Petitioner rated his pain at a 6/10. He stated that physical therapy did not help his pain. His aggravating factors were the same. Petitioner's examination was the same. Dr. Ludwig assessed chondromalacia of the knee. Petitioner stated that he tried bracing in the past. Dr. Ludwig told petitioner that his MRI was normal except for some edema in the fat pad. Dr. Ludwig told petitioner he could not fix this problem with surgery. He told petitioner he could live with it or try and seek a 2nd opinion. Dr. Ludwig released petitioner on an as needed basis.

On 5/6/15 petitioner presented to Dr. Blair Rhode for consultation of his right knee pain related to a work injury in June of 2014. He stated that he slipped and fell at work on a wet floor. He stated that he was carrying a hot skillet, slipped, and twisted on his right leg. He reported that he impacted his right side on the ground. Petitioner reported that he has been off work since July. Petitioner complained of anterior and medial sided knee pain. Petitioner gave a history of a right knee scope in 2007 for a prior workers compensation injury, but was fine until his work injury in June of 2014. An examination revealed full active and passive flexion and extension, no effusion, and pain with patellofemoral compression. Petitioner had medial and lateral joint line tenderness. X-rays showed no evidence of joint space narrowing or degenerative changes. Dr. Rhode took petitioner off work. Petitioner signed a Consent to Use and Disclosure of Protected Health Information. He gave permission for his records to be sent to Strong Law Offices.

On 5/20/15 petitioner returned to Dr. Rhode. He complained of ongoing medial sided knee pain. He presented his MRI of the right knee, which Dr. Rhode was of the opinion that it showed a prior partial medial meniscetomy without frank re-tear. Dr. Rhode performed an injection into petitioner's right knee. Dr. Rhode assessed knee pain and contusion of the knee. Dr. Rhode took petitioner off work and told him to followup in two weeks.

On 6/4/15 petitioner returned to Dr. Rhode's office and saw his physician's assistant Lori Welke. He reported that the injection helped reduce the swelling and some pain. He reported that he still had popping and a sensation that his knee was going to give out. He complained of pain in the extremes of flexion and extension. He stated that it felt like it did before the surgery in 2007. He stated that he continues to wear his brace and take ibuprofen. Dr. Rhode noted that petitioner gave a history of a twisting, and direct blow injury to his right knee

due to falling on a wet floor at work in June of 2014. Dr. Rhode was suspicious of a meniscus tear (re-tear). He told petitioner to continue to wear his brace and continued him off work.

On 6/12/15 petitioner underwent a repeat MRI of the right knee. The impression was small joint effusion, otherwise negative.

On 6/15/15 petitioner reported to Wilke worsening pain over the last 4 days. He complained of anterior/medial pain in the right knee worse with weight bearing and stairs. He also complained of a painful popping and unstable sensation in his knee. Wilke noted that petitioner's most recent MRI was negative, but there may still be a tear that is not evident. Petitioner was given Tramadol and continued off work.

On 7/1/15 petitioner followed-up with Dr. Rhode. He reported that he was still symptomatic. He stated that he was using a brace but continued to experience medial sided knee pain with mechanical complaints of locking and catching. He also reported patellofemoral pain. Dr. Rhode agreed that the MRI did not demonstrate any frank meniscal tear. He recommended an arthroscopic evaluation and possible partial medial meniscectomy. Petitioner was continued off work.

On 8/18/15 petitioner underwent a Section 12 examination at the request of the respondent performed by Dr. Richard Lehman at Professional Athletic Orthopedics, LLC. In addition to his examination, Dr. Lehman performed a record review of records from 2006 through 7/1/15. Petitioner's chief complaint was pain and discomfort in the medial right knee. Petitioner gave a history of falling on a wet floor in the kitchen at work and smashing his right knee into the concrete. He complained of pain below the patellofemoral articulation after the injury. Dr. Lehman noted that petitioner is a diabetic, which he believes is a factor in his symptomatology. Dr. Lehman was of the opinion that the surgery petitioner had on 5/15/07 was for parapatellar plica which is a nontraumatic process. A physical examination revealed varus bilaterally in both knees. Dr. Lehman noted that petitioner exhibited gross symptom magnification during his examination. Dr. Lehman was of the opinion that petitioner's x-rays were negative with excellent joint spacing and absolutely no evidence of loss of joint spacing and his MRIs were normal.

Based on his examination and record review, Dr. Lehman diagnosed a normal right knee exam. Dr. Lehman was of the opinion that petitioner had no evidence of trauma on either of his right knee MRIs. He noted no bone marrow edema, soft tissue changes, or articular cartilage loss. He was of the opinion that there is no evidence that petitioner's incident, as described, created any disease in his right knee. Dr Lehman was of the opinion that petitioner has no need for physical therapy. Dr. Lehman noted that petitioner reported significant pain in the face of 2 normal MRIs, normal x-rays, and a normal examination. It was his impression that

petitioner's symptoms could not be understood pathologically or orthopedically. Since petitioner had a normal examination Dr. Lehman was of the opinion that petitioner's knee was normal. He was also of the opinion that petitioner's complaints are not related to the June 2014 incident. He did not believe the petitioner has any treatable pathology in his right knee. He did not recommend arthroscopic surgery or any more physical therapy. He did not believe the petitioner had a temporary exacerbation or any preexisting pathology. Dr. Lehman was of the opinion that petitioner's knee was normal when he had his prior arthroscopic evaluation, as were the three additional MRIs he has had that were all normal. He was of the opinion that although petitioner has subjective complaints, there is no evidence of objective complaints of pain and no evidence of objective pathology. Dr. Lehman was of the opinion that petitioner is at MMI and can work without restrictions. He was further of the opinion that even if petitioner did have a minor strain to his knee on 6/27/14, it had long since healed.

On 9/15/15 petitioner underwent a right knee partial medial meniscectomy performed by Dr. Rhode. His postoperative diagnosis was right knee medial meniscal tear. Petitioner followed-up postoperatively with Dr. Rhode. Petitioner was continued off work. Petitioner followed-up at Dr. Rhode's office on 10/8/15 and formal physical therapy was recommended. Petitioner was continued off work.

On 10/15/15 petitioner presented to Memorial Industrial Rehab for physical therapy on the referral of Dr. Blair Rhode. The date of onset was identified as 10/9/15. He complained of right knee pain following a right knee meniscectomy on 9/15/15. It was noted that petitioner initially injured his knee on 6/28/14 when he fell on a wet floor at work. He reported that injections and therapy did not help his symptoms. He reported some popping of the knee, as well as some pinching, and shifting of the knee. Petitioner reported that he had not worked since 6/28/15. Petitioner was to be seen twice a week for 6 weeks. Petitioner was seen 12 times between 10/15/15 and 11/25/15. Petitioner met 7 of his 9 therapy goals.

Petitioner followed-up at Dr. Rhode's office on 11/4/15. He was continued off work. On 12/2/15 Dr. Rhode noted that petitioner continued to improve. An injection was discussed. Petitioner was released to light medium duty work. On 1/7/16 petitioner was seen by Wilke. He complained of medial joint line pain, numbness and burning in his knee, and pinching sensation on the sides of his knee. He complained of pain with any prolonged position, especially standing. He noted a sense of an unstable knee. He noted that his pain was much less than before surgery. An injection was performed. Petitioner was continued on light medium duty. On 1/27/15 petitioner complained of ongoing anterior and medial knee pain, that was the same as before. Dr. Rhode told petitioner he was beginning to plateau. Petitioner was extremely concerned about his residual symptomatology. Dr. Rhode ordered a repeat MRI. He took petitioner off work.

On 1/28/16 petitioner underwent a repeat MRI of the right knee. The impression was partial meniscectomy of the body of the medial meniscus. Linear signal abnormality in the body medial meniscus, which may be secondary to the partial medial meniscectomy, was noted. A partial linear oblique tear in the region of the partial meniscectomy of the body medial meniscus could not be excluded.

On 2/10/16 petitioner last followed-up with Dr. Rhode. Petitioner still had anterior and medial knee pain. petitioner's range of motion was -5 to 110 degrees. He had pain with patellofemoral compression, and medial joint line tenderness. Dr. Rhode noted that the MRI report did not demonstrate an obvious tear recurrence or pathology along the posterolateral aspect of the knee. Dr. Rhode believed that petitioner was plateauing. He believed petitioner was capable of working modified medium duty. Dr. Rhode recommended an FCE.

Petitioner underwent an FCE on 2/24/16 on the referral of Dr. Rhode. Petitioner gave maximal effort on all test items. Petitioner was found capable of functioning within the Light Physical Demand Level with material handling tasks of waist to floor lift, and within the Medium Physical Demand Level with waist to crown lift. Petitioner demonstrated that he was able to perform waist to floor lifts with 20 pounds on an occasional basis, and waist to crown lift with 30# occasionally. Petitioner was unable to complete front carry on a "frequent" or "occasional" basis.

On 3/23/16 petitioner returned to Dr. Rhode with ongoing complaints. Dr. Rhode believed that petitioner had plateaued. He believed petitioner required permanency in the form of modified light duty with limited ladders, squatting, kneeling, crawling, bending and stooping. He noted that petitioner could perform frequent stairs. He was of the opinion that these restrictions were permanent.

On 5/4/16 petitioner returned to Dr. Rhode. Dr. Rhode was of the opinion that petitioner had reached maximum medical improvement. Petitioner's condition and complaints remained unchanged. Dr. Rhode was of the opinion that petitioner would likely require future oral medications.

On 8/4/16 the evidence deposition of Dr. Richard Lehman, an orthopedic surgeon, was taken on behalf of respondent. Dr. Lehman's primary focus is sports related injuries. Dr. Lehman treats knees and performs surgery on knees. Dr. Lehman was of the opinion that diabetics have greater trouble with their joints. Dr. Lehman noted that when petitioner presented to the emergency room following his injury in June of 2014 he had no instability or loose feelings in his right knee; no weakness in his right knee; no catching or popping in his right knee; and no stiffness in his right knee. He noted that petitioner's examination appeared normal at that time. His diagnosis was superficial abrasion at the infrapatellar area, or contusion. Dr. Lehman noted that Dr. Ludwig's McMurray test was negative, which meant he saw no evidence of a meniscal tear. Dr. Lehman noted

that any type of palpatory stress to the skin he performed on petitioner was painful, and this type of pain response was exaggerated. He found petitioner's behavior inconsistent with someone with a meniscal injury. Dr. Lehman was of the opinion that petitioner was bowlegged and this can result in someone having medial knee pain. Dr. Lehman reviewed the arthroscopic photos of Dr. Rhode's surgery and was of the opinion that it showed mild degenerative fraying (4 millimeters) of the medial meniscus that was not traumatic in nature, and could not have caused the symptoms petitioner complained of. He was of the opinion that it is impossible to have a meniscus tear that is traumatic and have an absolutely normal MRI. Dr. Lehman was of the opinion that the fraying of the free margin is a normal finding for someone born in 1974, like petitioner was. He was of the opinion that the fraying was not caused by the fall.

He opined that petitioner's right knee was free from any trauma related injury. Dr. Lehman opined that the surgery performed by Dr. Rhode was not necessary to address petitioner's complaints. Dr. Lehman opined that someone with a non-pathological examination and normal MRI are not going to get better if they have surgery. He opined that petitioner was not a candidate for an arthroscopy. Dr. Lehman opined that objectively petitioner had a normal right knee upon his examination. Dr. Lehman opined that a contusion of the knee would resolve in no more than ten days, and a sprain would resolve in 4-6 weeks. He further opined that the injection should have given him temporary resolution of his discomfort, and given that it did not, one would not expect that a knee arthroscopy would resolve the pain. Dr. Lehman agreed with Dr. Ludwig that petitioner could have returned to work by 7/28/14 full duty. He opined that petitioner did not suffer any continuing disability as a result of the fall on 6/27/14. Dr. Lehman was of the opinion that petitioner did not need any time off of work. He was of the opinion that petitioner only needs ice, elevation, and some anti-inflammatories.

Dr. Lehman noted that since petitioner was still having knee pain in May of 2016, 8 months following the surgery in September of 2015, that means the surgery did not address his pain, which would make sense given there was no meniscal pathology.

On cross examination Dr. Lehman noted that fraying of the meniscus is a normal finding in surgery and he would not normally comment on it. However, Dr. Lehman opined that based upon the history petitioner provided of striking his right knee, and twisting his right knee after the fall, this mechanism of injury could not reasonably cause 4 millimeters of tearing in his meniscus. He opined that you cannot cause a tear in the meniscus by striking the knee, and petitioner gave a history of smashing his knee into the concrete. Dr. Lehman opined that a twisting injury to the knee would cause a radial tear or a bucket-handle tear, but not a fraying of the meniscus. Therefore, he opined that no mechanism of twisting or direct trauma to the right knee would produce fraying of the meniscus. Dr. Lehman further opined that even if petitioner had a degenerative process in

his right knee a direct trauma to the knee, or twisting of the knee, could not cause his symptomatology to become symptomatic.

On 9/29/16 the evidence deposition of Dr. Leo Ludwig, an orthopedic surgeon, was taken on behalf of respondent. Dr. Ludwig noted that when he performed the surgery on petitioner in 2007 the medial and lateral menisci were grossly normal in appearance. He noted that after petitioner returned to work on 8/3/07, on 8/4/07 petitioner started having pain similar to his preoperative pain, but not quite as intense. However, petitioner's physical exam at that time was pretty benign. He released petitioner to full duty work and told him to return in 6-8 weeks if he was still having problems. Petitioner did not call or return to Dr. Ludwig until 7/17/14. Dr. Ludwig noted that on 7/17/14 and 8/20/07 petitioner had a little crepitation. Dr. Ludwig saw no evidence of ligament damage or meniscal tear on 7/17/14. Dr. Ludwig was of the opinion that the edema in the suprapatellar fat pad on the 8/6/14 MRI was not clinically significant. Dr. Ludwig saw nothing on the MRI that would explain petitioner's complaints of pain. Dr. Ludwig opined that petitioner's right knee problems would not rise to the level of disability. Dr. Ludwig opined that a direct blow injury is not a mechanism that causes a meniscal tear. Dr. Ludwig could not find any objective evidence or objective explanation for petitioner's complaints.

On cross examination Dr. Ludwig was of the opinion that the fall in June of 2014 was causative of petitioner's contusion and the chondromalacia in his right knee, and petitioner still had these complaints the last time he examined him. Dr. Ludwig did not recommend a diagnostic arthroscopy in petitioner's case because he got nervous when he saw the physical therapy notes indicating the high pain levels that petitioner had. He was concerned that this was a situation that he could not solve with surgery. Dr. Lehman was of the opinion that an arthroscopy would be the gold standard for determining what is actually going on within the joint itself, and would be better than an MRI for intra-articular pathology.

On 11/16/16 the evidence deposition of Dr. Blair Rhode, an orthopedic surgeon was taken on behalf of petitioner. Dr. Rhode was of the opinion that the arthroscopy demonstrated a residual horizontal cleavage tear to the medial meniscus. He was also of the opinion that petitioner's chondral surfaces demonstrated no evidence of cartilage change, which would support that the meniscus was his pain generator. He was of the opinion that the operative findings were consistent with his physical findings. Dr. Rhode opined that the petitioner's slip and fall while at work was causative to his tear recurrence which necessitated his treatment, including the surgery and physical therapy. He further opined that petitioners need for restrictions are related to the accident.

On cross examination Dr. Rhode agreed that when he first saw petitioner he had full range of motion of his right knee, had no effusion, no ligament instability, and no evidence of degenerative changes in the knee.

Dr. Rhode could not recall if he performed a McMurray exam on petitioner when he first saw him. He agreed this was a test to determine if there is a meniscal pathology. Dr. Rhode was of the opinion that when he saw petitioner on 5/20/15 there was no evidence on the MRI of a retear of the meniscus. Dr. Rhode testified that when he performed surgery on petitioner's right knee on 9/15/15 there was no evidence of any chondromalacia in the right knee, or any evidence of loose bodies, or synovitis. Dr. Rhodes agreed that the surgery did not resolve petitioner's complaints. He was of the opinion that petitioner had more residual symptomatology than he expected. He was of the opinion that petitioner had minimal improvement. He also agreed that the lack of improvement could be that the meniscus was not what was causing his problem. Dr. Rhode testified that petitioner came to him for a 2nd opinion.

Since petitioner left his employ with respondent he has had three other employers since the beginning of April 2017. These employers are Premar Security, where he guarded a warehouse and watched employees coming in and out. He also had to do rounds, but did not do rounds on the 2nd floor of the warehouse because of the stairs, which he stated he could not transcend. He also worked for Securitas Security. There he sat behind a desk and watched cameras, gates, and employees coming in and out of Kincaid Power Plant. For the past 2-3 weeks petitioner has worked at the Holiday Inn Express on Dirksen Parkway in Springfield. There he cleans the common areas. This includes vacuuming hallways and taking out the garbage. Petitioner testified that he never exceeded his restrictions while performing any of these jobs.

Petitioner testified that his not currently taking any prescription pain medications. He testified that all he takes is over the counter pain medication, that he takes before he goes to work each day.

Petitioner testified that he currently sits more because he cannot be on his right leg too long. He testified that he can't fish and play with his kids outside like he used to. Petitioner complained of sharp pain in his right knee that pops when he gets up or when sleeping. He testified that he has some problems with activities at home. He reported some loss of strength in his right leg. Petitioner also complained of trouble kneeling on his right leg and getting up. Petitioner testified that he limps a little.

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

The threshold issue in this case is whether or not the petitioner's current condition of ill-being as it relates to his right knee is causally related to the injury petitioner sustained on 6/27/14. It is unrebutted that petitioner slipped and fell while at work on 6/27/14. However, the mechanism of that injury and the causal relationship between his current condition of ill-being as it relates to his right knee and the accident on 6/27/14 is an issue, given that the record contains different mechanisms of how the actual injury occurred on 6/27/14, as well as differing expert opinions.

It is also unrebutted that petitioner sustained a prior injury to his right knee in 2006 and underwent a right knee arthroscopy with excision of parapatellar plica on 5/15/07. Following that surgery petitioner testified that he continued to have pain in the front of his right knee. On 8/3/07 petitioner returned to work and again had some pain similar to what it was preoperatively, but not as intense. When petitioner last saw Dr. Ludwig on 8/20/17 Dr. Ludwig noted some tenderness along the medial aspect of the patella over the retinaculum, where there was a little crepitation. Petitioner testified that he had a brace and would take aspirin for his pain.

Following the slip and fall on 6/27/14 petitioner presented to the emergency room at Memorial Medical Center. He reported that he fell on a wet floor at work and smashed his right knee on the concrete floor. Petitioner complained of right knee pain below the knee cap with any movement. However, his examination was normal, and all testing was negative. His range of motion was also normal. He was assessed with a contusion of the lower extremity.

On 7/17/14 petitioner returned to Dr. Ludwig, who performed his surgery in 2007. He complained of right knee pain. He reported that he slipped on a wet floor at work. Dr. Ludwig assessed acute pain and a contusion of the right knee. He told petitioner that he believed he had sustained a contusion to his right knee. He prescribed ibuprofen for 3 weeks and to see what happens.

When petitioner reported he was not better an MRI was performed that showed no evidence of internal derangement. It also showed that the menisci, cruciate and collateral ligaments were intact. All that was seen was edema in the suprapatellar fat pad that could possibly reflect impingement.

On 8/18/14 when petitioner followed-up with Dr. Ludwig his examination showed no swelling and the alignment of his knee was neutral. No effusion was noted, and his range of motion and strength were normal. Petitioner had subjective complaints of tenderness along the medial and lateral joint line. Dr. Ludwig performed a ligament exam that revealed a positive patellofemoral compression and patellofemoral crepitation of 1+. Dr. Ludwig reviewed the MRI and noted that all the structural elements were intact including the menisci, cruciate, and collateral ligaments. He saw very mild edema in the suprapatellar fat-pad. He noted no sign of any cartilage loss in any of the articular surfaces, and no significant bone marrow edema in the patella. Dr. Ludwig assessed a contusion of the right knee and chondromalacia of the right knee. He was of the opinion that petitioner did not need any surgery. He offered a cortisone shot and formal therapy. Petitioner declined. Dr. Ludwig was of the opinion that petitioner had bruised the back of his kneecap when he fell and had some posttraumatic chondromalacia. He released petitioner on an as needed basis.

When petitioner returned to Dr. Ludwig on 12/29/14 with ongoing complaints. Dr. Ludwig reiterated that he has some chondromalacia or inflammation under his patella, and that this is not generally a surgical problem. He again referred petitioner to formal therapy to address his chondromalacia.

Petitioner underwent physical therapy from 1/29/15 to 2/27/15. On 2/24/15 petitioner reported that he had fallen and landed on his right knee on Saturday (three days prior), and that made his right knee worse. Three days later petitioner was discharged from therapy because he had made little to no progress.

Petitioner returned to Dr. Ludwig on 3/16/15 and his examination was the same. Dr. Ludwig again assessed chondromalacia of the right knee, and told petitioner his MRI was normal except for some edema in the fat pad, that could not be fixed with surgery. He told petitioner he could seek a 2nd opinion. He released petitioner from his care.

Petitioner sought a 2nd opinion from Dr. Blair Rhode. He told Dr. Rhode that he slipped and fell on a wet floor. He further reported that he was carrying a hot skillet, slipped, and twisted on his right leg. He reported that he impacted the right side on the ground. He complained of medial and lateral joint line tenderness. Petitioner reported that following his right knee scope in 2007 he was fine until his work injury in June of 2014. X-rays showed no evidence of joint space narrowing or degenerative changes. Dr. Rhode reviewed the MRI of the right knee and was of the opinion that it showed a prior partial medial meniscectomy without frank re-tear. He also injected petitioner's right knee. Dr. Rhode assessed knee pain and contusion of the knee.

Petitioner reported the injection helped reduce the swelling and some pain. He also reported that his right knee felt like it did before the surgery in 2007. A repeat MRI of the right knee on 6/12/15 was still negative with some small joint effusion. Despite these findings, and based on petitioner's ongoing complaints, Dr. Rhode recommended an arthroscopic evaluation and possible partial medial meniscectomy.

Respondent had petitioner examined by Dr. Lehman. Petitioner gave a history of falling on a wet floor in the kitchen at work and smashing his right knee into the concrete. He complained of pain below the patellofemoral articulation after the injury. Dr. Lehman believed that petitioner's diabetes was a factor in his symptomatology. Dr. Lehman noted gross symptom magnification during his examination. He reviewed the x-rays and MRI and noted that the joint spacing was excellent and the MRI was normal. Following his examination of petitioner, Dr. Lehman noted that petitioner's right knee examination was normal. He was of the opinion that there is no evidence petitioner's incident as described, created any disease in the right knee. He opined that petitioner's complaints are not related to the June 2014 incident and cannot be explained pathologically or orthopedically. He did not believe petitioner had any treatable pathology in his right knee. He

did not recommend any surgery or more therapy. He noted that petitioner had three normal MRIs. Dr. Lehman was of the opinion that even if petitioner had a minor strain to his knee on 6/27/14, it would have long since healed.

Despite the normal MRI findings Dr. Rhode performed a right knee partial medial meniscectomy on 9/15/15. Dr. Rhode's diagnosis post operatively was right knee medial meniscus tear. Post-operatively petitioner underwent a course of therapy and followed-up with Dr. Rhode. Despite the surgery and postoperative therapy and injection, petitioner's condition did not improve significantly. He continued to complain of medial joint line pain, numbness and burning in his knee, and pinching sensation in the sides of the knee. He also complained of pain with prolonged positions, especially standing. He noted a sense of an unstable knee. Despite all these ongoing complaints, petitioner reported that his pain was much less than before surgery. On 5/4/16 when petitioner last followed-up with Dr. Rhode his complaints were the same.

At trial petitioner testified that as he was coming around the corner on 6/27/14 while holding a hot skillet, he slipped and fell on some water. He testified that when he fell his feet went above his head and he landed with his right foot twisted underneath him. Then on cross examination he testified that when he slipped and fell he landed on his hands and knees and his right leg twisted inward at the ankle. He further stated that when he fell he caught himself with his hands, and then hit both his right and left knees together on the ground.

The arbitrator finds the mechanism of injury petitioner provided to the emergency room to be the most credible, given that it is the most contemporaneous to the injury, and most likely the most accurate given its proximity to the injury. This mechanism of injury was also consistent with the mechanism of injury he provided Dr. Lehman. Petitioner told Dr. Lehman that he fell on a wet floor in the kitchen at work and smashed his right knee into the concrete. He made no mention of any twisting of his right leg when he fell. It was not until petitioner presented to Dr. Rhode that his mechanism of injury of changed and he alleged that when he slipped and fell he twisted his right leg. Then when petitioner testified at trial, his mechanism of injury changed yet again. At trial, he testified that when he fell his feet went above his head and he landed with his right foot twisted underneath him. Then on cross-examination he testified that he landed on his hands and knees and his right leg twisted inward at the ankle, and he caught himself with his hands when he fell, before hitting both his right and left knees together on the ground.

Based on the above, as well as the credible evidence, the arbitrator finds the most credible mechanism of injury is that petitioner slipped on some water and fell smashing his right knee on the concrete floor.

Following the injury petitioner ultimately underwent 3 MRI's of his right knee that revealed that all structural elements were intact including the menisci, cruciate, and collateral ligaments. Following these MRI's Dr. Ludwig diagnosed a contusion of the right knee and some post traumatic chondromalacia of the right knee. He was also of the opinion that petitioner bruised the back of his kneecap. He was of the opinion that surgery would not help these problems. Dr. Ludwig testified that following petitioner's surgery in 2007 petitioner continued with pain similar to his preoperative pain, but not as intense. He also testified that petitioner had crepitation in his right knee following the surgery in 2007, as well following the injury on 6/27/14. Dr. Ludwig saw nothing on the MRI of the right knee that would explain petitioner's complaints of pain. He also could find no objective evidence or objective explanation for petitioner's complaints. He opined that a direct blow injury is not a mechanism of injury that causes a meniscal tear.

Petitioner also presented to Dr. Rhode. He testified that he sought Dr. Rhode out by himself. However, the respondent noted that Dr. Rhode is in Peoria where petitioner's attorneys have an office, petitioner's attorneys have been known to send clients to Dr. Rhode; and petitioner had his medical records from Dr. Rhode sent to his attorneys' office. Even though Dr. Rhode admitted that the MRIs did not demonstrate any meniscal tear, he recommended an arthroscopic evaluation and possible partial medial meniscectomy. The arbitrator finds the mechanism of injury petitioner told Dr. Rhode of a twisting and direct blow injury to be inconsistent with the credible evidence that supports a finding that petitioner slipped and fell on his right knee on the concrete, without any twisting involved. Despite the normal MRIs Dr. Rhode performed a right knee partial medial meniscectomy and diagnosed a right knee medial meniscus tear. Post operatively petitioner did not improve significantly. During his deposition Dr. Rhode even admitted that when he first examined petitioner he had full range of motion of his right knee, no effusion, no ligament instability, no evidence of degenerative changes in the knee, and a normal MRI. Despite, these findings he still performed surgery, and then agreed that the surgery did not resolve petitioner's complaints, and petitioner had more residual symptomatology than he expected. He also agreed that the lack of improvement could be that the meniscus was not what was causing petitioner's problems.

Petitioner was also examined by Dr. Lehman, at the request of the respondent. He reiterated that the MRI's of petitioner's right knee and his examination of petitioner's right knee were normal. He also noted that petitioner had excellent joint spacing in his right knee. Dr. Lehman noted some gross symptom magnification during his examination of petitioner. His impression was that petitioner's symptoms could not be understood pathologically or orthopedically. He opined that petitioner had no treatable pathology in his right knee, and that his complaints were not related to the 6/27/14 incident. He believed that even if petitioner had sustained a

minor strain, it would have resolved in 4-6 weeks. Dr. Lehman believed petitioner's behavior was inconsistent with someone with a meniscal type injury. He noted that petitioner was bowlegged and had diabetes, and these conditions can result in someone having medial knee pain. Dr. Lehman even reviewed the arthroscopic photos of Dr. Rhode's surgery and was of the opinion that it showed only mild degenerative fraying of the medial meniscus that was not traumatic in nature and could not have caused the symptoms petitioner complained of. He opined that it is impossible to have a meniscus tear that is traumatic and have an absolutely normal MRI like petitioner did. He further opined that the fraying margin of petitioner's medial meniscus was a normal finding for someone born in 1974, like petitioner was. Dr. Lehman also opined that you cannot cause a tear in the meniscus by smashing your knee into the concrete. He further opined that even if petitioner had a twisting injury, as he reported to Dr. Rhode and testified to at trial, that would result in a radial tear or a bucket handle tear, which petitioner did not have. He opined that the fraying was not caused by the fall. He was of the opinion that the surgery performed by Dr. Rhode was not necessary to address petitioner's complaints. He believed that someone with a non-pathological examination and normal MRI are not going to get better if they have surgery. He was further of the opinion that since petitioner had no lasting improvement from the injection, then one would not expect that a knee arthroscopy would resolve the pain, which is exactly what happened following petitioner's surgery.

Based on the above, as well as the credible record, the arbitrator finds the petitioner's current condition of ill-being is not causally related to the injury he sustained on 6/27/14. The arbitrator bases this opinion on the opinions of Dr. Ludwig and Dr. Lehman, which the arbitrator finds more persuasive than those of Dr. Rhode, especially given the fact that Dr. Rhode's opinions are based on an inconsistent mechanism of injury than that provided to the emergency room, Dr. Ludwig, and Dr. Lehman. The arbitrator finds the credible record supports a finding that petitioner did not sustain a twisting injury to his right knee, but rather stuck his right knee on the concrete floor when he fell. The arbitrator also bases this opinion on the three normal MRI's petitioner underwent; the opinions of Dr. Ludwig, Dr. Lehman and Dr. Rhode that there is no objective evidence or explanation for petitioner's complaints; the fact that petitioner had pain following his surgery in 2007, that was similar or not as intense as it was preoperatively; that Dr. Rhode admitted that petitioner's lack of improvement postoperatively could mean that petitioner's meniscus was not what was causing petitioner's pain; that Dr. Lehman was of the opinion that being a diabetic and bowlegged are conditions that can result in someone having medial knee pain; and that petitioner reported on 2/24/15 he reported to his therapist that three days prior he fell and landed on his right knee and this worsened his condition.

The arbitrator finds petitioner's current condition of ill-being causally related to the injury he sustained on 6/27/14 only through 3/16/15 when he was released from care on an as needed basis by Dr. Ludwig.

J. WERE 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's current condition of ill-being causally related to the injury he sustained on 6/27/14 only through 3/16/15 when he was released from care on an as needed basis by Dr. Ludwig, the arbitrator finds all medical services for petitioner's right knee that were provided from 6/27/14 through 3/16/15 were reasonable and necessary to cure or relieve petitioner from the effects of his injury on 6/27/14. The arbitrator finds all treatment after 3/16/15 was not reasonable or necessary to cure or relieve petitioner from the effects of his injury. Although Dr. Ludwig recommended petitioner seek out a 2nd opinion, the arbitrator finds the petitioner's visit to Dr. Rhode for a 2nd opinion not reasonable or necessary given the fact that petitioner failed to provide a consistent history of the injury on 6/27/14, and his objective physical examination at that point was normal.

Based on the above, as well as the credible evidence, the arbitrator finds the Respondent shall pay reasonable and necessary medical services for petitioner's right knee through 3/16/15, 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. WHAT TEMPORARY BENEFITS ARE IN DISPUTE?

Following the injury on petitioner on 6/27/14 petitioner first sought treatment at the emergency room, and was referred to Dr. Bussing, his primary care physician. Petitioner was not taken off work by the doctor in the emergency room. Dr. Bussing took petitioner off work from 7/8/14 through 7/10/14. Petitioner next presented to Dr. Ludwig on 7/17/14. Dr. Ludwig authorized petitioner off work from 7/17/14 through 7/28/14. Petitioner was not taken off work again prior to 3/16/15, the date the arbitrator finds petitioner's current condition of ill-being was no longer causally related to the injury on 6/27/14.

Based on the above, as well as the credible record, the arbitrator finds the petitioner was temporarily totally disabled from 7/8/14 through 7/10/14, and from 7/17/14 through 7/28/14, a total of 2-1/7 weeks. Respondent shall receive credit for the $327.00 it has already paid for temporary total disability benefits. Given that the maintenance benefits petitioner is claiming are for a period of time after 3/16/15, the petitioner's claim for maintenance benefits is denied.

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

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

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the petitioner was a dishwasher at the time of the injury. Petitioner was released to full duty without restrictions by Dr. Ludwig on 7/28/14. Petitioner was not taken off work again prior to 3/16/15, the date through which the arbitrator found a causal connection between petitioner's right knee condition and the injury on 6/27/14. The Arbitrator therefore gives lesser weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 40 years old at the time of the accident. Given that petitioner was given a full duty release by Dr. Ludwig on 7/28/14 and was not taken off work again before 3/16/15, the date through which the arbitrator found a causal connection between petitioner's right knee condition and the injury on 6/27/14, the arbitrator finds no credible evidence to support a finding that petitioner was not capable of continuing in his capacity as a dishwasher. Therefore, the arbitrator gives lesser weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the arbitrator notes that the petitioner offered no evidence regarding his future earnings capacity. Therefore, the arbitrator gives lesser weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator finds petitioner was discharged from care by Dr. Ludwig on 3/16/15 without restrictions. Dr. Ludwig was of the opinion petitioner had crepitation in his right knee following the surgery in 2007, as well as following the injury on 6/27/14. Dr. Ludwig saw nothing on the MRI of the right knee that would explain petitioner's complaints. He assessed a contusion and posttraumatic chondromalacia. He could find no objective evidence or explanation for petitioner's complaints of pain. He was of the opinion that a direct blow injury is not a mechanism of injury that causes a meniscal tear. Dr. Lehman was also of the opinion that petitioner had no treatable pathology in his right knee, and that his complaints were not related to the 6/27/14 incident. He believed that petitioner had sustained a minor strain. He noted that petitioner also had three normal MRIs. Even Dr. Rhode noted when he first examined petitioner that petitioner had full range of motion of his right knee, no effusion, no ligament instability, no evidence of degenerative changes in the knee, and a normal MRI. Dr. Rhode was also of the opinion that the surgery did not resolve petitioner's complaints, and petitioner had more residual symptomatology than he expected.

The Arbitrator therefore gives greater weight to this factor.

Based on the above factors, as well as the credible record, the Arbitrator finds that petitioner sustained a permanent partial disability to the extent of 2.55% loss of use of the right leg pursuant to Section 8(e) of the Act. This loss of use of the right leg is in addition to the 28.45% loss of use of the right leg petitioner settled for with respect to a prior injury to his right knee on 6/8/06 (06 WC 30456).

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Kathy Underwood
Petitioner,

vs. No: 15 WC 20093

20IWCC0059

State of Illinois,
Dept. of Human Services,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 31, 2018 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.

SD LACCU026

20IWCC0059

Pursuant to §19(f)(1) of the Act, claims against the State of Illinois are not subject to judicial review. Therefore, no appeal bond is set in this case.

DATED: JAN 28 2020

Marc Parker

Barbara N. Flores

Deborah L. Simpson

mp-wj
o-01/07/20
68

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

UNDERWOOD, KATHY Case# **15WC020093**
Employee/Petitioner

ILLINOIS DEPT OF HUMAN SERVICES
Employer/Respondent

20IWCC0059

On 7/31/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.16% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4377 LAW OFFICE OF MICHAEL MILES
PO BOX 907
CARBONDALE, IL 62901

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

0558 ASSISTANT ATTORNEY GENERAL
NICOLE M WERNER
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

0498 STATE OF ILLINOIS
ATTORNEY GENERAL
100 W RANDOLPH ST 13TH FL
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

JUL 31 2018

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

Kathy Underwood
Employee/Petitioner

v.

Illinois Department of Human Services
Employer/Respondent

Case # **15** WC **20093**

Consolidated cases: _____

20IWCC0059

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Lee**, Arbitrator of the Commission, in the city of **Herrin**, on **May 10, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **March 19, 2015**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

Timely notice of 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 **$38,793.39**; the average weekly wage was **$746.03**.

On the date of accident, Petitioner was **51** years of age, ***single*** with **0** dependent children.

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

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

Respondent shall be given a credit of **$0** for TTD, **$5,400** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$5,400**.

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

ORDER

Petitioner failed to prove her current condition of ill-being is causally related to the alleged injury. Accordingly, her claim for benefits 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

7/28/18
Date

JUL 31 2018

STATE OF ILLINOIS)
)SS
COUNTY OF WLLIAMSON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

KATHY UNDERWOOD,
Employee/Petitioner

v.

Case # 15 WC 20093

STATE OF ILLINOIS – DEPARTMENT OF HUMAN SERVICES,
Employer/Respondent

20IWCC0059

FINDING OF FACTS

Petitioner was employed as a personal assistant for the Illinois Department of Human Services. Petitioner alleges on March 19, 2015 she suffered repetitive trauma to her right knee while helping a client out of the tub. This case was tried before Arbitrator Lee at the Herrin docket on May 10, 2018. The issues in dispute are causal connection, medical bills, TPD, nature and extent, and credit for payment of disputed TPD benefits.

On April 13, 2015, Petitioner filled out a Workers' Compensation Employee's Notice of Injury. (RX3). Petitioner indicated that on March 19, 2015, she was assisting a client from the tub when she twisted her right knee and slipped. (RX3).

Medical History

On July 20, 2010, Petitioner presented to Dr. Kazmi at Massac Memorial Hospital complaining of right leg pain and swelling. (RX6). Petitioner was having difficulty ambulating and using a cane. (RX6). Petitioner indicated she felt like her right calf was going to explode and rated her pain an eight out of 10. (RX6). An ultrasound was ordered to rule out deep venous thrombosis. (RX6).

On July 21, 2010, Petitioner underwent a right lower extremity duplex venous ultrasound due to right leg pain and swelling to rule out deep venous thrombosis. (RX6). The impressions were negative at that time. (RX6).

On July 15, 2011, Petitioner underwent an MRI of her lumbar spine due to low back pain and right leg pain and weakness. (RX6).

On August 8, 2011, Petitioner presented to Trinity Neuroscience Institute complaining of low back pain and right knee pain. (RX6). She injured herself while mowing her grass. (RX6). Her

greatest discomfort was around the medial side of her right knee. (RX6). Petitioner was referred to the Orthopaedic Institute of Southern Illinois for evaluation of her right knee. (RX6). She was diagnosed with right knee MCL/meniscus injury. (RX6).

On August 17, 2011, Petitioner filled out a patient intake form at the Orthopaedic Center of Southern Illinois. (RX6). She indicated she has had pain in her right knee since July 2010 when she fell in her yard. (RX6). She indicated this is not a work related injury. (RX6). Petitioner was hospitalized for three days due to this fall. (RX6). Petitioner indicated her right knee pain was sharp, achy, and burning, with swelling and giving way. (RX6). She rated her pain a seven out of 10 and that she had been using a knee brace. (RX6).

On August 17, 2011, Petitioner presented to Dr. Wood at the Orthopaedic Institute of Southern Illinois for her right knee. (RX6). Petitioner fell in July 2010, causing immediate swelling and pain in her right knee and was hospitalized. (RX6). She has had persistent problems with her right knee since that time that have gotten progressively worse. (RX6). Petitioner indicated she cannot straighten her leg and has chronic swelling in her right calf. (RX6). Petitioner had limited range of motion with her right knee and walked with an antalgic gait. (RX6). X-rays of Petitioner's right knee showed advanced degenerative changes with a decrease in the medial joint space and diffuse periarticular osteophytes in a tri-compartmental fashion. (RX6). Petitioner was diagnosed with moderate to advanced degenerative joint disease in her right knee as well as a degenerative medial meniscal tear. (RX6). Petitioner's right knee was aspirated and she was given a cortisone injection. 9RX6). Petitioner was prescribed physical therapy, medication, analgesic cream, and a cane. (RX6).

On October 5, 2011, Petitioner returned to Dr. Wood for her right knee. (RX6). Petitioner complained of significant pain in both knees. (RX6). Petitioner indicated her knee pain precluded her from walking more than a quarter mile. (RX6). Petitioner indicated she did not feel she could go on living like this. (RX6). X-rays of both knees showed significant degenerative arthritis. (RX6). Petitioner was recommended to undergo supartz injections. (RX6).

On October 24, 2011, Petitioner underwent supartz injections in her right and left knees. (RX6).

On November 2, 2011, Petitioner underwent supartz injections in her right and left knees. (RX6).

On November17, 2011, Petitioner underwent supartz injections in her right and left knees. (RX6).

On July 7, 2014, Petitioner filled out a patient intake form at the Orthopaedic Center of Southern Illinois. (RX6). Petitioner indicated she had pain in both knees after a fall in her home. (RX6). She indicated this is not a work related injury. (RX6).

On July 7, 2014, Petitioner presented to Dr. Wood at the Orthopaedic Institute of Southern Illinois for both knees. (RX6). Petitioner indicated she had pain in both knees for several years. (RX6). She had previously injured the right knee and still has persistent dysesthesias. (RX6).

Petitioner was diagnosed with advanced degenerative joint disease in both knees. (RX6). Another round of supartz injections were recommended and waiting for approval. (RX6). Dr. Wood aspirated both of Petitioner's knees and gave her bilateral knee cortisone injections. (RX6).

On August 6, 2014, Petitioner underwent supartz injections in her right and left knees. (RX6). Both knees were also aspirated. (RX6).

On August 20, 2014, Petitioner underwent supartz injections in her right and left knees. (RX6).

On August 28, 2014, Petitioner underwent supartz injections in her right and left knees. (RX6). Petitioner was to follow up in six months. (RX6).

On March 20, 2015, Petitioner presented to Dr. William Ribbing at Rural Health complaining of right knee pain. (PX3). It was noted Petitioner weighed 272 pounds and was five feet, nine inches tall, with a BMI of 40.2. (PX3). Petitioner was ambulating normally. (PX3). An MRI was ordered. (PX3). There was no mention of a work injury. (PX3).

On March 26, 2015, Petitioner underwent an MRI of her right knee at Union County Hospital. (PX4). The impressions were: 1) complex tear of the medial meniscus with flap formation and extrusion of the body related to loss of hoop containment; 2) tri-compartmental osteoarthritis with most severe changes involving the medial compartment with thinning and fissuring of the cartilage of the patella as well; 3) joint effusion, non-specific, slit-like popliteal cyst, and small loose body posteriorly; 4) muscle atrophy; 5) low to intermediate grade sprain of the medial collateral ligament with component scarring, mucoid degeneration versus minimal sprain of the anterior cruciate ligament with intact fibers identified; and 6) patellar/quadriceps tendinosis with enthesopathy, subcutaneous edema anteriorly. (PX4).

On March 30, 2015, Petitioner presented to Dr. John Wood at the Orthopaedic Institute of Southern Illinois for her right knee. (PX5). Petitioner filled out a patient intake form indicating this was a workers' compensation claim. (PX5). She did not indicate if she ever had previous similar problems or complaints. (PX5). She did indicate that she was currently working and that she had no hobbies. (PX5). It was noted Petitioner had chronic right knee arthritis and had previously undergone viscous supplementation in August. (PX5). Petitioner indicated that on March 18, 2015, she was assisting a client in the bathroom at work when her right knee had an episode and she had a sudden sharp pain. (PX5). X-rays of Petitioner's right knee showed severe arthritis and bone-on-bone findings. (PX5). Petitioner was given a cortisone injection. (PX5). Petitioner was diagnosed with arthritis and prescribed physical therapy and visco supplementation. (PX5). Dr. Wood indicated Petitioner was currently working full duty and that he would allow her to continue to do so. (PX3). However, it was noted Petitioner requested light duty restrictions of minimal carrying and lifting, so Dr. Wood gave those restrictions. (PX5). There were no restrictions given regarding the amount of time Petitioner could work per day or week. (PX5).

On April 20, 2015, Petitioner followed up with Dr. Wood. (PX5). Petitioner complained of right knee pain due to lifting while at work on March 19, 2015. (PX5). It was noted that Petitioner had not previously reported this to work, but was now turning it in as a workers'

compensation claim. (PX5). Petitioner denied any previous right knee problems, but was aware there was some underlying arthritis. Dr. Woods reviewed Petitioner's MRI which showed degenerative arthritis and a degenerative meniscal tear. (PX5). Petitioner was diagnosed with arthritis and given a steroid injection. (PX5). Physical therapy was again ordered as Petitioner indicated she did not go to formal physical therapy yet. (PX5). Per Petitioner's request, Dr. Wood continued her light duty restrictions of no lifting or carrying more than 15 pounds and standing/walking 30 minutes per hour, no stairs. (PX5). There were no restrictions given regarding the amount of time Petitioner could work per day or week. (PX5).

On April 21, 2015, Petitioner followed up with Dr. Ribbing. (PX3). No chief complaint was noted. (PX3). Petitioner was assessed with knee pain. (PX3).

On May 28, 2015, Petitioner returned to Dr. Wood. (PX5). Petitioner continued to complain of right knee pain. (PX5). It was noted Petitioner claimed her symptoms began at work on March 19, 2015 due to twisting. (PX5). Dr. Wood indicated Petitioner had a degenerative meniscal tear, but her symptoms were not related to that. (PX5). Petitioner was being treated for arthritis and an arthroscopy would be of minimal benefit. (PX5). Dr. Wood indicated Petitioner's arthritis was aggravated. (PX5). Petitioner was prescribed visco supplementation and physical therapy. (PX5). Petitioner was given restrictions of no lifting or carrying more than 15 pounds and standing/walking 15 minutes per hour. (PX5). There were no restrictions given regarding the amount of time Petitioner could work per day or week. (PX5).

On June 11, 2015, Petitioner followed up with Dr. Wood for her right knee. (PX5). Petitioner indicated her condition was unchanged. (PX5). Petitioner was diagnosed with arthritis and degenerative joint disease. (PX5). Petitioner was given restrictions of no lifting or carrying more than 15 pounds and standing/walking 15 minutes per hour. (PX5). There were no restrictions given regarding the amount of time Petitioner could work per day or week. (PX5).

On July 9, 2015, Petitioner returned to Dr. Wood. (PX5). Petitioner's symptoms were unchanged. (PX5). She was given a supartz injection. (PX5).

On July 16, 2015, Petitioner returned to Dr. Wood. (PX5). Petitioner's symptoms were improving. (PX5). She was given a supartz injection. (PX5).

On July 23, 2015, Petitioner returned to Dr. Wood. (PX5). Petitioner's symptoms were improving. (PX5). She felt like she could do more. (PX5). She was given a supartz injection. (PX5). Petitioner was given restrictions of no lifting or carrying more than 15 pounds and standing/walking 30 minutes per hour. (PX5). There were no restrictions given regarding the amount of time Petitioner could work per day or week. (PX5).

On September 3, 2015, Petitioner returned to Dr. Wood. (PX5). Petitioner's symptoms were improving. (PX5). She rated her current pain as a two out of 10. (PX5). Dr. Wood discussed Petitioner's meniscal tear and aggravated pre-existing arthritis, as well as the importance of injection therapy and proper footwear. (PX5). Dr. Wood indicated Petitioner could work 40 hours a week and that she could walk and stand 45 minutes per hour. (PX5). This was the first indication regarding the amount of time Petitioner could work per week. (PX5).

On October 26, 2015, Petitioner returned to Dr. Wood for her right knee. (PX5). Petitioner filled out a new patient intake form indicating she injured her right knee at work on March 19, 2015. (PX5). Petitioner denied having previous or similar problems in her right knee prior to this injury. (PX5). Petitioner also indicated that this injury was not with her current employer as she was with a new company. (PX5). Petitioner indicated her problem was the result of a pivoting motion. (PX5). Petitioner indicated she could no longer continue working with the pain and wanted to proceed with surgery. (PX5). Dr. Wood noted Petitioner had significant bone-on-bone arthritis that he believed was aggravated by Petitioner's work injury. (PX5). Petitioner was given a cortisone injection and recommended to undergo a total right knee replacement. (PX5). Petitioner was given restrictions of working four hours only daily. (PX5).

On December 17, 2015, Petitioner underwent a Section 12 examination with Dr. Richard Lehman. (RX4). Dr. Lehman reviewed Petitioner's medical records and performed a physical examination. (RX4). Petitioner indicated she was helping a client in the shower when she twisted her right knee and began having pain. (RX4). It was noted Petitioner was five feet, nine inches tall and weighed 272 pounds, with a BMI of 40.2. (RX4). On physical examination, Petitioner was unable to straighten her knee and had limited range of motion. (RX4). Petitioner had significant swelling in the calf and lower leg. (RX4). X-rays showed end-stage arthritis in both the left and right knees with tibiofemoral collapse in both knees. (RX4). There was bone-on-bone changes that appear to be chronic and severe. (RX4). There was also a macerated tear of the medial meniscus with extrusion of the meniscus. (RX4). The MRI also showed osteoarthrosis, thinning of the cartilage, and the patella with loss of medial joint space completely. (RX4). There was a loose body and mild overload of the medial collateral ligament. (RX4). Dr. Lehman noted Petitioner had previously treated her right knee with injection therapy in 2014 and had treated for arthritis in 2011, as well. (RX4).

Dr. Lehman diagnosed Petitioner with right knee end-stage degenerative arthritis with complete loss of joint space. (RX4). Dr. Lehman opined there was no causal relationship between Petitioner's diagnosis and her alleged work injury as she had long term pre-existing arthritis and had treated for same ion the past. (RX4). Petitioner's condition was already bone on bone and her alleged injury could not have made the arthritic process worse as Petitioner was already end stage with no joint space. (RX4). Petitioner's joint had been degenerative for many years and has been a complete loss of joint space for many years. (RX4). Dr. Lehman indicated a total knee replacement would be reasonable, but unrelated to the alleged work injury. (RX4). Dr. Lehman indicated Petitioner's accelerated BMI and significant calf swelling were worrisome for deep venous thrombosis. (RX4). Dr. Lehman indicated Petitioner may have had a soft tissue injury due to her alleged work injury, however her current symptoms are 100% due to her pre-existing long term degenerative arthritis with complete joint space collapse. (RX4). Dr. Lehman indicated the MRI showed no pathology that could be related to the alleged work injury. (RX4).

On February 1, 2016, Dr. Wood continued to recommend Petitioner undergo surgery. (PX5). He indicated as of February 23, 2016, Petitioner could work five hours only daily. (PX5).

On June 21, 2016, Petitioner underwent a right total knee arthroplasty for right knee primary degenerative arthritis. (PX5).

On July 6, 2016, a nurse note indicated Petitioner came in to the Orthopaedic Institute of Southern Illinois for staple removal. (PX5). The incisions looks good with no signs of infection. (PX5). Petitioner was to begin physical therapy. (PX5).

On August 3, 2016, Petitioner followed up with Dr. Wood for her right knee. (PX5). X-rays showed her prosthesis in good placement. (PX5). Petitioner was to continue physical therapy. (PX5). Petitioner was to stay off work for two weeks, then work four hours a day for two weeks, then return to work full duty in four weeks. (PX5).

On September 28, 2016, Petitioner returned to Dr. Wood for her right knee. (PX5). Petitioner indicated she still had some pain and weakness, but she was improving. (PX5). She was able to walk with a good, steady gait with no assistive device. (PX5). She had full extension with no instability. (PX5). X-rays showed good position of hardware. (PX5). Petitioner indicated she was working. (PX5). Petitioner was to follow up in nine months at the one year marker from her surgery. (PX5).

On June 28, 2017, Petitioner followed up with Dr. Wood for her right knee. (PX5). Petitioner indicated she had some pain, but her symptoms were mild. (PX5).Petitioner did have some swelling, but had adequate quad tone and strength and full flexion. (PX5). Petitioner indicated the knee itself did not hurt and she was pleased with the results of the knee as fat as pain is concerned. (PX5). Petitioner indicated she is working. (PX5).

Testimony

Dr. Richard Lehman testified via evidence deposition on August 24, 2017. (RX5). Dr. Lehman testified he is a board certified doctor in both sports medicine and orthopedic surgery. (RX5, tr. 4). His practice is primarily focused on knee and shoulder injuries and he performs surgery 18 to 20 times a week. (RX4, tr. 4-5). Dr. Lehman testified he reviewed Petitioner's medical records and performed a physical examination. (RX4, tr. 8-10). Petitioner indicated she injured her right knee when she twisted it while helping a client out of the shower. (RX4, tr. 10). Dr. Lehman reviewed the films from Petitioner's right knee MRI which showed severe osteoarthritis with complete loss of medial joint space and collapse of the medial joint space and a complex tear with significant signal in the medial meniscus and extrusion of the meniscus from the joint. (RX4, tr. 11). Dr. Lehman testified the medical records showed Petitioner had previously treated for her right knee and undergone x-rays in 2011. (RX4, tr. 11-12). Petitioner had also underwent hyaluronic acid injections in 2014. (RX4, tr. 14). Dr. Lehman diagnosed Petitioner with right knee end stage degenerative arthritis with complete loss of joint space. (RX4, tr. 14). Dr. Lehman opined Petitioner current right knee condition was not in any way caused, related to, or aggravated by the alleged work place injury. (RX4, tr. 15). This is based on the imaging studies of Petitioner's right knee x-ray in 2011 compared to her MRI. (RX4, tr. 15). Also, Petitioner's meniscus is extruded, which is a process that takes many years. (RX4, tr. 16). Petitioner's complex tear of her medial meniscus is a degenerative type tear, meaning it tears along the planes of avascularity, where there is no blood flow to the meniscus. (RX4, tr. 16). The meniscus tears horizontally, vertically, and radially, then gets extruded from the knee. (RX4, tr. 16). In reviewing morphology meniscus tears, these tears are chronic and long term and by the time the meniscus gets extruded, it is a long term process. (RX4, tr. 16). Petitioner also has tri-compartmental

osteoarthritis with complete space collapse, with absolutely no joint space, as seen on x-rays. (RX4, tr. 16). This is again a long process that takes many years to occur. (RX4, tr. 16). Based on the imaging studies, the fact that Petitioner has treated her for right knee arthritis since 2011, and that she is bone on bone; Petitioner's condition could not get any worse and the work injury could not change the architecture of her knee. (RX4, tr. 17). Dr. Lehman testified the work injury may have caused a soft tissue strain, but that was not evidenced on MRI. (RX4, tr. 17).

Dr. Lehman further testified he did not believe Petitioner tore her meniscus on March 19, 2015. (RX4, tr. 18). Dr. Lehman testified that based on the architecture of Petitioner's meniscus tear, it was chronic and long term, which is supported by the medical literature. (RX4, tr. 18). Dr. Lehman also testified there was no aggravation as Petitioner is bone on bone with no cartilage left, so there is nothing to aggravate. (RX4, tr. 19). This is not an acute on chronic situation. (RX4, tr. 19). Dr. Lehman testified Petitioner was bone on bone prior to the alleged injury and that it would be impossible for her to have been pain free and fully functional prior to this alleged injury. (RX4, tr. 20). No one gets treatment for an asymptomatic knee over a three year period of time. (RX4, tr. 20). Dr. Lehman indicated Petitioner would be a candidate for a total knee replacement and he was concerned that she may have deep venous thrombosis, but neither of those would be related to the alleged work injury. (RX4, tr. 21).

Dr. Lehman testified Petitioner had multiple factors that would affect her right knee condition. (RX4, tr. 210. This includes her age of 52 years old and her weight/height differential. (RX4, tr. 21-22). Petitioner's BMI is over 40, and anyone with a BMI over 25 has a higher chance of getting degenerative arthritis, and the higher the BMI, the younger a person will develop arthritis. (RX4, tr. 22). As such, Petitioner's weight is a significant factor in her development of degenerative arthritis. (RX4, tr. 22).

On cross-examination, Dr. Lehman testified he did not believe that Petitioner could have been pain free in her right knee as she had severe degenerative arthritis and complete end stage collapse of her joint. (RX4, tr. 24). He testified it is hard to determine if she could have been fully functional, but thought that she had learned to compensate, as people with degenerative arthritis tend to do. (RX4, tr. 24-25). So Petitioner could have been completely functional in her job and compensate for the things she needed to do, but he is not sure if she would have had the ability to run or do something more aggressive. (RX4, tr. 25). Dr. Lehman testified Petitioner continued to have complaints of pain throughout the medical records he reviewed. (RX4, tr. 29). Dr. Lehman testified that he did not diagnose Petitioner with deep venous thrombosis, but it is the practice that when a patient's calf is swollen, a venous Doppler or ultrasound would be ordered to rule out a blood clot. (RX4, tr. 30). Dr. Lehman testified he had a good understanding of her claimed mechanism of injury. (RX4, tr. 30-31).

Petitioner testified at Arbitration that in 2015 she was working for the Department of Human Services. Her job as a home healthcare worker included taking care of elderly disabled people; doing errands, cooking, cleaning, and helping them with their needs. On March 19, 2015, she was working as a home healthcare worker for two clients. On that date, she was at one of her client's house giving her a bath. Petitioner testified when she went to help her client out of the tub, her right knee twisted and there was water on the floor. Petitioner testified that she worked 55 to 60 hours a week between her two clients in 2015.

Petitioner testified after that incident, she went to Rural Health and an MRI of her right knee was ordered. She was eventually referred to Dr. Wood at the Orthopaedic Institute of Southern Illinois. Petitioner testified she had previously seen Dr. Wood and had been diagnosed with degenerative joint disease in both knees. She testified in July 2014, her left knee was worse than her right knee.

Petitioner testified that after March 19, 2015, her right leg swelled constantly and that she had to have her daughter come help her so some of the tasks for her clients as she could no longer do them herself. (RX6). Petitioner testified she continued to treat with Dr. Wood and at some point he restricted her to working no more than five hours a day. She testified she is claiming temporary partial disability for 25 hours a week and that her wage was 13 dollars an hour.

Petitioner testified Dr. Wood performed a total right knee replacement on June 21, 2016. Petitioner testified she sometimes wish she had never had surgery and that it is not the same. Petitioner testified her symptoms were a little different after surgery, but she still had the swelling and there are limitations on what she can do. Petitioner testified there were no plans for treatment for her right knee prior to March 19, 2015. She has not had surgery on the left knee.

Petitioner testified that prior to March 19, 2015, she was able to perform her duties; she had a little bit of pain every once in a while, but she would take Tylenol and it was okay. After March 19, 2015, it was hard to do her duties and she had pain and swelling in the right knee.

On cross-examination, Petitioner was asked if she had previous treatment for her right knee prior to March 19, 2015 and she testified she did not have anything before, but she had seen Dr. Wood. She then testified that Dr. Wood had given her inflammation medication for her right knee prior to March 19, 2015. She did not recall if she treated with Dr. Wood for her right knee in 2011. She could not recall falling in her yard in August 2011, but did remember being in the hospital. She did not recall being diagnosed with advanced degenerative joint disease and a degenerative medial meniscus tear in her right knee in August 2011. She did not recall getting a cortisone injection in her right knee in 2011. Petitioner did recall getting supartz injections in both of her knees in 2011. She also recalled undergoing three rounds of supartz injections in both knees in 2014. Petitioner testified she would not dispute anything in her medical records.

Petitioner testified she underwent an IME with Dr. Lehman, but he did not indicate he thought she may have deep venous thrombosis. Petitioner testified she has never been checked for deep venous thrombosis in her right knee or leg. Petitioner testified she does not recall ever having previous complaints of swelling in her right knee or leg.

Petitioner testified in her position for the Department of Human Services, it is her responsibility to find her own clients, she is not assigned clients. It is the client's right to hire and fire her as she works for them. If a client was to end her contract with Petitioner, it would be Petitioner's responsibility to find a new client, DHS or DORS would not provide her one. Petitioner testified she has worked for her one client, Miss Beer, for over 20 years.

On cross examination, Petitioner was asked if she twisted her knee and she said no, it just gave way. She testified she did not fall to the ground. Petitioner was asked if she told Dr. Wood at

her one year follow up appointment that she was pleased with the results as far as pain is concerned with her knee, and she said that she may have told him she accepted it. She testified she would not dispute anything in her medical records.

Petitioner testified she is currently working. She has not returned to her doctor for her right knee since her one year follow up appointment in June 2017. Petitioner is not undergoing any formal physical therapy or injections. She does do some exercises on her own. Petitioner testified she does not take any medications for her knee. She will occasionally wear a brace.

CONCLUSION OF LAW

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

The Arbitrator concludes the record as a whole does not support a finding that Petitioner's right knee condition is causally related to the March 19, 2015 accident. It has long been recognized that, in preexisting condition cases, recovery will depend on the employee's ability to show that a work-related accidental injury aggravated or accelerated the preexisting disease such that the employee's current condition of ill-being can be said to have been causally connected to the work-related injury and not simply the result of a normal degenerative process of the preexisting condition. See *Caterpillar Tractor Co. v. Indus. Com'n.* 92 Ill.2d 30, 36–37, 65 Ill.Dec. 6, 440 N.E.2d 861 (1982); *Sisbro Inc. v. Indus. Com'n.*, 207 ill.2d 193, 204-205, 797 N.E.2d 665, 672 (2003).

It is clear from the record that Petitioner had long term, chronic issues with regard to her right knee. Her medical records indicate she was treated for right knee problems as far back as 2010. Petitioner even noted on a patient intake form that she was hospitalized after a fall in July 2010 when she injured her right knee. In 2011, Petitioner was diagnosed with advanced degenerative arthritis and a degenerative medial meniscus tear and again underwent extensive treatment for her right knee including injections, physical therapy, aspiration, and supartz injections. In 2014, Petitioner once again sought treatment for her advanced degenerative arthritis in her right knee and went through another round of supartz injections. The Arbitrator takes note that Petitioner's last supartz injection for her right knee was less than seven months prior to March 19, 2015 and Petitioner was supposed to follow up with her doctor for her right knee at that time. Arthritis is a degenerative chronic condition that progresses with time and age and that is reflected in the medical records as Petitioner sought treatment again and again for her right knee over the years.

The Arbitrator is not persuaded by the notes in Dr. Wood's medical records that indicate the March 19, 2015 injury aggravated Petitioner's underlying degenerative condition. Dr. Wood did not include a basis to support this claim in his medical records, nor was his deposition taken to give him a chance to explain his opinion. Instead, the Arbitrator finds the Section 12 examiner, Dr. Lehman, persuasive. Dr. Lehman diagnosed Petitioner with right knee end stage degenerative arthritis with complete loss of joint space and opined Petitioner's right knee condition was not in any way caused, related to, or aggravated by the alleged work place injury. He based this on the fact that Petitioner has tri-compartmental osteoarthritis with complete space collapse, with absolutely no joint space, as seen on x-rays. This is again a long process that takes many years to occur. Also, Petitioner's meniscus is extruded, which is another process that takes years to develop.

Based on the imaging studies, the fact that Petitioner has treated her for right knee arthritis since 2011, and that she is bone on bone; Petitioner's condition could not get any worse and the work injury could not change the architecture of her knee. Dr. Lehman also testified there was no aggravation as Petitioner is bone on bone with no cartilage left, so there is nothing to aggravate. The Arbitrator finds this testimony credible and gives it significant weight.

Also, it is not clear what injury, if any, actually occurred on March 19, 2015. The first medical record available after the alleged injury is from the next day, March 20, 2015. Petitioner saw her primary care doctor complaining of right knee pain, however, she does not mention any work related injury. She was then referred to Dr. Wood and on March 30, 2015, she tells him that her right knee had an episode at work while helping a client in the bathroom causing sharp pain, but gives no further details. At her follow up appointments, she continues to change her story-stating that her right knee pain was due to lifting, then it was due to twisting, then it was due to pivoting. Petitioner also gave two different accounts as to how the injury occurred at trial, first stating that while she was helping her client in the tub the floor was wet and her right knee twisted. Then on cross examination, she testified her right knee did not twist, it gave way. The Arbitrator also notes that at trial was the first time Petitioner alleged there was water on the floor. She did not mention that to any doctors and the record does not reflect that she ever alleged that she slipped on a wet floor. These multiple accounts make it impossible to discern what happened on March 19, 2015 and whether an injury actually occurred, or if Petitioner simply experienced pain, as she had over the years, in her arthritic right knee.

Further, Petitioner is not a credible witness. There are many inconsistencies throughout the record and in Petitioner's own testimony, including:

- When Petitioner filled out a patient intake form on October 26, 2015, she indicated she injured her right knee at work on March 19, 2015 and denied having previous or similar problems in her right knee prior to this injury. However, her medical records reflect that Petitioner had previous similar problems with her right knee as she treated extensively for same over the course of years.

- On cross-examination, Petitioner was asked if she had previous treatment for her right knee prior to March 19, 2015 and she testified Dr. Wood had given her inflammation medication. However, the medical records reflect the Petitioner treated much more extensively than she admitted to prior to March 19, 2015.

- Petitioner testified she has never been checked for deep venous thrombosis in her right knee or leg and she does not recall ever having previous complaints of swelling in her right knee or leg. Again, Petitioner's medical records contradict this, as she underwent ultrasound testing to rule out deep venous thrombosis in 2010. Petitioner's medical records also indicate complaints of right knee swelling in 2010, 2011, and 2014.

- Petitioner testified that prior to March 19, 2015, she was able to perform her duties and only had a little bit of pain every once in a while. This does not comport with her medical records, which show she treated extensively for chronic right knee pain and even told her treating doctor in 2011 "she does not feel she can go on living like this."

- Petitioner testified there were no plans for treatment for her right knee prior to March 19, 2015. However, her medical records indicate that at her last appointment in August 2014, she was supposed to follow up with Dr. Wood for her knees in six months, which is approximately when the alleged injury occurred.

- Petitioner gave multiple different accounts as to the mechanism of injury, as outlined above.

- Petitioner testified she sometimes wish she had never had surgery and that it is not the same. However, this is not supported by the medical records which show that at Petitioner last appointment on June 28, 2017, her symptoms were mild and she indicated the knee itself did not hurt and she was pleased with the results of the right knee as far as pain is concerned.

Petitioner may just be a poor historian, but based upon her multiple inconsistencies; the veracity of Petitioner's testimony is called into serious question.

Based upon the foregoing, the Arbitrator finds that Petitioner did not prove her current condition of ill-being is causally related to the alleged injury. As such, no permanency shall be awarded and Petitioner's claim for benefits is denied and all other issues are moot.

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?

Based upon the foregoing, the Arbitrator finds that Petitioner did not prove her current condition of ill-being is causally related to the alleged injury. As such, no medical services or expenses shall be awarded and Petitioner's claim for benefits is denied and all other issues are moot.

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

Based upon the foregoing, the Arbitrator finds that Petitioner did not prove her current condition of ill-being is causally related to the alleged injury. As such, no permanency shall be awarded and Petitioner's claim for benefits is denied and all other issues are moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Judith Boykin,

Petitioner,

vs.

NOS: 11 WC 41519
12 WC 18593
17 WC 28259

UPS,

Respondent.

ORDER

This matter comes before Commissioner Kathryn A. Doerries pursuant to a Joint Motion to Approve Agreed Amendments to Settlement Contracts in cases 11 WC 41519, 12 WC 18593 and 17 WC 28259. Pursuant to the parties' agreed joint motion, the Commission finds the following:

That on December 20, 2012, Arbitrator Kane approved a single Settlement Contract Lump Sum Petition and Order in cases 11 WC 41519 and 12 WC 18593. By the terms of the contract, Petitioner retained certain rights under §8(a) of the Act.

That on October 19, 2017, Arbitrator Huebsch approved a Settlement Contract Lump Sum Petition and Order in case 17 WC 28259. By the terms of the contract, Petitioner retained certain rights under §8(a) of the Act. Petitioner was not represented by counsel in this case.

That on October 31, 2019, Arbitrator Huebsch approved a Settlement Contract Lump Sum Petition and Order in case 18 WC 20445, for a lump sum of $200,241.60, plus $9,758.40 for a "future medical allocation MSA".

That the parties entered into an Agreed Amendment to Settlement Contract Approved on December 20, 2012, in cases 11 WC 41519 and 12 WC 18593, agreeing and stipulating that Petitioner's rights under §8(a) were waived effective September 20, 2019, in consideration for a lump sum of $1,250.00, as part of the negotiation of the settlement in case 18 WC 20445. Said Agreed Amendment was signed by Petitioner, Attorney for Petitioner and Attorney for Respondent.

That the parties also entered into an Agreed Amendment to Settlement Contract Approved on October 19, 2017, in case 17 WC 28259 agreeing and stipulating that Petitioner's rights under §8(a) were waived effective September 20, 2019, in consideration for a lump sum of $1,250.00, as part of the negotiation of the settlement in case 18 WC 20445. Said Agreed Amendment was signed by Petitioner and Attorney for Respondent.

That on September 20, 2019, with the benefit of counsel, Petitioner agreed to waive her §8(a) rights for consideration of $1,250.00, in cases 11 WC 41519 and 12 WC 18593 at the time she elected to settle case 18 WC 20445.

That on September 20, 2019, with the benefit of counsel, Petitioner also agreed to waive her §8(a) rights for consideration of $1,250.00, in case 17 WC 28259 at the time she elected to settle case 18 WC 20445.

That the Commission has jurisdiction over this matter as §8(a) rights remained open pursuant to the terms of the Settlement Contracts in cases 11 WC 41519, 12 WC 18593 and 17 WC 28259.

That based upon these stipulations, the parties have agreed to modify the terms of the Settlement Contracts in 11 WC 41519, 12 WC 18593 and 17 WC 28259, and terminate Petitioner's §8(a) rights effective September 20, 2019, for total consideration of $2,500.00

IT IS THEREFORE ORDERED BY THE COMMISSION that the Parties' Joint Motion to Approve Agreed Amendments to Settlement Contracts in cases 11 WC 41519, 12 WC 18593 and 17 WC 28259 is granted.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's rights under §8(a) of the Act in case 11 WC 41519 were terminated effective September 20, 2019.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's rights under §8(a) of the Act in case 12 WC 18593 were terminated effective September 20, 2019.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's rights under §8(a) of the Act in case 17 WC 28259 were terminated effective September 20, 2019.

IT IS FURTHER ORDERED BY THE COMMISSION that as consideration for termination of Petitioner's rights under §8(a) of the Act in cases 11 WC 41519 and 12 WC 18593, the Respondent shall pay Petitioner $1,250.00.

IT IS FURTHER ORDERED BY THE COMMISSION that as consideration for termination of Petitioner's rights under §8(a) of the Act in case 17 WC 28259, the Respondent shall pay Petitioner an additional $1,250.00.

IT IS FURTHER ORDERED BY THE COMMISSION that the heretofore approved Settlement Contracts Lump Sum Petitions and Orders in cases 11 WC 41519, 12 WC 18593 and 17 WC 28259, remain in full force and effect, and shall be read in concert with this Order and the stipulations of the parties as recited herein.

Kathryn A. Doerries

KAD/bsd
Dated: 012820
42

JAN 28 2020

STATE OF ILLINOIS)
) SS
COUNTY OF COOK)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Brittany M. Theis,

Petitioner,

vs. No. 13 WC 12736

Steak N Shake Operations, Inc., and
American Zurich Insurance Company,

Respondents.

ORDER

On May 23, 2014, an Arbitrator filed a decision in this case awarding temporary total disability, medical expenses and permanent partial disability benefits. Neither party filed a petition for review of the Arbitrator's decision. Rather, on December 30, 2014, Petitioner filed a petition for review under section 8(a) of the Workers' Compensation Act (the Act).

Thereafter, the petition was set for five status dates in 2015, four status dates in 2016, eight status dates in 2017, five status dates in 2018, and five status dates in 2019. On November 14, 2019, the "final date," the attorneys for both sides appeared before Commissioner Stephen Mathis, but Petitioner again did not appear. Petitioner's counsel requested yet another continuance. Defense counsel objected. Commissioner Mathis dismissed the 8(a) petition.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's petition for review under section 8(a) is dismissed, *nunc pro tunc* November 14, 2019.

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: JAN 2 9 2020
SM/sk
44

Stephen Mathis

STATE OF ILLINOIS)
) SS.
COUNTY OF WINNEBAGO)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jose Manuel Flores

Petitioner,

vs. NO. 15WC 18309

Northwest Pallet Supply Co.,

Respondent.

20IWCC0060

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, causal connection, medical expenses, prospective medical care, 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 17, 2017 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: JAN 29 2020
SJM/sj
o-12/18/2019
44

Stephen J. Mathis

L. Elizabeth Coppoletti

Douglas D. McCarthy

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

FLORES, JOSE MANUEL
Employee/Petitioner

Case# **15WC018309**
15WC009574

NORTHWEST PALLET SUPPLY CO
Employer/Respondent

20IWCC0060

On 4/17/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.95% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2489 BLACK AND JONES
JASON ESMOND
308 W STATE ST SUITE 300
ROCKFORD, IL 61101

1408 HEYL ROYSTER VOELKER & ALLEN
LYNSEY WELCH
120 W STATE ST 2ND FL
ROCKFORD, IL 61105

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

Jose Manuel Flores
Employee/Petitioner

v.

Northwest Pallet Supply Co.
Employer/Respondent

20 IWCC0060

Case # **15 WC 18309**

Consolidated cases: **15 WC 9574**

An *Application for Adjustment 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 **Rockford, Illinois**, on **February 15, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☒ 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**

FINDINGS

20 IWCC0060

On the date of accident, **March 17, 2015**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

Timely notice of this alleged 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's average weekly wage was **$400.00**.

On March 17, 2015, Petitioner was **38** years of age, ***married*** with **0** dependent children.

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

ORDER

Having found that Petitioner failed to prove that he sustained an accidental injury or that a causal relationship existed between his condition of ill-being and the alleged accident of March 30, 2015, Petitioner claim for compensation is hereby denied. (See companion case 15 WC 9574)

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

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

Signature of Arbitrator

4/13/17
Date

ICArbDec

APR 17 2017

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JOSE FLORES,

Petitioner,

vs. NO: 15 WC 009574

NORTHWEST PALLET SUPPLY,

20IWCC0061

Respondent.

DECISION AND OPINION ON REVIEW

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

Petitioner was employed as a line worker, repairing pallets on December 30, 2014, the date of the alleged work accident. He testified that on that date he was stacking pallets and that several pallets fell on him, striking him in the lower back. Petitioner testified that he reported the injury to Marcos Perez, his supervisor, who provided him with over the counter medication and that Petitioner continued to work. Petitioner further testified that he reported the accident to Andrew Perez the following day. Petitioner continued to work but testified that he was experiencing back pain.

Respondent called both Andrew Perez and Marcos Perez as witnesses at trial. They both testified that they were never notified by Petitioner that he had sustained a work accident on December 30, 2014 either verbally or in writing. The medical records introduced reflect that Petitioner first sought medical care for the alleged work accident on March 30, 2015. The Commission notes that on March 30, 2015 Petitioner tested positive for cocaine metabolites.

20IWCC0061

The Commission views the evidence differently from the Arbitrator, who denied compensability on the basis that Petitioner failed to provide timely notice of accident. The Commission finds that Petitioner failed to sustain his burden of proof that he sustained a work accident on December 30, 2014. Based upon the foregoing the Commission affirms and modifies the decision of the Arbitrator in finding that Petitioner's claim is denied.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's claim for compensation is hereby denied on the basis of failure to prove by a preponderance of the evidence that an accident occurred on December 30, 2014.

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: JAN 29 2020
SM/msb
o-12/18/19
44

Stephen Mathis

Douglas McCarthy

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

FLORES, JOSE MANUEL
Employee/Petitioner

Case# **15WC009574**

15WC018309

NORTHWEST PALLET SUPPLY
Employer/Respondent

20IWCC0061

On 4/17/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.95% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2489 BLACK AND JONES
JASON ESMOND
308 W STATE ST SUITE 300
ROCKFORD, IL 61101

1408 HEYL ROYSTER VOELKER & ALLEN
LYNSEY WELCH
120 W STATE ST 2ND FL
ROCKFORD, IL 61105

STATE OF ILLINOIS)
)SS.
COUNTY OF Winnebago)

20IWCC0061

☐ 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

Jose Manuel Flores
Employee/Petitioner

v.

Northwest Pallet Supply Co.
Employer/Respondent

Case # **15 WC 9574**

Consolidated cases: **15 WC 18309**

An *Application for Adjustment 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 **Rockford, Illinois**, on **February 15, 2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☒ 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**

FINDINGS

On the date of accident, **December 30, 2014,** Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident ***was 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's average weekly wage was **$400.00**.

On December 30, 2014, Petitioner was **38** years of age, ***married*** with **0** dependent children.

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

ORDER

Having found that Petitioner failed to prove he provided timely notice of accident, his 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

4/13/17
Date

ICArbDec

APR 17 2017

STATEMENT OF FACTS

Petitioner testified that he began working for Respondent on or around December 9, 2014. Petitioner testified that his job was to repair wooden pallets. He worked at a table next to conveyor belts that brought wooden pallets to him. He would pull the pallet from the line to his table and repair them. Petitioner estimated that the pallets weighed approximately 60-80 lbs. If the pallets were broken, Petitioner would replace the broken piece of wood with another piece, using a hammer and nails. Once the pallet was repaired, he would lift it to another conveyor belt that would take the pallet away. He worked on a full time basis, approximately 40 hours a week. Petitioner testified that he would repair approximately 400 pallets per day.

Petitioner testified that on December 30, 2014, he was stacking pallets onto his table. There were approximately 10 pallets stacked when they fell on to him, striking him on the lower back. Petitioner testified that the impact knocked him forward and took his breath away. He described feeling something pop in his back with the immediate onset of lower back pain. He also had some pain in his left shoulder, but it was mainly confined to his lower back. Petitioner testified that he reported the injury to Marcos, one of his supervisors, who provided him with over the counter medication. Petitioner testified that he reported the injury to Andy, his boss, the next day. Petitioner reported that Andy informed him that if he didn't like the job, he could leave. Petitioner testified that he took the medication and continued working.

Petitioner returned to his regular job, lifting and repairing pallets, with increasing back pain. He indicated that his back pain increased each day. By March 17, 2015, his pain had become severe enough that he sought representation for his injury. On March 24, 2015, he filed his Application for Adjustment of Claims, alleging a repetitive trauma injury with an onset date of March 17, 2015. (Arb. Ex. 3).

Andrew Perez testified for Respondent. Andrew is the regional operations manager for Respondent and was the Production Manager at the time of Petitioner's injuries. He testified that Petitioner did not report his December 2014 injury to him. He confirmed that Petitioner worked full time, pulling pallets from a conveyer belt onto a table to repair them before moving them to a lower conveyor belt to take them away. Andrew testified that the pallets were 48" x 40" and weighted 20-30 pounds. He agreed that Petitioner likely repaired between 350 and 600 pallets per day.

Marcos Perez was also called to testify for Respondent. Marcos was Petitioner's supervisor. He testified that Petitioner did not report an injury to him on December 30, 2014. He did acknowledge that he would occasionally provide medication to injured workers, but did not recall Petitioner reporting an injury. He also confirmed the job description provided by Petitioner with lifting pallets from a work table to a conveyor.

Petitioner was seen at Physician's Immediate Care on March 30, 2015. (Px. 1) He reported lower back pain since December 30, 2014 following a work related injury. The records note that a pallet fell down and landed on his back. The physician noted an altered gait and posture, positive straight leg raising on the left, and reduced range of motion of the lumbar spine. Petitioner was diagnosed with lumbago and provided restrictions of no lifting over shoulder greater than 5 lbs. with no lifting below shoulder of more than 10 lbs. until April 6, 2015. (Px. 1). At that time, Petitioner also tested positive for cocaine metabolites. Petitioner testified that he had taken some pills from a friend to alleviate his back pain. The pills had not helped, but he believes they were the reason for the failed drug test. Petitioner returned to Physicians Immediate Care on April 6, 2015. In addition to ongoing back pain complaints, Petitioner also reported neck pain. An

examination was determined to be abnormal. There was spasm/tenderness of the paraspinal muscles. Also noted were positive Waddell's signs and abnormality of paracervical muscles. He was continued on medication and restrictions. (Px. 1)

Petitioner was initially provided light duty work within his restrictions. He put stamps on pallets for approximately a week until he was terminated due to the drug test on April 6, 2015.

Petitioner was again seen at Physician's Immediate Care on April 13, 2015. At that time, he was advised to continue on restrictions and medication. He was also recommended to begin physical therapy. (Px. 1) Petitioner testified that he was unable to pursue physical therapy due to a lack of insurance.

At Respondent's request, Petitioner underwent a Section 12 examination with Dr. Stephen Weiss on June 8, 2015. (Rx. 1) Dr. Weiss was also deposed on April 29, 2016. Dr. Weiss testified that Petitioner suffered a lumbar contusion that had resolved by the time of his examination on June 8, 2015. Dr. Weiss indicated he was basing his opinions solely on the history as provided by Petitioner. The doctor provided that Petitioner's treatment had been reasonable and necessary and that Petitioner was at maximum medical improvement. Dr. Weiss testified that although Petitioner had subjective pain complaints, his physical examination was normal and, thus, Petitioner did not require treatment or diagnostic testing. He felt Petitioner could return to work full duty at the time of his examination. (Rx.1)

Petitioner obtained his own Section 12 examination with Dr. Jeffrey Coe on October 27, 2015. (Px. 3) Dr. Coe offered the opinion that Petitioner's current condition of ill-being was causally related to his initial injury on December 30, 2014 and the ongoing work activities performed through March 17, 2015. Dr. Coe opined that Petitioner required additional treatment to include consultation with an orthopedic specialist and consideration of an MRI or CT scan. Dr. Coe also testified that Petitioner required ongoing work restrictions to limit lifting to 10 lbs. or less on an occasional basis and to limit repetitive bending or twisting. (Px. 3)

On December 12, 2015, Petitioner presented to Crusader Clinic where he saw Physician Assistant Micah Tiegs for complaints of back pain. At that time, he was prescribed Tramadol and an MRI. (Px. 2) Petitioner testified that he was unable to undergo the MRI due to a lack of insurance.

Petitioner testified that he was unable to seek other employment initially after his termination from Respondent due to his lower back pain. On September 11, 2016, Petitioner acquired new employment with Forrest Pallet. He completed an Application for Employment on September 8, 2016. (Rx. 9) His Application listed prior employment for DJM Pallet Receiving from January 10, 2014 - July 20, 2016. Petitioner testified that he never worked for DJM Pallet. Petitioner provided that his wife prepared the application and the DJM reference should have reflected Northwest Pallet Supply as his previous employer. Petitioner testified that his new job with Forrest Pallet requires him to cut wood or sweep the floor. He builds smaller pallets. He described ongoing pain with the work, but is attempting to push through it.

Petitioner described ongoing lower back pain. He described it as a burning pain with numbness and tingling at times. He indicated that the pain radiates down his legs to his calves. He takes Tylenol and Advil with limited relief. He would like to see a specialist to determine if anything additional can be done.

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 the following:

To obtain compensation under the Act, a claimant bears the burden of showing, by a preponderance of the evidence, that he has suffered a disabling injury which arose out of and in the course of his employment. Sisbro v. Industrial Commission, 207 Ill. 2d 193, 203, 797 N.E. 2d 665, 671-672 (2003). An injury occurs within the course of an employee's employment if the injury occurs within the time and space boundaries of the employment. Id. An injury "arises out" of an employee's employment when the employee was performing acts he was instructed to perform by his employer, acts which the employee might reasonably be expected to perform relating to his assigned duties. Id.

For an injury to arise out of the employment its origin must be in some risk connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury. Caterpillar Trucker Company v. Industrial Commission, 129 Ill. 2d 52 (1989). A risk is incidental to employment where it belongs to or it is connected with what an employee has to do in fulfilling his duties. Id.

Petitioner's initial medical record and the history he provided to both Dr. Weiss and Dr. Coe is consistent with a pallet falling onto him, and striking him in the back, on December 30, 2014. Petitioner testified to experiencing an immediate onset of lower back pain at that time. He continued to work, performing additional and repetitive lifting of pallets through March 17, 2015. Petitioner credibly testified that with his ongoing work activities, his back pain continued to increase. Petitioner and his supervisor testified that Petitioner would repair anywhere from 350-600 pallets on a daily basis. While the testimony of the pallets was disagreed upon, the Arbitrator finds that the lifting up 350-600 pallets on a daily basis, even if only weighing 20 lbs. a piece, would result in an aggravation of his lower back condition.

The Arbitrator finds Petitioner's testimony, and that of Andrew Perez and Marco Perez, credible when assessing his work activities.

As noted above, Petitioner acquired new employment with Forrest Pallet on September 11, 2016. The Arbitrator is concerned by the apparent conflict with Petitioner's testimony regarding his explanation why DJM Pallet Receiving appears on Forrest Pallet's Application for Employment prepared on September 8, 2016. Petitioner's explanation that his wife prepared the application and the DJM reference should have reflected Northwest Pallet Supply as his previous employer is troublesome. Nevertheless, the Arbitrator finds that Petitioner sustained his burden of proving an accident arose out of and in the course of his employment with Respondent. Petitioner's testimony regarding his injury and work activities are unrebutted. Also, his supporting histories to the medical providers are consistent.

With respect to E.) Was timely notice of the accident given to Respondent, the Arbitrator finds as follows:

Having relied in part on the credibility of both Andrew Perez and Marco Perez regarding Petitioner's work activities, the Arbitrator also finds their testimony credible that Petitioner did not report his December 30, 2014 injury to them. As such, the Arbitrator finds that Petitioner failed to prove he provided timely notice of his accident of December 30, 2014 to Respondent. Regarding his repetitive trauma claim, Petitioner filed his Application for Adjustment of Claim on March 24, 2015, a week after his alleged onset date of March 17, 2015. As such, the application provided Respondent with timely notice of the repetitive trauma claim.

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

Petitioner was examined by Dr. Stephen Weiss pursuant to Section 12 of the Act on June 8, 2015. With a caveat, Dr. Weiss opined that a causal relationship existed between Petitioner's low back condition and the

work incident on December 30, 2014. The doctor opined Petitioner suffered a contusion/sprain in his lumbar spine and that Petitioner was at MMI requiring no further medical treatment as of his examination in June 2015. Dr. Weiss made it clear that his causation opinions were based on Petitioner's history of work-injury on December 30, 2014. The Arbitrator is persuaded by the opinions of Dr. Stephen Weiss. The Arbitrator finds that Petitioner's condition of ill-being on March 17, 2015 was a sequela from his December 30, 2014 work injury and as such any causal relationship is directed towards the December 30, 2014 accident. Having said that, the Arbitrator previously found that Petitioner failed to prove he provided timely notice of the December 30, 2014 to Respondent. As such, any compensation that would otherwise be associated thereto is hereby denied.

All remaining issues are rendered moot.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Belen De Avila,

Petitioner,

vs. No. 19 WC 03751

Kerry Ingredients,

Respondent.

20IWCC0062

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b-1) having been filed by Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical expenses, prospective medical care, temporary disability, penalties and attorney fees, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation, medical benefits or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327 (1980).

Petitioner, who was 58 years old at the time of the arbitration hearing, testified through a Spanish interpreter. On December 3, 2018, Petitioner worked as a cleaning person under restrictions from a prior injury. That day, Petitioner fell outside and was rescued by the local fire department. The accident reports in evidence state Petitioner slipped and fell in Respondent's parking lot at the end of her workday.[1] Petitioner testified that she received emergency treatment at Alexian Brothers Medical Center (Alexian Brothers) and followed up at Alexian Brothers and Occupational Health Centers of Illinois. She underwent physical therapy at Athletico from

[1] In the request for hearing form, the parties stipulated to accident arising out of and in the course of employment.

December 18, 2018 through January 25, 2019. Subsequently, Petitioner underwent MRI studies of the cervical and lumbar spine on February 4, 2019. She also underwent electrodiagnostic studies. On February 5, 2019, Dr. Sajjad Murtaza, a physiatrist at Occupational Health Centers, recommended injections into the cervical spine. Respondent denied the injections. Petitioner then consulted Dr. Nikhil Verma at Midwest Orthopaedics at Rush on March 8, 2019. Dr. Verma had previously performed surgery on Petitioner's right shoulder and imposed permanent restrictions. Dr. Verma obtained an updated MRI of the right shoulder and referred Petitioner to Dr. Kern Singh. Dr. Singh obtained repeat MRIs of the cervical and lumbar spine, recommended surgery on the cervical spine, and took Petitioner off work on April 11, 2019. Alternatively, Dr. Singh recommended work restrictions. In the meantime, on March 12, 2019, Petitioner met with Mary Bellerose and Anna Montoya about her job duties. In addition to her restrictions from Dr. Verma, Petitioner sought accommodation due to an unrelated problem with her foot.[2] Instead, Petitioner believed, Respondent gave her more work. Petitioner continued to work until April 27, 2019. Petitioner then sought a second opinion from Dr. Carl Graf. She has not seen a doctor since obtaining the second opinion. Regarding her current symptoms, Petitioner described severe pain in the neck and back. Petitioner does not think she could get by without the surgery recommended by Dr. Singh. Petitioner agreed that if surgery was awarded, she would work hard in postoperative physical therapy and work hardening to get back to work. Petitioner acknowledged on cross-examination that in late December 2018 to early January 2019 she visited her son in Japan for a couple of weeks.

Mary Bellerose, a quality assurance and technical manager, testified that Respondent is a manufacturer of extruded sugar products, such as sprinkles. Petitioner was assigned to Ms. Bellerose's sanitation group. On February 25, 2019, Ms. Bellerose and Jay Patel met with Petitioner about her job duties. On March 12, 2019, Ms. Bellerose and Respondent's human resources manager, Anna Montoya, met with Petitioner because Petitioner brought in a new doctor's note. Respondent accommodated Petitioner by lowering storage racks and assigning a sedentary task between cleaning tasks. According to Ms. Bellerose, Petitioner's job did not involve bending or stooping or exceed a 10-pound lifting restriction. Petitioner performed the modified duties until the end of April. Ms. Bellerose thought Petitioner performed her job duties well.

Petitioner testified in rebuttal, explaining that her pain continued to worsen, causing her to stop working on April 27, 2019.

The medical records from Alexian Brothers show that on December 3, 2018, the emergency room attending physician noted the following mechanism of injury and complaints: "[The patient] presents *** with c/o R hip pain s/p a fall during which she slipped on ice, fell backwards, and fell onto the concrete ground PTA. She also reports having lower back pain that radiates towards her mid back, along with mild neck pain. She did not hit her head or suffer any LOC during the fall." A CT scan of the head was normal. A CT scan of the cervical spine

[2] The medical records from Petitioner's podiatrist, spanning the time period from August 10, 2018 through April 12, 2019, contain work restrictions and FMLA paperwork due to problems with Petitioner's foot.

showed cervical spondyloarthropathy. X-rays of the lumbar spine showed no obvious fracture. The attending physician diagnosed a hip contusion, cervical strain and lumbar strain. On December 6, 2018, Petitioner returned to the emergency room with complaints of right shoulder pain, right lateral neck pain, right hip pain, headache and low back pain. She stated she was unable to sleep due to the pain. Petitioner was prescribed medication and instructed to follow up at the occupational health clinic.

The medical records from Occupational Health Centers of Illinois show that on December 7, 2018, Petitioner complained of pain in the low back, neck and right shoulder, rating the pain a 7/10. The attending physician: diagnosed strain, sprain and contusion; prescribed physical therapy; and imposed light duty work restrictions. On December 13, 2018, Petitioner followed up, reporting worsening low back pain and no improvement in her other symptoms. Petitioner's restrictions were continued. On December 21, 2018, Petitioner reported some improvement with physical therapy. Her restrictions were continued. On January 9, 2019, Petitioner returned, reporting no improvement. She was referred to Dr. Murtaza due to persistent symptoms. Petitioner's restrictions were no lifting, pushing or pulling over 10 pounds, no reaching above shoulder level with the right arm, only occasional bending, and no operation of a washer/sweeper machine.

Physical therapy records from Athletico from December 15, 2018 through January 25, 2019, show Petitioner complained of persistent symptoms.

An MRI of the cervical spine performed February 4, 2019, was interpreted by the radiologist as follows: "1. Multilevel moderate spondylotic changes ***. 2. Disc osteophyte complex at C5-6 causing moderate foraminal and central canal stenosis ***. 3. Disc osteophyte complex at C6-7 causing mild neural foraminal/central canal stenosis. 4. Disc osteophyte complex at C4-5 causing mild to moderate neural foraminal stenosis. 5. Disc osteophyte complex at C3-4 causing mild neural foraminal/central canal stenosis."

An MRI of the lumbar spine performed February 4, 2019, was interpreted by the radiologist as follows: "1. Multilevel spondylosis with facet arthrosis and ligamentum flavum hypertrophy ***. 2. Disc osteophyte complex at L4-5 causing mild neural foraminal and central canal stenosis. 3. Disc osteophyte complex at L5-S1 causing mild neural foraminal and central canal stenosis."

On February 5, 2019, Petitioner complained to Dr. Murtaza of persistent pain in the neck, right shoulder and low back. Dr. Murtaza reviewed the MRIs, recommended cervical facet injections, ordered electrodiagnostic studies, and continued Petitioner's restrictions.

An electrodiagnostic report dated March 5, 2019, states the following impression: "The above electrodiagnostic study demonstrates evidence for a left-sided low lumbar radiculopathy. The level is likely at L5 ***. Clinical correlation is advised as the patient's subjective complaints are on the right side."

20IWCC0062

The medical records from Midwest Orthopaedics at Rush show that on June 2, 2017, Dr. Verma imposed permanent restrictions of no lifting over 15 pounds and no significant work overhead. The restrictions followed an arthroscopic rotator cuff repair. On March 8, 2019, Petitioner returned to Dr. Verma with concerns about her right shoulder, also reporting a neck injury as a result of the accident on December 3, 2018. Dr. Verma ordered an MRI of the right shoulder and referred Petitioner to Dr. Singh for an evaluation of the neck. He continued Petitioner's restrictions from Occupational Health Centers of Illinois. The MRI was interpreted by the radiologist as showing postoperative and degenerative findings in the right shoulder.

On April 3, 2019, Petitioner consulted Dr. Singh about her neck pain, which she rated a 6/10, describing the work accident on December 3, 2018. Regarding Petitioner's psychological status, Dr. Singh noted anxiety. Physical examination was benign. Dr. Singh provisionally diagnosed a cervical muscle strain and cervical radiculopathy, and instructed Petitioner to bring a CD of her cervical MRI.

On April 4, 2019, Dr. Mark Levin examined Petitioner at Respondent's request. Petitioner described her job duties and the work accident on December 3, 2018. "Her current complaint is *** neck pain and right arm pain, which at the beginning of her shift is a 6 out of 10 and at the end of the shift is an 8 to 9 out of 10. She uses over-the-counter medications and feels that the neck and arm pain is the worst. She feels she has decreased range of motion of her neck and it hurts her on both the right and left side. She has pain with flexion and extension and the shooting pain goes to her right elbow. She has numbness of her hand bilaterally constantly with constant weakness in the upper extremity and night pain. She feels it is worse with activities. ¶ She also complains of constant low back pain, which at the beginning of the shift is a 5 to 6 out of 10 and by the end of the shift is an 8 out of 10. She reports tingling going down her right leg and numbness on and off with tingling to the right lateral knee. *** She feels that she limps due to a lot of walking and standing at work. She reports that her right shoulder pain is a 7 to 8 out of 10 and painful if she moves her right shoulder and now has triceps pain. Prior to this injury, she did not have triceps pain, but always did have some pain in the shoulder. She can sit for less than 16 minutes, does minimal standing, occasionally limps when she walks, can drive for 30 minutes, and has increasing neck and back pain. She has continued to work her normal job in sanitation."

Physical examination was notable for: obesity; "very slow shifting gait, which at times is non-physiologic;" inability per Petitioner to toe-toe walk and heel-heel walk on the left side; "[d]uring other parts of the exam, she is seen to walk in a reciprocal gait, as well as when leaving the exam room she is noted to be able to walk in a normal fashion;" complaints of pain over the entire cervical paraspinal muscles with no cervical spasm; complaints of trapezial pain bilaterally with no trapezial spasm; diffuse pain over the entire thoracic spine with no thoracic spasm; diffuse tenderness over the pectoral muscles bilaterally with no spasm; limited range of motion; pressing on the right earlobe elicited a report of pain and numbness in the right leg; palpation over the lumbar spinous processes elicited a report of shooting pain to the right arm; squeezing

the left arm elicited a report of neck pain, which she did not have prior to the squeezing; flexion and extension of the left wrist elicited reports of low back pain; "[n]eutral position of the right wrist gives her low back pain with numbness over the right leg;" "[p]inprick is non-dermatomal in the upper extremities and varies with multiple testing;" "[s]he reports the entire thoracic and upper back sensation is greater on the left than the right, but normal in the lumbar spine;" inconsistent straight leg raise test; and inconsistent strength testing.

Dr. Levin reviewed the MRIs ("the films" and reports) from February 4, 2019, noting multilevel chronic changes. He also reviewed an accident report and medical records. Dr. Levin concluded: "[The claimant's] subjective complaints of pain are out-of-proportion to objective findings and there are multiple inconsistencies on her clinical exam. Her MRI studies fail to show any acute pathology and show preexisting underlying degenerative changes." Dr. Levin declared Petitioner at maximum medical improvement and able to return to work within her pre-injury permanent restrictions.

On April 5, 2019, Petitioner followed up with Dr. Verma, who reviewed the right shoulder MRI and found the rotator cuff to be intact and the shoulder examination to be benign. Dr. Verma opined much of Petitioner's pain came from the cervical spine. He continued Petitioner's restrictions.

On April 11, 2019, Petitioner underwent cervical and lumbar MRIs ordered by Dr. Singh. Cervical MRI impression: "No significant change since the prior MRI cervical spine dated 02/04/2019. 1. At C5-C6 there is mild spinal canal, mild to moderate right and moderate to severe left foraminal stenosis. No high-grade canal or foraminal narrowing at any other level. 2. Disc degeneration at multiple levels with mild disc height loss and mild degenerative endplate changes at C5-C6 and C6-C7. Uncovertebral and facet arthrosis at multiple levels. Minimal anterolisthesis of C3 and mild anterolisthesis of T1 and T2." Lumbar MRI impression: "No significant change compared to the prior MRI lumbar spine dated 02/04/2019. 1. S-shaped mild scoliotic deformity of the lower thoracic and lumbar spine with lumbar levo convexity at L5-S1. Mild right lateral subluxation of L3 and L4. Grade I anterolisthesis of L4 and L5. 2. Disc degeneration and mild intervertebral disc height loss at multiple levels with multilevel mild degenerative endplate changes. Facet arthropathy at multiple levels, moderate at L4-L5 and L5-S1. 3. No critical spinal stenosis at any level. At T12-L1 there is mild spinal canal stenosis. At L5-S1 there is moderate right foraminal stenosis. No high-grade foraminal narrowing at any other level."

On April 11, 2019, Dr. Singh reviewed the MRIs and reexamined Petitioner, noting significant abnormalities on physical examination suggestive of myelopathy. Dr. Singh diagnosed: "1. C5-6 central spinal stenosis with cord effacement. 2. Diffuse lumbar spondylosis. 3. Degenerative scoliosis." Dr. Singh recommended a disc replacement at C5-C6, tentatively scheduled for May 8, 2019, continuing Petitioner's restrictions in the interim. In a contemporaneous "Quick Report," Dr. Singh indicated the proposed surgery was related to the work accident and Petitioner was unable to work.

On April 26, 2019, CorVel denied the surgery.

In a letter to CorVel dated June 26, 2019, Dr. Singh addressed Dr. Levin's report. Dr. Singh criticized Dr. Levin for performing Waddell testing without a full neurological examination. Dr. Singh further criticized Dr. Levin for not personally reviewing the imaging studies and missing severe foraminal stenosis at C5-C6. Lastly, Dr. Singh stated that Dr. Levin did not perform cervical spine surgery.

On July 16, 2019, Dr. Levin issued an addendum report responding to Dr. Singh's criticisms. Dr. Levin stated that he did perform and document a neurologic exam and did personally review the MRI films. Dr. Levin further stated: "The foraminal stenosis that Dr. Singh has related to this alleged work injury had to be preexisting to her alleged work injury and the comments and opinions demonstrated are that that was not caused or aggravated by her alleged work injury." "Any need for surgical intervention for any foraminal stenosis would be required irrespective of the alleged work injury of December 3, 2018, and, therefore, is not related to that alleged work injury." Lastly, Dr. Levin stated that although he does not perform cervical spine surgery as the primary surgeon, he has assisted on such surgeries.

The medical records from Dr. Graf dated August 13, 2019, show Petitioner complained of radiating neck and low back pain, describing the accident on December 3, 2018. Dr. Graf performed a physical examination and reviewed cervical and lumbar MRIs, finding the symptoms clinically correlated with the C6 nerve distribution and were objectively substantiated by the imaging studies demonstrating foraminal narrowing at C5-C6. Dr. Graf diagnosed: "1. Cervical disc disorder at C5-C6 level with radiculopathy ***. 2. Cervicalgia ***. 3. Low back pain ***. 4. Spondylolisthesis, lumbar region." Dr. Graf agreed with Dr. Singh's recommendation for a disc replacement surgery at C5-C6. Regarding the low back, Dr. Graf noted the spondylolisthesis at L4-L5 and recommended a lumbar epidural steroid injection at that level and physical therapy.

Lastly, on September 5, 2019, Dr. Avi Bernstein issued a records review report at Respondent's request, concluding the imaging studies did not support a need for surgery and noting "the distinct difference in examination under Dr. Singh's evaluations from April 3, 2019, to April 11, 2019."

The Arbitrator questioned Petitioner's credibility and found: "Petitioner's current condition of ill-being, except for initial contusions, sprains, and strains is not causally related to the [undisputed] accident." The Arbitrator awarded the medical expenses Petitioner incurred through February 4, 2019, and no other benefits. We disagree and find that Petitioner's neck and low back conditions continue to be causally connected to the work accident on December 3, 2018.

20IWCC0062

In finding that Petitioner's neck and low back conditions continue to be causally connected to the work accident, the Commission relies on the mechanism of injury, Petitioner's advanced age, the diagnostic studies and the opinions of Dr. Singh and Dr. Graf. The Commission acknowledges the various inconsistencies and unusual behaviors noted by Dr. Levin, Dr. Bernstein and the Arbitrator. The record indicates Petitioner suffers from nervousness and anxiety, which greatly affect how she expresses herself. Indeed, Dr. Singh noted Petitioner's anxiety during the initial visit. However, the objective evidence, viewed in light of the mechanism of injury and the chain of events, supports Petitioner's claim.

Having found in Petitioner's favor on the issue of causation, the Commission further finds that Petitioner is entitled to past and prospective medical benefits, as well as temporary total disability benefits from April 30, 2019 through the date of the arbitration hearing on October 7, 2019. However, penalties and attorney fees are not warranted, given the reports from Dr. Levin.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 31, 2019, is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $366.67 per week for a period of 23 weeks, from April 30, 2019 through October 7, 2019, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b-1) 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, medical benefits or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay related medical bills in evidence pursuant to §§8(a) and 8.2 of the Act. Respondent shall be given §8(j) credit for the amounts paid by its group health insurance, provided that Respondent holds Petitioner harmless from any claims and demands by any providers of the benefits for which Respondent is receiving this credit. Respondent shall also be given credit for any medical payments made by its workers' compensation carrier.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall authorize and pay for further treatment recommended by Dr. Singh and Dr. Graf, pursuant to §§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 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: JAN 2 9 2020
o-01/15/2020
SM/sk
44

Stephen Mathis

L. Elizabeth Coppoletti

Douglas McCarthy

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19 (b-1) ARBITRATOR DECISION

DeAVILA, BELEN
Employee/Petitioner

Case# **19WC003751**

KERRY INGREDIENTS
Employer/Respondent

20IWCC0062

On 10/31/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

Unless a party does the following, this decision shall be entered as the decision of the Commission:

1) Files a Petition for Review within 30 days after receipt of this decision; and

2) Certifies that he or she has paid the court reporter $ 750.00 for the final cost of the arbitration transcript and attaches a copy of the check to the Petition; and

3) Perfects a review in accordance with the Act and Rules.

If the Commission reviews this award, interest of 1.61% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0926 LEONARD LAW GROUP LLC
JOSEPH LEONARD
300 S ASHLAND AVE SUITE 101
CHICAGO, IL 60607

1739 STONE & JOHNSON CHARTERED
PATRICK DUFFY
111 W WASHINGTON ST SUITE 1800
CHICAGO, IL 60602

20 IWCC0062

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-1)

Belen DeAvila
Employee/Petitioner
v.
Kerry Ingredients
Employer/Respondent

Case # **19** WC **3751**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. Petitioner filed a *Petition for an Immediate Hearing Under Section 19(b-1) of the Act* on **September 10, 2019**. Respondent filed a *Response* on **September 30, 2019**. The Honorable **Thomas L. Ciecko**, Arbitrator of the Commission, held a pretrial conference on **September 24, 2019**, and a trial on **October 7, 2019**, in the city of **Chicago**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **December 3, 2019**, Respondent ***was*** operating under and subject 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, except for initial contusions, sprains, and strains is not causally related to the accident.

In the year preceding the injury, Petitioner earned $**38,600.00**; the average weekly wage was $**550.00**.

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

Respondent ***has*** paid all reasonable and necessary charges for all reasonable and necessary medical services it is obligated to pay.

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

Respondent is entitled to a credit for all medical bills paid through Respondent's group medical plan under Section 8(j) of the Act.

ORDER

Medical benefits
Respondent shall pay reasonable and necessary medical services to Alexian Brothers Medical Center; Occupational Health centers of Illinois up to February 4, 2019; and Athletico Physical Therapy, if not already paid, pursuant to the fee schedule. No further medical benefits are awarded.

Temporary total disability
No temporary total disability benefits are awarded.

Penalties and fees
No penalties or attorneys' fees are awarded.

Prospective medical care
No prospective medical care is awarded.

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

RULES REGARDING APPEALS Unless a party 1) files a *Petition for Review* within 30 days after receipt of this decision; and 2) certifies that he or she has paid the court reporter $**750.00** or the ***final*** cost of the arbitration transcript and attaches a copy of the check to the *Petition*; and 3) perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

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

Signature of Arbitrator

OCT 31 2019

10/31/19
Date

Belen DeAvila v. Kerry Ingredients, No. 19 WC 3751

Preface

The parties proceeded to hearing October 7, 2019, on a Request for Hearing and a Petition for Immediate Hearing under Section 19(b-1) of the Act, indicating the following disputed issues: whether Petitioner's current condition of ill-being is causally connected to an injury that occurred December 3, 2018; whether Respondent is responsible for unpaid medical bills; whether Petitioner is entitled to a period of temporary total disability; whether petitioner is entitled to prospective medical treatment; and whether Petitioner is entitled to penalties/ attorney's fees under section 19(k) and Section 16 of the Act. Belen DeAvila v. Kerry Ingredients, No. 19 WC 3751 Transcript of Evidence on Arbitration at 4,5; Arbitrator's Exhibit 1.

Petitioner testified with the aide of an interpreter. She could not spell her name for the court reporter. During testimony, the interpreter sometimes could not understand what Petitioner was saying. Except for answering a leading question from her attorney, Petitioner often gave less than a straight answer to questions posed to her. DeAvila at 16, 32, 34, 136.

Findings of Fact

Belen DeAvila (Petitioner), a 56 year old female, testified that on December 3, 2018, she had an accident, a fall outside and was rescued by Elk Grove Village Fire Department. There was no testimony to support a claim that Petitioner sustained accidental injuries which arose out of and in the course of employment. However, the parties have stipulated to that and are bound by the stipulation. Walker v. Industrial Commission, 345 Ill. App. 3d 1084 (2004). Petitioner testified she was taken to Alexian Brothers Hospital. DeAvila at 17.

At the time, Petitioner was working with permanent restrictions for a right arm injury suffered several years ago. She had surgery leading to the restrictions. DeAvila at 16; Respondent's Exhibit 8.

The records of Alexian Brothers Medical Center indicate Petitioner arrived in the emergency room by ambulance December 3, 2018. She complained of right hip pain, low back pain, and mild neck pain, saying she slipped on ice and fell backwards. She said she just felt sore and wanted to go home. Diagnostics were done: a CT of her head and brain were normal; a CT of the cervical spine showed moderate degenerative disc changes; an x-ray of the lumbar spine showed degenerative disc disease and scoliosis; and an x-ray of the right hip showed no fractures or dislocations. Petitioner was diagnosed with a contusion of the hip and cervical strain. She was given Tylenol and ibuprofen, told to use ice and follow up with her doctor. Petitioner's Exhibit 3.

Petitioner returned to Alexian Brothers December 6, 2018, complaining of right shoulder pain. An x-ray of her right shoulder was normal. She was given pain medication and Flexeril. Petitioner's Exhibit 3.

Petitioner testified she followed up with Occupational Health Center, and Dr. Murtaza. DeAvila at 19, 21.

The records of Occupational Health Center of Illinois reflect Petitioner was first seen there December 7, 2018. Her assessment was: lumbosacral strain; lumbar contusion; strain of neck muscle; cervical strain; and sprain of the right shoulder. Their plan was physical therapy, medication and modified duty regarding lifting, push/pulling, and reaching. Diagnostics were requested. Petitioner was subsequently seen three times in December 2018 and January 2019 for what was called "recheck". The same assessments were made. Petitioner had sporadically and inconsistently done physical therapy. She was referred to a physiatrist for treatment. It is unclear why. Petitioner's Exhibit 5.

The records of Dr. Sajjad Murtaza indicate he saw Petitioner January 15, 2019. He assessed her with right greater than left cervical and lumbar spine pain with signs of radiculopathy. He recommended MRIs of the cervical and lumbar spine. Petitioner's Exhibit 6.

Petitioner's MRI of the cervical spine, done February 4, 2019, revealed multilevel moderate spondylotic changes and discosteophyte complex at C5-6, C6-7, C4-5, and C3-4, causing stenosis. An MRI of the lumbar spine, done February 4, 2019, revealed multilevel spondylosis with facet arthrosis and disc osteophyte complex at L4-5 and L5-S1.

Petitioner returned to Dr. Murtaza February 5, 2019. He reviewed the MRIs and assessed cervical and lumbar spondylosis. He recommended facet injections at C4-C5, C5-C6, and C6-C7 for diagnostic and therapeutic purposes to improve Petitioner's neck pain. Murtaza thought Petitioner's MRI did not support her severe subjective complaints. He recommended an EMG. That was performed March 5, 2019, at Excel Occupational Health Clinic, and revealed evidence of left side low lumbar radiculopathy, with level likely at L5.

A Physician Work Activity Status Report issued March 5, 2019, diagnosed Petitioner with a contusion of the lower back and pelvis. Her activity was modified with restricted lifting, bending, push/pull, and squatting and kneeling. Petitioner's Exhibit 6.

During December 2018 and January 2019, Petitioner was seen at Athletico Physical Therapy. Her records indicate that Initial Evaluation on December 15, 2018, indicated comorbidities of obesity and high blood pressure. Her rehabilitation potential was thought to be good. She was seen 11 times with a notation she was away on a lengthy trip out of the country and was developing fear avoidance behaviors. Petitioner's Exhibit 9.

That trip was a 16 hour flight to Japan to visit her son and sightsee for two weeks. DeAvila at 41-43.

Petitioner testified she sought an opinion on her own at Midwest Orthopaedics. Her testimony was grossly misleading, as her attorney referred her there. She testified she saw Dr. Verma, who referred her to Dr. Singh. DeAvila at 21, 22; Respondent's Exhibit 8.

The records of Midwest Orthopaedics reflect Petitioner was seen by Verma March 8, 2019, for her neck and right shoulder. Verma wanted an updated MRI and referred Petitioner to Dr. Singh for her evaluation of her neck. Petitioner was returned to work with her restrictions. That MRI showed osteoarthritis, a degenerative labrum tear, and post-surgical rotator cuff. Dr. Singh saw Petitioner April 3, 2019. He noted Petitioner denied difficulty with fine motor functions and diagnosed her with cervical muscular strain and cervical radiculopathy. He thought Petitioner had a cervical mediated problem, and recommended physical therapy. Petitioner's Exhibit 11.

An MRI of the lumbar spine showed disc degeneration, scoliotic deformity and moderate to mild stenosis. An MRI of the cervical spine showed disc degeneration and mild/moderate foraminal stenosis at C5-6, essentially the wear and tear of normal daily living. Petitioner's Exhibit 11.

Petitioner saw Dr. Singh April 11, 2019. He now said, eight days later, Petitioner has difficulty with fine motor function. He diagnoses Petitioner with C5-6 central spinal stenosis with cord effacement; diffuse lumbar spondylosis; and degenerative scoliosis. He recommended surgery, a C5-6 total disc replacement. He makes no reference to a work injury. On April 3, 2019, Singh simply noted, we do not know why, "She is reporting this as a Workers' Compensation injury." It is of significance that nowhere in the notes of Dr. Singh, of either April 3, 2019, or April 11, 2019, does he indicate Petitioner's condition is connected to a work injury. Surprisingly, it is only in a separate detached "Quick Report", to whom or why we do not know, that indicates it was "amended," dated April 11, 2019, does Singh fill in a form that says, "Diag/treatment causally related to the alleged industrial accident [x] Yes." Petitioner's Exhibit 11. This record is not conclusive proof of any medical or surgical matters. 820 ILCS 305/16. This Quick Report, whatever it is, is essentially weightless.

Petitioner submitted to an independent medical examination April 4, 2019, by Dr. Mark Levin of Barrington Orthopedic Specialists. Petitioner had an interpreter. Petitioner told Levin she had worked for Respondent for nine years and worked in sanitation. She said she slipped in a parking lot leaving work, hitting her right elbow and landing flat on her back. She told Levin she was treated at Alexian Brothers and Concentra, then switched to doctors referred by her attorney. She said she was working light duty with restrictions and doing home exercises. Petitioner was working under permanent restrictions for a previous shoulder surgery.

Dr. Levin conducted, by the looks of it, an extensive physical examination, noting Petitioner was obese. He reviewed records going back to 2015, including comprehensive medical records of Petitioner's treatment. He noted the MRI of the cervical spine of February 4, 2019, indicated chronic spondylitic changes, no acute disc herniation, and long standing central and foraminial stenosis. Levin noted the MRI of the lumbar spine of February 4, 2019, indicated chronic longstanding central and foraminial stenosis.

Dr. Levin found Petitioner's subjective complaints of pain were out of proportion to his objective findings and noted multiple inconsistencies in Petitioner's clinical examination. Levin found Petitioner's MRI showed no acute pathology, but preexisting underlying degenerative

changes. He said from an orthopedic standpoint, Petitioner was at MMI and could return to work full duty with her permanent restrictions. He could not substantiate additional treatment.

Dr. Levin's report of the independent medical examination was reviewed by Dr. Kern Singh on June 26, 2019. Singh attempted, poorly, to be critical of Levin's examination, attempted to infer a sinister motive by Levin, suggest Levin missed portions of the records, and attempted to justify his recommendation for surgery. Dr. Levin responded in a report letter of July 16, 2019, by gutting Singh's criticism so as to giving it no weight in this matter. Dr. Levin noted Singh recommends surgical intervention that came from a combination of chronic preexisting, longstanding stenosis, saying the need for surgical intervention was not related to a work injury. Respondent's Exhibit 8, 9.

The medical records in this case were reviewed on September 5, 2019, by Dr. Avi Bernstein of the Spine Center. His report, while containing typos galore, concluded he could not recommend surgical intervention of Petitioner because it was not supported by radiographic studies, and specifically noted the distinct difference in examination under Dr. Singh from April 3, 2019, to April 11, 2019. This Arbitrator did, too.

Petitioner testified she saw Dr. Graff for a second opinion. We do not know why she kept seeking further opinions. DeAvila at 24.

The records of Dr. Graff indicate Petitioner saw him once, August 13, 2019. He assessed Petitioner with cervical disc disorder at C5-C6; Cervicalgia; low back pain; and spondylolisthesis lumbar region. He stated a recommended C5-6 cervical disc replacement would be considered reasonable. There was no recitation of a causal connection to Petitioner's fall. Petitioner's Exhibit 14.

Petitioner testified she has seen no physician since Dr. Graff. DeAvila at 25.

Conclusions of Law

At its core, Petitioner requests a C5-6 total disc replacement and related treatment.

Disputed issue **F** is, is Petitioner's current condition of ill-being causally connected to the injury sustained December 3, 2018, the slip and fall in a parking lot.

To obtain compensation under the Act, an employee must establish by a preponderance of the evidence a causal connection between a work related injury and the employee's condition of ill-being. Vogel v. Illinois Worker's Compensation Commission, 354 Ill. App. 3d 780, 786 (2005). Whether such a relationship exists is a question of fact. R & D Thiel v. Illinois Worker's Compensation Commission, 398 Ill. App. 3d 8858, 867 (2010).

The evidence in this case indicates that Petitioner did suffer, at most, contusions, sprains, and strains as a result of the slip and fall. I rely on the records of Alexian Brother's Medical Center and the numerous diagnostics done of Petitioner by her treating physicians and hospital;

the diagnostics done on Petitioner indicate, from the first done at Alexian Brothers, and forward thereafter, myriad degenerative, chronic, longstanding conditions.

I further rely on the examination of Petitioner by Dr. Levin. He conducted an extensive examination of Petitioner and her diagnostic testing and medical records and reports. All Petitioner's diagnostic evidence showed preexisting underlying degenerative changes. This is also supported by the medical records and radiographic studies reviewed by Dr. Bernstein.

Petitioner's sole sliver of evidence suggested to support some sort of cervical or low back injury comes from Dr. Singh, and falls far short of the preponderance of the evidence Petitioner needs. Singh saw Petitioner twice. The first time he diagnosed Petitioner with cervical muscular strain. Eight days later, as if he channeled Asclepius, he suddenly recommended surgical intervention on Petitioner for chronic preexisting conditions. He never noted a connection between the fall and Petitioner's medical condition. In his Quick Report, he reflexively, without explanation, notes his diagnosis was causally related to the "Industrial Accident." However, it was Petitioner who told Singh this was a worker's compensation injury. Singh merely spat it back on the Quick Report. What Singh was doing was recommending surgery for Petitioner's chronic degenerative disc disease and that is what Dr. Graff thought reasonable. There is a constant recognition of degenerative changes and degenerative scoliosis, none of which were caused by the fall.

I find, as a conclusion of law, Petitioner's current condition of ill-being, other than contusions, sprains and strains, not causally connected to the slip and fall in the parking lot.

Disputed issue **J**, whether Respondent is liable for unpaid medical bills, is really directed to an employer's obligation to pay for all necessary medical and surgical services reasonably required to relieve from the effects of Petitioner's injury. 820 ILCS 305/8(a).

I find, as a conclusion of law, Respondent is liable for necessary medical services required to relieve Petitioner from her injury relating to her strains and contusions, to Alexian Brothers Medical Center; Occupational Health Centers of Illinois up to February 4, 2019 (that is prior to and does not include the visit to Dr. Murtaza of February 5, 2019, and recommended facet injections); and Athletico Physical Therapy. No further obligation is required of Respondent.

Disputed issue **L** is whether Petitioner is entitled to temporary total disability from April 30, 2019, to hearing.

A claimant is temporarily totally disabled from the time an injury incapacitates her from work until such time as she is recovered or restored as the permanent character of her injury will permit. The dispositive inquiry is whether the claimant's condition has stabilized, reached maximum medical improvement as an example. Considerations are given to a release to return to work, medical testimony, and evidence concerning the injury and extent of the injury. Interstate Scaffolding, Inc. v. Worker's Compensation Commission (Urban), 385 Ill. App. 3d 1040, 1043 (2008).

Petitioner testified she worked, from the fall to April 27, 2019, within prior restrictions given her for a right shoulder injury. DeAvila at 28-30.

Dr. Levin, as a result of his independent medical examination of April 4, 2019, found Petitioner at MMI with a return to work with her permanent restrictions. She worked competently, without problems, within her restrictions. DeAvila at 83-90. Dr. Singh placed Petitioner off work April 11, 2019, but that was in anticipation for unrelated surgery for degenerative conditions.

I find, as a conclusion of law, Petitioner is not entitled to temporary total disability.

Disputed issue **M** is whether Petitioner is entitled to penalties/attorney's fees under Section 19(k) and Section 16 of the Act.

Section 19(k) requires more than an unreasonable delay in payment. It is not enough for a claimant to show that the employer simply failed, neglected or refused to make payment or unreasonably delayed payment of compensation without good and just cause. It is intended to address situations where there is not only a delay, but the delay is deliberate or the result of bad faith or improper purpose. Here, imposition of penalties is discretionary. Jacobo v. Illinois Worker's Compensation Commission, 2011 Ill. App. (3d) 100807WC.

I find, as a conclusion of law, no bad faith or improper purpose on the part of Respondent at all.

The standard for awarding attorney's fees under Section 16 of the Act is higher than the standard for awarding penalties under Section 19(l), as these fees are intended to address situations where there is not only a delay, but the delay is deliberate or the result of bad faith or improper purpose. The imposition of these fees is discretionary. Id.

I find, as a conclusion of law, no deliberate or bad faith on the part of Respondent.

No penalties or attorney's fees are awarded in this matter.

Disputed issue **O** is whether Petitioner is entitled to prospective medical care.

Section 8(c) of the Act obligates an employer to pay for medical and surgical services and necessary medical and surgical services thereafter incurred reasonably required to cure or relieve from the effects of the accidental injury. Specific procedures 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. Petitioner bears the burden of proving, by a preponderance of the evidence, her entitlement to the award of medical care. Questions regarding entitlement to prospective medical care under Section 8(a) are factual inquiries. Dye v. Illinois Worker's Compensation Commission, 2012 Ill. App. (3d) 100907WC.

Petitioner seeks a C5-6 cervical disc replacement and physical therapy and lumbar epidural steroid injection at L4-5. Petitioner's Exhibit 11; Petitioner's Exhibit 14.

Dr. Levin found the disc replacement surgery not related to any injury Petitioner suffered at work. Dr. Bernstein found surgical intervention not supported by radiographic studies. Neither of the proposed medical services is for a condition connected to Petitioner's fall. Such is discussed in disputed issue **F**, and prospective medical care is not awarded.

Petitioner insists 820 ILCS 305/8.7(i)(3) mandate a utilization review before denying payment of or refusing to authorize payment of medical services, and so because no review was done, the prospective medical care must be paid for and authorized. DeAvila at 11-12.

Section 8.7(i) outlines the procedure by which a medical provider submits to a utilization review. It does not mandate or require such review prior to the denial of payment or refusal to authorize payment of medical services rendered or proposed to be rendered. It is merely a restriction on utilization review involving the denial of payment or refusal of authorization on the grounds the extent and scope of medical treatment are excessive or unnecessary pursuant to utilization review guidelines, not, for example, causal connection. The denial here was not based on extent and scope, but on lack of causal connection.

820 ILCS 305/12 specifically and clearly authorizes a Respondent to rely on an examination of Petitioner to support a denial of compensation. And they did.

I find, as a conclusion of law, Petitioner is not entitled to the requested surgery, therapy or injections.

Arbitrator

10/31/19
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

MARIA CASARRUBIAS-VELASCO,

Petitioner,

vs. NO: 12 WC 018316

UIC MEDICAL CENTER,

Respondent.

20IWCC0063

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 19, 2018, 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.

8800021105

20 I W C C 0 0 6 3

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $36,900.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JAN 2 9 2020
KAD/mav
O: 12/10/19
42

Kathryn A. Doerries

Thomas J. Tyrrell

Maria E. Portela

Sep 11 2008

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CASARRUBIAS-VELASCO, MARIA
Employee/Petitioner

Case# **12WC018316**

UIC MEDICAL CENTER
Employer/Respondent

20IWCC0063

On 1/19/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.60% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in 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
IAN ELFENBAUM
940 W ADAMS ST SUITE 300
CHICAGO, IL 60607

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

0000 HEYL ROYSTER VOELKER & ALLEN
BRAD ANTONACCI
33 N DEARBORN ST 7TH FL
CHICAGO, IL 60602

0902 UNIVERSITY OF IL/CLAIMS MGMT
1737 W POLK ST
M/C 940 SUITE B9
CHICAGO, IL 60612

0904 STATE UNIVERSITY RETIREMT SYS
PO BOX 2710 STATION A
CHAMPAIGN, IL 61825

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

JAN 19 2018

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

Notes:

STATE OF ILLINOIS)
)
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Maria Casarrubias-Velasco
Employee/Petitioner

v.

UIC Medical Center
Employer/Respondent

Case # 12 WC 18316

Consolidated cases: _____

20IWCC0063

An *Application for Adjustment 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 Ill. Workers' Compensation Commission, in the city of Chicago, on 11/13/2017. After reviewing all of the evidence presented, the arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED 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? 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 the respondent?
N. ☐ Is the respondent due any credit?
O. Other _____

20 IWCC0063

FINDINGS

- On 8/17/2011 , the respondent UIC Medical Center *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.
- Petitioner's current condition of ill-being *is* causally related to the accident.
- In the year preceding the injury, Petitioner earned $**35,244.56**; the average weekly wage was $**705.88**.
- On the date of accident, Petitioner was **48** years of age, ***single,*** with **1** dependent child.
- Petitioner ***has*** received all reasonable and necessary medical services.
- Respondent ***has*** paid all appropriate charges for all reasonable and necessary medical services.
- Respondent shall be given a credit of $ **0** for TTD, $**2,347.21** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**2,347.21**.
- Respondent is entitled to a credit of $ **23,048.57** under Section 8(j) of the Act (non-occupational benefits).

ORDER

- The respondent shall pay the petitioner temporary total disability benefits of $ 470.25 /week for 75-6/7 weeks, from 4/6/2012 through 9/18/2013 , which is the period of temporary total disability for which compensation is payable.
- The respondent shall pay the petitioner the sum of $ 423.23 /week for a further period of **62.5** weeks, as provided in Section 8(d)2 of the Act, because the injuries sustained caused a 12.5% loss to the Petitioner's whole person.
- The respondent shall pay the petitioner compensation that has accrued from 8/17/2011 through 11/13/2017, and shall pay the remainder of the award, if any, in weekly payments.
- The respondent shall pay the further sum of $ (all paid) for necessary medical services, as provided in Section 8(a) of the Act.
- The respondent shall pay $ 0 in penalties, as provided in Section 19(k) of the Act.
- The respondent shall pay $ 0 in penalties, as provided in Section 19(l) of the Act.
- The respondent shall pay $ 0 in attorneys' fees, as provided in Section 16 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 of 1.60 % shall accrue from the date listed below to the day before the 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

01-19-18
Date

JAN 19 2018

State of Illinois)
)
County of Cook)

BEFORE THE
ILLINOIS WORKERS COMPENSATION COMMISSION

Maria Casarrubias-Velasco,	)	
	)	
Petitioner,	)	**IWCC No. 12WC 18316**
	)	
v.	)	Arb. Kurt Carlson
	)	
UIC Medical Center,	)	
	)	
Respondent.	)	

20IWCC0063

FINDINGS OF FACT

1. Petitioner's job duties and work history

The Petitioner, Maria Casarrubias-Velasco, testified that she was hired in 2006 as a housekeeper or Building Service Worker at Respondent's hospital. Tr. 7. She passed a pre-employment physical. Tr. 8. Petitioner testified that she was regularly scheduled to work a forty-hour week. In the year before her August 17, 2011 accident, she recalled earning $17.02 per hour, with a wage increase later in the year. Tr. 11. Petitioner's Exhibit 7 and Respondent's Exhibit 4 showed that Petitioner's hourly wage increased to $17.11 on March 1, 2011 and to $17.36 on May 1, 2011. (Px 7, Rx 4)

Petitioner's main assignment was "discharges", or the cleaning and disinfecting of rooms for the next patient after a patient is discharged. Tr. 10-11. She testified that discharges involve a thorough cleaning of all surfaces in the room: doors, telephones, side tables, etc. Floors are swept and mopped, and bathroom fixtures such as tubs, showers, toilets and sinks are scrubbed. The bed itself must be cleaned as well, including the mattress, the area underneath and the headboard and footboard. Tr. 9-10. Petitioner testified that she worked an eight-hour shift, and completed between eight and thirteen rooms a shift. Employees were given half an hour to clean a room after discharge, or 45 minutes for an isolation room. Tr. 10.

Petitioner testified that after changing the bed linens, the dirty linens are bagged and taken to the soiled linen room, where they are tossed into a dumpster or hamper. She testified that the height of the front of the soiled linen hamper was just above her head, and she would have to grab each bag of linen from the floor and toss it over the edge. Tr. 12. Each room cleaned required a separate trip to the linen room.

Petitioner testified that she collected trash from each discharge room, and was also expected to pull daily trash from every room on the floor. Tr. 10. The trash was collected in a 30-gallon barrel with wheels, which was emptied into a dumpster when full. Petitioner estimated that she emptied the trash barrel seven or eight times per shift. Tr. 13.

Petitioner testified that she had had a workplace injury in the 1990's for which she had filed a workers' compensation claim. That injury had required surgery to both elbows. Since coming to work for UIC in 2006, she had filed a back strain claim which she settled in 2009, as well as a finger injury and a needle-stick injury. Tr. 36. She testified, however, that she had never had any injuries or medical care for her right arm or shoulder (Tr. 37), nor had she ever had any problems with her left shoulder. Tr. 29. At the time of her August 17, 2011 accident she had seen a doctor recently for other reasons, but had had no medical care for any arm or shoulder condition. Tr. 13-14. Petitioner testified that she is right-handed. Tr. 14.

2. Date of Accident: August 17, 2011

The Petitioner testified that on August 17, 2011, she started her shift as usual, and went to clean out a "discharge" room. She changed the bed linens, cleaned the room, and went to the linen room where she tossed the soiled linen. Tr. 14. Petitioner then wheeled her trash barrel to the dumpster and emptied it. While Petitioner was wheeling it out of the trash area, the barrel tipped over and fell. *Id.* Petitioner testified that she did not let go of the trash barrel: "It went down, and I went down with it and it jerked my arm down." Tr. 14-15. Petitioner demonstrated how she had pulled the barrel back into an upright position, with her right arm outstretched at just below 90° or shoulder level. Tr. 15. She testified that after she pulled the barrel back up, she felt a pain in her right shoulder. She kept working, but by end of her shift the pain was intolerable. Tr. 15-16. She reported the injury to her supervisor that day. However, because she was working the 3:00 to 11:00 shift, the Employee Health clinic was closed by the time her shift was over. Tr. 16.

3. **Initial medical care through UIC Employee Health**

The next day, August 18, Petitioner reported to the hospital's Employee Health clinic, where she saw the nurse practitioner. Petitioner reported that her shoulder pain was initially "not that bad" right after the accident, but had increased to 7-8/10 by the day's end. The pain was worse with pronation/supination of the arm and when raising her arm above shoulder level. She was diagnosed with a shoulder strain, and given light duty with limited use of her right arm, ibuprofen and an ice pack. (Px 3, p. 52; Tr. 16-17)

Petitioner returned to the clinic on August 26, reporting shooting pains down her arm and persistent pain with reaching above shoulder level. She had reported some left wrist and forearm pain due to overuse of the left hand, for which she had been issued a splint. Nurse practitioner Bedore ordered physical therapy "pending approval" and increased her restrictions to add a 10-minute break every two hours. *Id.*, p. 53. On September 1, he added "no trash handling" to her restrictions, and again recommended physical therapy. *Id.*, pp. 55-56. On September 15, 2011 he repeated the physical therapy prescription. *Id.*, p. 57.

On September 21, 2011, Petitioner began physical therapy at UIC Hospital. (Px 2a, p. 143) Her shoulder pain was noted to be worse while working, especially wiping surfaces in circular pattern, and better in the morning after rest. The therapist's impression was of a possible rotator cuff or labral tear. *Id.*, p. 143.

On October 3, 2011, Petitioner returned to the clinic, where nurse Bedore noted some improvement with ibuprofen; however, Petitioner was still unable to raise her arm above shoulder level without exacerbating the pain. (Px 3, p. 59) She reported tolerating light duty, except when her supervisor exceeded her restrictions. She was assessed as having "right arm and shoulder pain with little functional improvement noted," and her light duty was continued. *Id.*, pp. 59-60. Two weeks later, on October 18, Petitioner was seen by Dr. Buchanan. She reported that her restrictions were not being met, and her physical therapist had noted that "PT was helping but work was hurting." *Id.*, p. 60. Dr. Buchanan spoke with Petitioner's supervisors, who explained they could not accommodate a restriction of periodic 20-minute breaks, but could arrange for shorter shifts. Dr. Buchanan then revised Petitioner's restrictions to limit her to a four-hour shift. *Id.*

On December 7, 2011, Petitioner returned to the clinic. She reported to nurse Bedore that

she was tolerating her four-hour shifts and felt her range of motion was improving with therapy. She continued to notice soreness and weakness in the right shoulder. (Px 3, p. 65) Petitioner was assessed as showing "continued, albeit slow, symptomatic and functional improvements." Nurse Bedore continued her medications and four-hour shift restriction. *Id.* On January 9, 2012, she was advanced to a six-hour shift with light duty restrictions. *Id.*, p. 66. On February 21, 2012 she again saw Dr. Buchanan, who noted that Petitioner had missed a few days due to shoulder pain which she felt was exacerbated by new tasks such as handling garbage bags and making beds. *Id*, p. 68. Dr. Buchanan continued Petitioner's six-hour shifts, but agreed that bed making was beyond her current restrictions. *Id.*

By March 9, 2012, Petitioner had completed physical therapy, and nurse Bedore felt she could "safely attempt a trial of return to regular duty." (Px 3, p. 71) On March 15, 2012, Petitioner reported that her shoulder soreness was increasing, and nurse Bedore imposed a twenty-pound lifting restriction. *Id.*, p. 72. By March 19, 2012, Bedore noted signs of persistent biceps tendinitis, and wrote that "Maria has been unable to tolerate full duty after a one-week trial." *Id.*, p. 73. Petitioner was restricted to one-armed work, and referred to UIC's orthopedic clinic. *Id.*

4. Petitioner consults Dr. Hutchinson

On March 29, 2012, Petitioner was seen by Dr. Mark Hutchinson, an orthopedic surgeon at UIC. Dr. Hutchinson noted a history of a work accident eight months earlier, on August 17, 2011. Petitioner had been rolling a large garbage can when the wheels jammed and it began to fall over. On trying to prevent it from falling, she had sudden pain in the right upper extremity. (Px 2a, p. 82) Petitioner complained of some neck pain, along with symptoms in her fingers and hand; however, her main complaint was her right shoulder, which was still painful with limited range of motion. Physical therapy and anti-inflammatory medication had failed to resolve the problem. *Id.* Dr. Hutchinson issued one-armed work restrictions, and ordered an MRI. *Id.*, p. 83.

The MRI, performed April 19, 2012, was read as suspicious for a small full-thickness rotator cuff tear, with additional partial-thickness tearing along the distal supraspinatus. The report also noted moderate diffuse tendinosis, and an *os acromiale* with mild arthritis at the AC joint. (Px 5) At Petitioner's next appointment on April 26, 2012, Dr. Hutchinson administered a cortisone shot to the right shoulder. However, based upon her MRI results, he also recommended she consider surgery. Dr. Hutchinson's diagnosis was an "acute-on-chronic rotator cuff

tendinopathy." *Id.*, p. 75. He noted that Petitioner's current symptoms stemmed from "a fall at work in August 2011," but also wrote that she "admitted to chronic low-intensity pain in that shoulder ... which was significantly aggravated by the fall." *Id.*, p. 74. (On cross, Petitioner did not recall telling Dr. Hutchinson that she had had shoulder pain prior to her accident: "When I seen him, I told him that I had pain because I had the injury before I seen him." Tr. 38.) Dr. Hutchinson also issued sedentary-only work restrictions. *Id.*, p. 89.

5. Respondent's Section 12 Examiner: Scot Player, M.D.

On May 16, 2012, at Respondent's request, Petitioner was examined by Scot Player, M.D. (Rx 1) Petitioner recalled the exam as lasting about ten minutes: "It seemed like I was in and out." Tr. 25, 45. Dr. Player asked Petitioner to demonstrate the action of pulling the trash can upright which had precipitated her symptoms, and noted that her right hand was "below shoulder level at about her lower chest level" when she did so. (Rx 1, p. 8) Dr. Player also reviewed the April 19, 2012 MRI and noted that "a small full thickness tear or a partial thickness tear cannot be excluded, although none is specifically identified." He gave his impression as "rotator cuff tendinosis secondary to congenital *os acromiale*." *Id.*

Dr. Player opined that Petitioner's accident of August 17, 2011 had been a minor shoulder strain from which she would have recovered by mid-December of 2011. He argued that the December 7, 2011 chart note from UIC Employee Health showed that she had achieved maximum medical improvement and had a "normal physical exam" by that time. (Rx 1, pp. 8, 16) Dr. Player also opined that the mechanism of injury involved in Petitioner's accident of August 17, 2011 would not "place the rotator cuff at risk for injury." *Id.*, p. 15.

Dr. Player opined that the cause of Petitioner's ongoing symptoms was not the accident, but *os acromiale*. This was a congenital formation of the acromion process which was present in 2.7% of the population and was usually bilateral. It was visible on her MRI and was "known to cause impingement syndrome," he stated. *Id.* Dr. Player opined that the Petitioner could return to full duty work, and required no further treatment for her work accident. In his opinion, any remaining pain complaints would be related to her congenital *os acromiale* condition and would have "no bearing on the 8/17/11 work incident." *Id.*, p. 16

6. August 14, 2012: Surgery

Petitioner testified that immediately after her examination by Dr. Player, her workers' compensation claim was denied. (Tr. 25; Px 2a, p. 95) She continued to see Dr. Hutchinson using her non-occupational group insurance. She also applied for and received SERS disability benefits from the state. Tr. 25-26. On June 28, 2012, Dr. Hutchinson recommended surgery, beginning with a less invasive arthroscopic procedure. (Px 2a, pp. 69-70)

On August 14, 2012 Petitioner underwent surgery, which consisted of the scheduled arthroscopic debridement and subacromial decompression, followed by a mini-open rotator cuff repair. (Px 4) The surgery confirmed the presence of a full-thickness rotator cuff tear, along with partial tearing of the articular surface. *Id.*, p. 3. The Petitioner testified that following surgery, she began post-operative physical therapy at UIC Hospital. (Tr. 26-27; Px 2a, p. 127) Dr. Hutchinson kept her off work, and evaluated her progress about every sixty days. Tr. 27.

7. Petitioner's Section 12 Examiner: David Hoffman, M.D.

On December 17, 2012, Petitioner underwent a Section 12 evaluation by orthopedic surgeon David Hoffman, M.D. (Px 1, Exh. 2) Dr. Hoffman noted a history of a right shoulder injury when a 30-gallon trash can tipped over and Petitioner tried to pull it upright with her right arm. He reviewed Dr. Hutchinson's office notes, which documented a prescription for surgery after eight months of physical therapy, followed by a cortisone injection, had produced little or no improvement. Dr. Hoffman also examined Petitioner, who was four months post-surgery, and reviewed the operative report as well as the April 2012 MRI report.

Dr. Hoffman disagreed with Dr. Player's opinion that Petitioner's congenital *os acromiale* was the sole cause of her injury. While there is some correlation between *os acromiale* and shoulder impingement, he noted, any impingement could have been caused simply by the type of work she did. Petitioner's work accident of August 17, 2011 had likely aggravated a pre-existing condition: "The act of trying to right a 30-gallon garbage bin exceeded the tensile strength of the rotator-cuff tendon, precipitating a tear in an already inflamed tendon." *Id.*, p. 4. At his evidence deposition, Dr. Hoffman testified that he had sustained a similar injury, and knew first-hand that overhead lifting was not required to tear the rotator cuff.

Dr. Hoffman concurred with Dr. Hutchinson's recommendation for surgery, as the rotator cuff tear revealed on Petitioner's April 2012 MRI had not responded to physical therapy, and could

not be expected to repair itself. (Px 1, Exh. 2, p. 5) Dr. Hoffman recommended several more months of physical therapy, possibly including work hardening, to give Petitioner the best chance of returning to her previous level of function. *Id.*

8. Functional Capacity Evaluation and release for work

On July 15, 2013, Petitioner completed physical therapy and was discharged. The therapist noted she was gaining strength, but continued to have sharp pain in the anterior shoulder with activity. (Px 2a, p. 146) Weakness was also noted in the last three digits of the right hand. *Id.* She could complete light overhead activities such as dusting for sixty seconds, but still lacked endurance at the right rotator cuff and scapula. *Id.*, p. 148. Dr. Hutchinson ordered an EMG, which was performed August 7, 2013. The results indicated a mild bilateral sensory neuropathy; however, motor neuron studies of Petitioner's right arm were normal. (Px 2a, pp. 27, 31) Dr. Hutchinson then ordered an FCE to determine Petitioner's current work tolerances. *Id.*, p. 49.

The FCE was performed at Schwab Rehab on August 27, 2013 and was judged valid, with maximum effort by Petitioner. (Px 6, p. 4) It found her capable of "light to medium" work, with floor-to-waist lifting of up to 20 pounds frequently, and up to 35 pounds occasionally. *Id.* For chest-to-overhead lifting, her limits were set at five pounds frequent and ten pounds occasional. *Id.*, pp. 8, 9. Petitioner reported anterior shoulder pain when lifting overhead. *Id.*

On September 12, 2013, Dr. Hutchinson noted that Petitioner had completed therapy. She continued to report brief periods of right shoulder pain with exertion, which ranged up to 7-8/10, and Dr. Hutchinson found some residual shoulder weakness. The FCE report was still pending. (Px 2a, pp. 45-47) On September 18, 2013, Dr. Hutchinson pronounced Petitioner at maximum medical improvement and released her to return to work with permanent restrictions as noted by her FCE report. He recorded his opinion that her maximum lifting tolerance should be even lower, if it were done frequently. *Id.*, p. 43.

9. Petitioner's return to work

Petitioner returned to work on September 23, 2013. Tr. 28. She was again assigned to handle discharges on the ward, working her regular shift and doing essentially the same duties she had performed before her accident. In February of 2014 she hit her head on an x-ray machine at work and sustained a possible concussion. Tr. 29. She was treated for about three weeks at

Employee Health, then released back to full duty work. Petitioner testified that she did not file a workers' comp claim regarding that incident. Tr. 30-31.

In November of 2014 Petitioner had a hernia that required surgery. She did not claim this as a work-related injury. Tr. 30. In May of 2015, she was injured at work by slipping on a wet floor. Petitioner testified that she didn't recall this incident. Tr. 31. The records of UIC Employee Health show about six weeks of treatment followed by a return to full duty on July 2, 2015. Tr. 31. Petitioner testified that she had some shoulder pain, and was not sure if it had to do with the fall, or was just post-operative pain from her shoulder surgery. Tr. 32. Shortly after being released from treatment for this slip-and-fall, Petitioner had her hernia surgery. Tr. 32.

In late 2015 Petitioner was transferred to a job cleaning offices, which included sweeping, mopping and emptying trash. There was no patient contact, and no changing of linens involved. Tr. 32. The position was in the same job class and pay grade as her work cleaning patient rooms. Tr. 32-33. In January 2016, Petitioner had an episode of right neck and shoulder pain brought on by lifting a trash bag. Tr. 33. She went to EE Health one time, where she was given light duty and pain medication. She was released back to regular duty March 1, 2016. Tr. 34. Petitioner testified that she was recently transferred back to a patient floor, doing discharges. Tr. 34.

On cross, Petitioner did recall a prior injury to her right hand and wrist when a bed fell on it in July 2008. Regarding another minor hand injury on January 6, 2010, Petitioner testified that she didn't recall the injury, but did not deny it. Tr. 41.

She testified that her work injury at Pampered Chef in the 1990's involved her elbows. Tr. 43. She agreed that she had surgeries to both elbows performed by Dr. Erickson, who gave her permanent light-duty restrictions. *Id.* Respondent's Exhibit 6 consisted of records of Dr. Erickson, which documented two years of treatment, including left elbow surgery in 1996 and right elbow surgery in 1997. On August 21, 1998, eight years before Petitioner was hired by Respondent and thirteen years before her August 2011 work accident, Dr. Erickson had recommended permanent light duty, opining that Petitioner would not be able "to get back to any kind of repetitive factory type or assembly type of work." (Rx 6)

10. <u>Petitioner's current condition</u>

Petitioner testified that her ongoing shoulder pain and weakness interferes with her daily life in various ways. She finds it painful to raise her hand to her head for any length of time, making it hard to do her hair. Grocery shopping is difficult, as she can't lift as much as before the accident. She is also unable to lift her grandchildren. Tr. 35. Petitioner testified that she used to love to play volleyball and other sports, but this is hard now. She is able to cook, but only for limited periods of time. *Id.* Petitioner agreed that the surgery performed by Dr. Hutchinson had improved her range of motion. She testified that she has not had further physician visits or used prescription medications for her shoulder since Dr. Hutchinson released her. Tr. 43-44. She uses over-the-counter medications like ibuprofen or Tylenol for shoulder pain, and occasionally puts an ice pack on her shoulder. Tr. 35, 45. Petitioner testified that she is working regular duty in the same job category as before her accident. Tr. 44. She had been working in the office area, where cleaning tasks are lighter, but she was recently transferred back to the patient care area. Tr. 32-34.

11. <u>Testimony of Cynthia M. Wright</u>

Cynthia M. Wright testified on behalf of Respondent. She has worked for Respondent since 2005, and was Petitioner's supervisor at the time of her August 2011 accident. At that time, Petitioner worked on the hospital's 6 West patient unit. Tr. 48-49. Her main duties were cleaning out patient rooms after discharge. Shown Respondent's Exhibit 8, Ms. Wright agreed that it was an accurate description of Petitioner's job duties at that time. She testified that the lifting requirements of the job were "between five and seven pounds," including trash disposal. Tr. 50. Ms. Wright agreed that Petitioner used a thirty-gallon rolling trash can to collect garbage, but testified that she would empty it only about three times per shift. Tr. 51.

On cross-examination, Ms. Wright agreed that each patient room cleaned would include a bag of soiled linen to be disposed of in the linen hamper. Tr. 52. She first testified that the entrance to this hamper was low, perhaps at waist level, then testified that in fact it was not a hamper, but a barrel. There was one such barrel on each floor, in the soiled linen room. Tr. 53.

Shown a photo of a linen hamper or dumpster from Petitioner's phone, Ms. Wright testified that it looked like the area where trash and gowns from the isolation rooms were discarded. She agreed that the top of the hamper was quite high. However, she insisted that the hamper was located in the basement, and that housekeeping employees did not use it. Other employees – "the

trash guys and whatever" – used that area, while housekeeping employees used a yellow barrel located on each patient floor. Tr. 55-57. The cell phone photo was not received into evidence.

Petitioner testified on rebuttal that she had taken the picture herself, and it was not in the basement; rather, it showed the current linen hamper on 6 East where she was working. The height of the hamper was above her head. At the time of her workplace accident in August 2011, she had used a similar hamper on 6 West to discard bags of soiled linen. Tr. 59-61.

12. <u>Deposition testimony of Dr. Hoffman, Petitioner's Section 12 examiner</u>

Dr. Hoffman testified by evidence deposition on March 30, 2016. (Px 1) Dr. Hoffman is an orthopedic surgeon with a subspecialty in joint replacement, who also performs a large volume of shoulder surgery. *Id.*, p. 6. He reviewed the details of Petitioner's accident of August 17, 2011, from his December 2012 examination report. Dr. Hoffman opined that this accident was the precipitating factor for Petitioner's rotator cuff tears and her need for surgery. *Id.*, p. 10.

Regarding Dr. Player's report, Dr. Hoffman testified that *os acromiale* is a congenital condition, which he described as an incomplete union of the acromion. (Px 1, pp. 10-11) He explained that this can predispose a person to a rotator cuff tear. However, it would ***<u>not</u>*** be the cause of the tear, as Dr. Player had alleged. *Id.* Dr. Hoffman noted that Dr. Hutchinson's operative report did not even mention the *os acromiale*, and that his surgery had involved only a routine subacromial decompression along with the open rotator-cuff repair. *Id.*, pp. 14-15. Moreover, Dr. Hoffman's review of the records confirmed that Petitioner's *os acromiale* had not resulted in any medical diagnosis or treatment for her shoulder prior to the accident. *Id.*, p. 11.

Dr. Hoffman testified that a history of sustained overhead work and repetitive tugging, pulling, etc. could also have placed Petitioner at higher risk for a rotator cuff tear (Px 1, p. 14), adding that her job as a hospital housekeeper clearly would involve such work. *Id.* In this sense her injury was an "aggravation of a pre-existing condition." *Id.*, p. 10. However, the tear itself was a "clean tear" and had resulted from Petitioner's accident involving the garbage pail. *Id.*

Dr. Hoffman also disagreed with Dr. Player that the trauma involved in that accident was insufficient to cause a rotator cuff tear. (Px 1, p. 13) He explained that the arm does not have to be overhead in order to engage the rotator cuff. It need only be extended, and the load lifted does not have to be very heavy in order to exceed the tensile strength of the tendon. *Id.* Dr. Hoffman added that this had happened to him personally: "I had my rotator cuff repaired this past April, and I was

lifting essentially about a 10-15 pound bag of dead leaves. That was it, with my arm in front of me," rather than extended overhead. *Id.*, pp. 13-14.

Dr. Hoffman testified that Petitioner's surgery of August 2012, and her prior light duty and lost time from work, had been reasonable and necessary in light of her injuries. (Px 1, p. 12). Her right shoulder symptoms when he examined her in December 2012, four months after the surgery, had included limited range of motion, pain and weakness, with some swelling and stiffness. *Id.*, pp. 8-9. These had been typical post-operative symptoms, and her post-operative physical therapy had also been reasonable. *Id.*, pp. 9, 12. Regarding Petitioner's prognosis, Dr. Hoffman opined that she had a fairly complex injury, with both complete and partial rotator cuff tears. As a result, her prognosis may be less than optimal. *Id.*, p. 12.

13. <u>Deposition testimony of Dr. Player, Respondent's Section 12 Examiner</u>

Dr. Player testified by evidence deposition on September 1, 2016. (Rx 2) Dr. Player is a general orthopedic surgeon, and in his prior practice 15-20% of surgeries involved the shoulder. Id., p. 9. However, he has not performed any surgery since 2006 due to a physical handicap. He sees 5-10 patients per week. *Id.*, pp. 8-9. Dr. Player also does 2-5 forensic examinations per week. He testified that 85% of them are for the defense *(Id.*, p. 74) but added that "30% of the time my report is adverse to what the client might want." *Id.*, pp. 82-83.

Dr. Player thought that Petitioner's work accident had produced only a minor strain, which had resolved by December 7, 2011. (Rx 2, p. 45) He opined that the cause of Petitioner's ongoing pain complaints after that date was her congenital *os acromiale*, rather than her work injury. *Id.*, p. 47. Dr. Player testified that he suspected Petitioner had an *os acromiale* in the left shoulder as well as the right, as the condition was usually bilateral. *Id.*, p. 48. He admitted, however, that despite this Petitioner had no history of left shoulder symptoms. *Id.*, p. 62. Dr. Player also admitted that he knew of no prior treatment for right shoulder pain prior to the accident of August 17, 2011, and that Petitioner had reported right shoulder pain in her first medical visit of August 18, 2011. *Id.*, p. 51. Nevertheless, he insisted that Petitioner's ongoing symptoms after December 2011 had been solely due to her *os acromiale*.

Dr. Player asserted that the rotator cuff "only functions when the arm is above shoulder level" and that Petitioner's right hand had been at "lower chest" level during her accident. He

therefore opined that the mechanism of injury could not lead to a rotator cuff tear. (Rx 2, pp. 38-39) He conceded that he did see a tear on Petitioner's MRI which was "partial to full-thickness" (*Id.*, pp. 17, 43), and that this was an objective finding. *Id.*, p. 60. Dr. Player had not reviewed the findings in Dr. Hutchinson's operative report of August 14, 2012, and had never been asked to do an addendum report on Petitioner's case. He had learned only on the date of deposition that Petitioner had in fact had surgery. (Rx 2, p. 59)

CONCLUSIONS OF LAW

As to issue "C", the occurrence of an accident that arose out of and in the course of Petitioner's employment, the Arbitrator finds as follows:

The Petitioner testified credibly as to the circumstances of her accident. Her testimony was consistent with the uniform description of the accident contained in all treating medical records. No testimony was offered to rebut Petitioner's consistent account of the accident, or her testimony that she reported it immediately to her supervisor. Petitioner sought medical care at the first opportunity, less than 24 hours after the accident, at which time an acute shoulder injury was documented. The Arbitrator therefore concludes that an accident occurred on August 17, 2011, that arose out of and in the course of Petitioner's work for Respondent.

As to issue "F", whether the Petitioner's present condition of ill-being is causally related to his injury, the Arbitrator finds as follows:

The Arbitrator first notes that the Petitioner was asymptomatic and regularly performing a physically challenging job for over five years prior to her August 17, 2011 accident. No evidence was offered to rebut Petitioner's own credible testimony on this point; in fact, the medical records of the employer's clinic confirm an absence of any prior time off work or medical treatment for shoulder complaints in the years prior to her accident. Following her injury, the Petitioner was immediately placed on light-duty restrictions by the Respondent's employee health clinic. She was briefly released for full-duty work in March 2012, but this proved to be unsustainable after only one week. The clinic staff reinstated Petitioner's restrictions and referred her to an orthopedic surgeon, who within a month had restricted her to sedentary duty and recommended surgery.

Proof of prior good health and change immediately following and continuing after an injury may establish that an impaired condition was due to the injury. *Navistar v. Industrial Comm'n*

(Diaz), 316 Ill. App 3d 1197, 1205 (2000). *See also Darling v. Industrial Comm'n*, 176 Ill. App. 3d 186, 193 ("A causal connection between work duties and a condition may be established by a chain of events including petitioner's ability to perform duties before the date of the accident and inability to perform the same duties following that date.").

Although at various points the Petitioner may have reported brief partial improvement to her nurse or physical therapist, there is no evidence of recovery significant enough to allow Petitioner to resume full duty work, or even to substantially loosen her restrictions. The records of UIC Employee Health document that every attempt to do so eventually resulted in recurring pain and renewed restrictions. Thus there was no interval of real functional recovery which would break the chain of causation between her injury of August 17, 2011 and her ongoing symptoms which resulted in the need for surgery. There is also no evidence of any subsequent accident or injury which would constitute an independent intervening cause of disability.

Respondent relies on the opinion of its Section 12 examiner, Dr. Player, that while Petitioner's August 2011 accident had resulted in a minor shoulder strain, the real cause of her ongoing right shoulder pain was her *os acromiale*, a pre-existing condition that was present since birth and clearly unrelated to her workplace accident. The Arbitrator is unpersuaded by Dr. Player's conclusions, for several reasons:

First and foremost, Dr. Player's analysis fails to explain Petitioner's long record of successful job performance prior to her accident. If *os acromiale*, in and of itself, were sufficiently debilitating to account for Petitioner's ongoing serious shoulder impairment after December 7, 2011, one would expect her to have been incapable of handling such heavy cleaning assignments for the five years prior to her accident as well. The Arbitrator also notes that Dr. Player thought it likely that Petitioner suffered from *os acromiale* in the left shoulder as well, yet he could not explain why her left shoulder was unimpaired. (Petitioner's left shoulder, of course, was not injured in her work accident and was therefore asymptomatic.)

Petitioner's examiner, Dr. Hoffman, explained that while her *os acromiale* may have made her more likely than the average person to suffer a rotator cuff tear at some point, it was not the cause of that injury. Rather, it was merely a predisposing factor which, without a traumatic injury, might never have resulted in symptoms. It is well-settled law that an injury which aggravates a pre-existing condition is compensable under the Act. *Chicago Board of Education v. Industrial Comm'n (Perry)*, 96 Ill.2d 239, 244-45 (1983).

Secondly, Dr. Player's reliance on the December 7, 2011 clinic note as evidence of "maximum medical improvement" simply has no basis in fact. Dr. Player argued that the records show a "normal physical exam." (Rx 1, pp. 8, 16) However, the records do not support a recovery from the work injury. To the contrary, the nurse practitioner who conducted the exam saw only "continued, albeit slow" improvement to the "soreness/weakness" of Petitioner's right arm and shoulder. He used the word "normal" only once, regarding certain motions of Petitioner's hand and wrist. Far from releasing her for full duty, nurse Bedore continued Petitioner's four-hour shifts, medications and hot/cold packs, while expressing hope she could advance to a six-hour shift within the next month. (Px 3, p. 65) However, the next three months brought only limited progress, culminating in a failed attempt to resume full duty, a return to one-handed restrictions and a referral to an orthopedic surgeon. Dr. Player's misreading of the medical records detracts from the overall credibility of his opinions regarding Petitioner's case.

Thirdly, Dr. Player was never provided with a copy of Dr. Hutchinson's operative report of August 14, 2012, and in fact was unaware until the day of his 2016 deposition that Petitioner had had surgery. The operative report conclusively refutes Dr. Player's theory that Petitioner sustained only a minor muscle strain from her August 2011 accident: the presence of a full-thickness rotator cuff tear was established as a fact at surgery. In contrast, Dr. Hoffman did review the operative report and was able to offer an opinion as to the likely cause of Petitioner's full- and partial-thickness rotator cuff tears. Dr. Hoffman argued convincingly that the mere presence of an *os acromiale* could not have caused these injuries. He also explained that the stress on Petitioner's shoulder resulting from the mechanism of accident was a competent cause of such injuries, regardless of whether her arm was raised above shoulder level or merely extended at mid-chest level.

Dr. Hoffman's opinions comport with the findings and opinions of Dr. Hutchinson, the treating surgeon, in recommending surgical intervention and documenting the tears found at surgery. Much like Dr. Hoffman, Dr. Hutchinson viewed Petitioner's shoulder condition as an "acute-on-chronic" injury, in which a specific trauma to an already irritated or chronically stressed tendon resulted in a tear.

The Arbitrator therefore adopts the opinions of Dr. Hoffman and Dr. Hutchinson, taken as

a whole, as more credible and persuasive than the opinion of Dr. Player. Based on those opinions, and on the contents of the medical records as a whole, as well as the Petitioner's credible testimony, the Arbitrator finds that Petitioner's current condition of ill-being is causally connected to her work accident of August 17, 2011.

As to issue "G", regarding the Petitioner's earnings in the year prior to her injury, the Arbitrator finds as follows:

The Arbitrator notes that there is no dispute as to the Petitioner's wage rate or hours worked; in fact, both parties made their calculations from the same set of wage documentation. (Px 7; Rx 4) Section 10 of the Act defines "average weekly wage" (AWW) as the employee's actual earnings during the 52 weeks prior to the injury. However, it provides that "if the injured employee lost five 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 (Lexis 2011); *see also D.J. Masonry v. Industrial Comm'n*, 295 Ill. App. 3d 924, 933-34 (1998).

The spreadsheet included in Petitioner's Exhibit 7 demonstrates a calculation of wages under Section 10 in accordance with *D.J. Masonry, supra.* (Px 7, p. 1) The Arbitrator therefore finds that Petitioner's total hours worked in the 52 weeks prior to her accident equated to 249.64 days, or 49.93 weeks. Her gross wage in that time period was $35,640.28, which, after subtracting overtime earnings, equals $35,244.56. Dividing that amount by 49.93 weeks yields an average weekly wage of $705.88, resulting in a TTD rate of $470.59 and a permanent partial disability rate of $423.53.

As to issue "K", regarding Petitioner's entitlement to Temporary Total Disability benefits, the Arbitrator finds as follows:

Respondent terminated TTD on May 17, 2012, immediately upon receiving the report of its Section 12 examiner, Dr. Player. Dr. Player found Petitioner's injuries to be work-related only through December 7, 2011, at which time Petitioner was working a four-hour shift and testified to having received TPD benefits. At trial, Respondent disputed liability for all TTD benefits.

Having found both accident and causal connection, the Arbitrator finds Petitioner entitled

to TTD from April 6, 2012, when she was taken off work, through September 18, 2013, when she was released for full duty by Dr. Hutchinson. In doing so, the Arbitrator notes that UIC Employee Health staff, who stayed in contact with Petitioner's supervisors and were familiar with her job duties, repeatedly gave her either "off-work" status, or "light duty" restrictions in the ten- to twenty-pound range throughout the TTD period. Evidently, clinic staff believed the lifting requirements of housekeeping staff were in excess of twenty pounds. Respondent's job description (Px 8), while listing a full menu of cleaning duties, does not attach a maximum weight, height or level of force to any task.

The Arbitrator therefore finds Respondent liable for TTD benefits for the entire period from April 6, 2012 through September 18, 2013, a period of 75-6/7 weeks, as well as for TPD benefits paid from November 4, 2011 through March 23, 2012 as listed on Respondent's Exhibit 5, page 1. Respondent did not specifically challenge the lost-time period, and paid non-occupational benefits for the duration of Petitioner's time off work. Rather, it disputed liability for TTD based on causation. Accordingly the Arbitrator, in granting TTD, also grants Respondent credit for payments already received by the Petitioner. (*See* Arb. Exhibit 1.)

As to issue "L", regarding the nature and extent of Petitioner's injuries, the Arbitrator finds as follows:

The Arbitrator notes that Petitioner's accident occurred prior to the September 2011 amendments to the Act. It is therefore not subject to the five-prong nature-and-extent analysis, including AMA ratings, contained in Section 8.1b of the current Act.

The Arbitrator notes that the Petitioner underwent a complex surgery, which included both arthroscopic debridement and subacromial decompression, and an open repair of the full-thickness rotator cuff tear which was confirmed at surgery. (Px 4) The medical records document a prolonged rehabilitation effort which included nine months of intensive physical therapy, followed by a Functional Capacity Evaluation.

Petitioner's valid FCE resulted in a recommendation for permanent "light to medium" work restrictions. These included floor-to-waist lifting limits of 20 pounds frequently and 35 pounds occasionally. In the chest-to-overhead range, a maximum of five-pound frequent and ten pound occasional lifting was imposed. (Px 6, pp. 8, 9)

The Petitioner testified credibly to ongoing pain, fatigue and physical limitations in her right arm and shoulder. These limit her ability to cook, clean and shop for groceries; to pick up her young grandchildren; to play sports she once enjoyed; and to perform everyday tasks such as putting up her hair. Dr. Hutchinson recognized the limits imposed by Petitioner's FCE report as permanent, and recommended even lower limits for frequent or repetitive work. (Px 2a, pp. 43, 45) Both he and Dr. Hoffman opined that Petitioner could not expect to recover full right shoulder function, given the complexity of her injury. She continues to use over-the-counter treatments such as ibuprofen and hot packs to manage her symptoms.

Taken as a whole, the evidence demonstrates that Petitioner has sustained a significant loss of physical and occupational function. The Arbitrator therefore finds this loss to be equivalent to 12.5% of the whole person, and awards compensation accordingly under Section 8(d)2 of the Act.

IT IS SO ORDERED:

Hon. Kurt Carlson, Arbitrator

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JAMIE HAWKINS,

Petitioner,

vs. NO: 14 WC 29022

VILLAGE OF BEECHER,

Respondent.

20IWCC0064

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, medical, temporary total disability (TTD), and permanent partial disability (PPD), 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 award of 7.5% person-as-a-whole and finds that Petitioner is entitled to 3% person-as-a-whole. The Commission adopts the Arbitrator's analysis of Section 8.1(b) and the weight assigned to each subsection. The Commission, however, finds that the evidence supports a reduction in the permanency award due to the minor nature of the injury. The Petitioner was diagnosed with a strain of her lower back and right shoulder as a result of her February 22, 2014 work-related injury. She underwent physical therapy and multiple injections and was released to work without restrictions. Petitioner currently works as a full-time police officer and testified that she experiences some occasional pain or tingling in the right shoulder and some tightness in her back. She is not, however, under any active medical care for those injuries. Thus, the Commission finds that 3% person-as-a-whole is proper and more in line with the evidence in the record. All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on January 8, 2019, is hereby modified as stated above, and otherwise affirmed

Appendix

20IWCC0064

and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $349.34 per week for a period of 96-1/7 weeks, February 23, 2014 through December 27, 2015, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner temporary partial disability benefits of $139.90 per week for a period of 68-4/7 weeks, December 28, 2015 through April 20, 2017, that being the period of temporary partial disability as provided in §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $319.00 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 15% loss of use of the right leg.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $319.00 per week for a period of 15 weeks, as provided in §8(d)(2) of the Act, for the reason that the injuries sustained caused 3% loss of use of the person-as-a-whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $86,535.33 for medical expenses under §8(a) of the Act and subject to the medical fee schedule.

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

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

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

DATED: JAN 29 2020

D Douglas McCarthy
Douglas McCarthy

DDM/tdm
O: 1/15/20
052

Stephen J. Mathis
Stephen Mathis

L Elizabeth Coppoletti
L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HAWKINS, JAMIS
Employee/Petitioner

Case# **14WC029022**

VILLAGE OF BEECHER
Employer/Respondent

20IWCC0064

On 1/8/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.47% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2356 DONALD W FOHRMAN & ASSOC LTD
ADAM J SCHOLL
101 W GRAND AVE SUITE 500
CHICAGO, IL 60654

0507 RUSIN & MACIOROWSKI LTD
NICOLE Z BRESLAU
10 S RIVERSIDE PLZ SUITE 1925
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF WILL)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Jamie Hawkins
Employee/Petitioner

v.

Village of Beecher
Employer/Respondent

Case # **14** WC **29022**

Consolidated cases: _____

20IWCC0064

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gregory Dollison**, Arbitrator of the Commission, in the city of **New Lenox, Illinois**, on **11/8/18**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

20 I I CC0064

FINDINGS

On **2/22/14**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**27,249.04**; the average weekly wage was $**524.02**.

On the date of accident, Petitioner was **35** years of age, ***single*** with **3** dependent children.

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

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

Respondent shall be given a credit of $**14,758.24** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**14,758.24**.

Respondent is entitled to a credit of $**26,676.51** under Section 8(j) of the Act. 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.

ORDER

Respondent shall pay reasonable and necessary medical services of $86,535.33, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $349.34/week for 96-1/7 weeks, commencing 2/23/14 through 12/27/15, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner temporary partial disability benefits of $139.90/week for 68-4/7 weeks, commencing 12/28/15 through 4/20/17, as provided in Section 8(a) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $319.00/week for 69.75 weeks, because the injuries sustained caused the 15% loss of the right leg (32.25 weeks) as provided in Section 8(e) of the Act and 7-1/2% loss of the person as a whole (37.5 weeks), 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

1/7/19
Date

JAN 8 - 2019

FINDINGS OF FACT:

20IWCC0064

Petitioner was employed as a part-time police officer with Respondent. She also had a second job as switchboard operator with St. Mary's Hospital. On February 22, 2014, Petitioner was on patrol when she received a call over the radio that there was an individual breaking into cars in a subdivision. Petitioner arrived on the scene along with another police officer with the department. Petitioner pulled over a vehicle that matched the description received on her radio. Petitioner ordered the driver out of the vehicle and proceeded to arrest the individual. Petitioner testified that she handcuffed the individual's left hand and when she tried to handcuff the right hand, he began to resist. Petitioner testified that her left pinky got caught in the handcuff chain. Petitioner then put her arm around the neck of the arrestee and he pushed backwards causing her to slam into the vehicle. Petitioner stated that her lower back and pelvic area made contact with the car. The arrestee then pulled himself forward and bent forward which caused Petitioner to flip onto the hood of the car. She then fell off the car onto arrestee where she struggled further with the arrestee and pepper sprayed him. Eventually, Petitioner and the other officer were able to subdue the arrestee and handcuff him.

Petitioner testified that following the incident, she noticed immediate pain of her lower back, shoulders and right hip. An ambulance was called, and Petitioner was transported to St. Margaret Mercy hospital. At the hospital, Petitioner provided a history of the accident and related her symptoms. (PX6, pp. 8-10) A CT scan was performed of her abdomen and pelvis that revealed no hemorrhage. (Id. at 11) Petitioner was assessed with 1.) injury due to alteration; 2.) left shoulder pain; 3.) right hip pain; and 4.) low back pain. She was discharged from the emergency room that same day. (PX6, 9.12)

On February 24, 2014, Petitioner was seen by Dr. Panuska at Presence St. Mary's Hospital Occupational Health Center. There she complained of pain to both shoulders, her right shoulder worse than her left, pain in her lower back, right hip and right lower leg. (PX3, p.11) Petitioner was diagnosed with a contusion/strain of lumbar back and right shoulder. (Id.) Petitioner was provided work restrictions, which neither of her two employers could accommodate. Petitioner received care from Presence St. Mary's Hospital Occupational Health Center from February 24, 2014 through March 17, 2014. (PX3)

On March 28, 2014, Petitioner presented to Dr. Juan Santiago-Palma of Oak Orthopedics. Petitioner provided a history as to how she was injured and reported symptoms of an aching sensation of the right shoulder and pain of the lower back that radiated into the lower buttocks, worse with standing, sitting, walking, coughing and straining. (PX8, p.83). She reported that her pain remained unchanged since the onset. (Id.) After completing his exam, Dr. Santiago-Palma diagnosed Petitioner with lower back pain, right sciatica and right shoulder pain. (Id. at p.84) Dr. Santiago-Palma prescribed medications and MRIs of the lumbar spine and right shoulder. (Id.) He also provided a work status note of no work until further notice. (Id. at 82) Both MRIs were performed on April 10, 2014. The lumbar MRI revealed postsurgical changes from a prior surgery and prominent posterior annular bulging at the L4-5 level and probable mild impingement of the traversing L5 nerve roots. (Id. at 149) The MRI of the right shoulder revealed mild acromioclavicular arthrosis. There was no focal rotator cuff tear or discrete labral tear. (Id. at 148)

Petitioner returned to Dr. Santiago-Palma on April 15, 2014. Dr. Santiago-Palma reviewed the MRIs and prescribed an epidural steroid injection at the L5-S1 disk level. (Id. at 80) He also prescribed physical therapy for the lower back and shoulder. (Id. at 81) The epidural injection was performed on May 6, 2014 at Riverside Hospital. Petitioner returned to Dr. Santiago-Palma on May 20, 2014. Petitioner continued to report lower back symptoms that were somewhat improved following the epidural injection. Petitioner also reported right hip pain upon internal rotation. (Id. at 76) Dr. Santiago-Palma prescribed an MRI of the right hip to

evaluate the hip. (Id. at 77) With regard to the right shoulder, Dr. Santiago-Palma performed a right subacromial joint injection to the right shoulder. (Id.)

The MRI of the right hip was performed on June 5, 2014. Petitioner followed with Dr. Santiago-Palma on June 12, 2014. Dr. Santiago-Palma indicated that the MRI of the hip did not reveal any significant abnormalities and it was his thought that her symptoms appeared to be emanating from the right hip joint. (Id. at 69) Dr. Santiago-Palma prescribed a right intra-articular joint injection to address her symptoms. (Id.) The intra-articular joint injection was performed on July 1, 2014. Petitioner returned to Dr. Santiago-Palma on July 15, 2014 and reported a 70% improvement following the injection. She also reported recurrent radicular symptoms down her right leg. (Id. at 69) With regard to her right hip issues, Dr. Santiago-Palma referred her to Dr. Antkowiak within his practice and recommended a second epidural steroid injection for her lower back. (Id.) Dr. Santiago-Palma performed the second epidural injection on July 30, 2014.

On August 1, 2014, Petitioner had her first office visit with Dr. Tomasz Antkowiak concerning her right hip. Petitioner reported continued pain of her right hip localized mostly to the anterior aspect of the hip and in the groin crease, worse with activity. (Id. at 64) Dr. Antkowiak examined Petitioner and diagnosed her with a femoral acetabular dysplasia with a possible labral overload or tear. (Id. at 65) Dr. Antkowiak prescribed physical therapy with limitations on range of motion, activity modification, and NSAIDs. (Id.) He also indicated that an MR arthrogram would be prescribed if no improvement. (Id.)

Petitioner revisited Dr. Santiago-Palma on August 22, 2014. Her chief complaint was low back pain. Dr. Santiago-Palma noted the second epidural steroid injection had helped significantly. Petitioner reported 70% improvement. Lidoderm patches were prescribed for his pain. (Id. at 54 and 59)

On September 11, 2014, Petitioner returned to Dr. Antkowiak and reported a slight improvement of her hip and groin pain. (Id. at 57) Her pain was mostly over the lateral aspect of the hip and the greater trochanter. (Id.) Dr. Antkowiak administered a cortisone injection into the right greater trochanteric bursae. (Id. at 58)

Petitioner was seen by Dr. Santiago-Palma on September 19, 2014. On that visit, she predominately complained of axial type symptoms along the lower back. (Id. at 55) Petitioner also related neck complaints to the doctor. (Id. at 53) Dr. Santiago-Palma prescribed median branch blocks along the bilateral L2, L3, L4, L5 and L5-S1 facet joints. (Id. at 55) He also recommended a cervical MRI. (Id.) The MRI was performed on September 24, 2014. Petitioner followed with Dr. Santiago-Palma the following day on September 25, 2014. Dr. Santiago-Palma reviewed the MRI and prescribed physical therapy that emphasized stabilization exercises and strengthening. (Id. at 50)

On October 9, 2014, Petitioner returned to Dr. Antkowiak with regard to her right hip. Petitioner reported that the cortisone injection did improve her symptoms and permitted her to sleep through the night, though she still had pain with hip flexion. (Id. at 46) Dr. Antkowiak continued the same management protocol. The doctor also provided that an MR arthrogram would be necessary if there was no improvement. (Id.)

Petitioner returned to Dr. Santiago-Palma on October 30, 2014. She reported symptoms concerning her lower back and neck. (Id. at 41) Dr. Santiago-Palma again recommended physical therapy to her cervical spine and median branch blocks of the lumbar spine. (Id. at 44)

At the request of Respondent, Petitioner was seen by Dr. Kevin Walsh for a Section 12 examination on November 6, 2014. In his report dated December 5, 2014, Dr. Walsh provided that Petitioner reported stabbing pain in the right groin, burning and aching across the front of her right thigh, pain of the right shoulder and burning and aching of the right elbow and right wrist. (RX2, p.2) She further stated that she continued to experience low back pain, leg pain and neck pain. (Id.) She told Dr. Walsh that Hydrocodone offered her

temporary relief and that the physical therapy and the injection she received provided her lasting relief. (Id.) After conducting a clinical examination and performing a medical record review, Dr. Walsh opined that Petitioner had an objectively normal physical examination. (RX2, p.8) Dr. Walsh opined that there were no objective abnormalities to support Petitioner's continued complaints of pain and discomfort in her right shoulder, right elbow, right wrist, right hand, right groin and right thigh. Dr. Walsh felt that Petitioner could return to work with no restrictions based on her objective physical examination. Dr. Walsh opined that at best, Petitioner suffered a soft tissue injury to her right hip, [right] shoulder, and low back as the result of the altercation. Dr. Walsh opined that healing had long since taken place. Dr. Walsh did not feel that her symptoms in November 2014 were related to an injury from February of 2014. Dr. Walsh opined that continued use of pain medication was not reasonable or necessary, nor were additional injections or therapy. Dr. Walsh noted that Petitioner had undergone an extensive amount of conservative treatment, including to her hip. He did not feel she required any orthopedic intervention. Dr. Walsh opined that Petitioner had reached maximum medical improvement. (Id. at pp.8-9)

On December 4, 2014, Petitioner followed up with Dr. Antkowiak concerning her right hip. Dr. Antkowiak noted that Petitioner continued to have groin pain and that Respondent never approved the requested physical therapy. Dr. Antkowiak again recommended an MR arthrogram. Dr. Antkowiak felt that Petitioner's history, clinical exam and radiographs were consistent with a possible labral tear. Dr. Antkowiak administered a second intra-articular hip injection for both a therapeutic and diagnostic purpose. He also provided documentation that indicated that Petitioner was to remain off work until further notice. (PX8, pp. 37-39)

Petitioner returned to Dr. Santiago-Palma on December 11, 2014 with symptoms of low back and right shoulder pain. (PX8, p.33) After conducting a clinical examination, Dr. Santiago-Palma performed a right subacromial joint injection to Petitioner's right shoulder and repeated his recommendation of median branch blocks to her lumbar facet joints. (Id. at pp. 35-36)

Petitioner testified that on or about December 15, 2014, she was notified by Respondent, that based on the medical report of Dr. Walsh, her temporary total disability benefits and medical as of December 9, 2014 would be discontinued. Petitioner testified that following the termination of benefits, she remained off work per her doctors' recommendations. Petitioner stated that she had no health insurance when her benefits were terminated but was able to subsequently obtain Medicaid insurance through the State. She attempted to use her insurance to obtain further care with Oak Orthopedic but was notified that they did not accept Medicaid.

Petitioner testified that she found a job working at Metabolic Management on December 28, 2015. She worked for that company until October of 2017. In her capacity at Metabolic Management in Grant Park, Petitioner's job duties primarily consisted of sending orders of supplements to doctors and other medical professionals. Petitioner stated her specific job was to type the labels for these orders. Petitioner stated the position did not involve lifting. She indicated however, that if she had to lift, the maximum weight would be up to 10 pounds. The position did not involve bending or stooping and it was a part time position. Petitioner testified that her taxes in 2016 reflected earnings of $16,337.00 or approximately $314.17 per week at her job at Metabolic Management.

Petitioner testified that she was able to use her Medicaid insurance to treat with her internist, Dr. Harris Waheed at First Family Care Clinic. Contained within the records of Dr. Waheed are several visits including February 12, 2015 and March 11, 2015 in which Petitioner related continued issues of right shoulder, right hip and back pain. Treatment of Dr. Waheed consisted of a prescription for Tramadol for pain. (PX5, p.40-43) The next time Petitioner mentioned low back symptoms occurred on June 9, 2016 wherein she complained of worsening low back pain. (Id. at pp. 50-51) Dr. Waheed recommended x-rays and discussed a possible referral to Dr. Santiago-Palma. (Id.) Petitioner returned to Dr. Waheed a month later on July 8, 2016 with complaints of right hip pain and instability that she reported she had had since her initial injury. (Id. at 52) She related to Dr.

Waheed that she felt that she was not getting better and noticed weakness in the right lower extremity. (Id.) Dr. Waheed prescribed an MRI and Tramadol for her pain. (Id. at 53)

The MRI of Petitioner's right hip occurred on July 26, 2016. The radiologist report indicated that there was mild effusion on the right hip with no evidence of acute fracture or avascular necrosis of the hip joints. (Id. at 74) Petitioner returned to Dr. Waheed on August 5, 2016 and reviewed the MRI results. Dr. Waheed noted the results of the MRI and indicated Petitioner was still complaining of pain and discomfort. Dr. Waheed recommended that she return to Dr. Antkowiak. (Id. at 54, 55)

Petitioner testified that she contacted Oak Orthopedics and Dr. Antkowiak agreed to accept her Medicaid insurance. Petitioner was seen on August 24, 2016. (PX8, p.29) Petitioner reported that she had no resolution of her symptoms since her last visit and significant groin pain worse with extensive walking and sitting. (Id. at p.30) Dr. Antkowiak examined Petitioner and reviewed the diagnostic studies. It was his impression that Petitioner continued to exhibit positive impingement signs and had a positive labral stress test. Dr. Antkowiak recommended an intra-articular hip injection and MR arthrogram. (Id. at pp. 31-32)

The MR arthrogram was performed on September 7, 2016. Petitioner followed with Dr. Antkowiak on September 14, 2016. Dr. Antkowiak noted that the MR arthrogram revealed no evidence of a labral tear. It was still his impression that her clinical exam was consistent with a diagnosis of possible labral tear. (Id. at 27) He assessed hip and groin pain; mild acetabular dysplasia, Cam impingement. Dr. Antkowiak stated that he intended to perform an intra-articular hip injection at the next visit. (Id.) Petitioner received the injection on October 12, 2016. (Id. at 24) At Petitioner's follow-up visit on December 7, 2016, Petitioner reported that the injection helped her for 3.5 weeks and then returned. (Id. at 19) Dr. Antkowiak assessed right hip – femoral acetabular impingement – Cam with possible labral tear. Based on her clinical presentation and response to the injection received, Dr. Antkowiak recommended a right hip arthroscopy. (Id. at 20)

On January 13, 2017, Dr. Antkowiak performed 1.) right hip acetabular labral tear and 2.) capsular closure and plication. In the operative report, Dr. Antkowiak described there was an acetabular labral tear that extended from 10 to 1 o'clock. (Id. at 114) Dr. Antkowiak performed a repair of the acetabular repair using sutures and anchors. (Id.) His post-operative diagnosis was hip femoral acetabular impingement and acetabular labral tear. (Id. at 113)

Petitioner had a post-operative follow-up on January 18, 2017. Formal therapy was prescribed. Petitioner returned on February 8, 2017 and reported that she was doing very well and had only mild pain and weakness in quad with no symptoms in her groin. (Id. at 13) At her March 8, 2017 visit with Dr. Antkowiak she mentioned only occasional stiffness but denied any groin pain or mechanical symptoms. (Id. at 7) Dr. Antkowiak instructed her to continue with her post-operative rehabilitation protocol. (Id. at 8)

Petitioner's final visit with Dr. Antkowiak occurred on April 19, 2017. Petitioner reported doing well with only mild discomfort. (PX9, p.3) Dr. Antkowiak stated that it was permissible to progress slowly to full activity. (Id. at 4) He further stated that she could return to work with no restrictions effective April 21, 2017. (Id.)

Dr. Antkowiak authored a detailed narrative report on April 19, 2017. The doctor outlined Petitioner's course of treatment through that point. The doctor stated that if Petitioner continued to make progress Petitioner was expected to make a full recovery and return to full duty work without significant residual disabilities. He stated that maximum medical improvement was expected at approximately six months from the surgical procedure. Dr. Antkowiak offer his opinion that it was reasonable to assume Petitioner's labral tear and injury occurred as a result of the reported work injury. The doctor stated that an acetabular labral tear "as seen in this situation" can often be the result of an acute injury. The doctor provided that her history showed she had no

significant hip or groin issues prior to the date the injury and since that time she had continual symptoms and pain. Dr. Antkowiak addressed the diagnostic arthroscopy with evaluation of the labrum. The doctor noted that a labral tear was identified that extended from approximately the 10 o'clock position on the acetabular labral phase to the 1 o'clock position. Dr. Antkowiak indicated he performed a dynamic exam under arthroscopic visualization for evidence of Cam impingement. The doctor provided that he did not visualize any areas of significant Cam impingement and therefore, a Cam resection was not necessary "as we found primary pathology to be an acetabular labral tear." (PX10)

Petitioner testified that she returned to work as a part-time police officer with Respondent in July of 2017. Petitioner testified that she became a full-time officer in June of 2018. She testified that she was still employed with Respondent and is able to perform all of the duties associated with her job. With respect to present complaints, Petitioner testified that she cannot drive for long periods of time without experiencing some pain discomfort. She experiences trouble sleeping when her pain occurs. She also stated that she sometimes experience shoulder discomfort with activity. She stated that her hip, while not bothering her every day, would sometimes bother her if she picks up her daughter. She has not received any additional medical treatment for her claimed injuries in this case since her discharge from care by Dr. Antkowiak on April 19, 2017.

At Respondent's request Petitioner underwent a second Section 12 examination with Dr. Walsh on June 25, 2018. In his report dated same, Dr. Walsh provided that he review additional medical records, diagnostics and performed an examination. Dr. Walsh, stated that "[i]t is clear the patient reports that she is asymptomatic at this time. Both her back and hip pain have resolved, although she did make markings on her pain diagram of symptoms still in her groin and her thigh area…" The doctor noted that his examination revealed well-healed surgical incisions. Petitioner had full flexion to 120 degrees and full abduction at 40 degrees. She could internally rotate to 50 degrees and externally rotate to 35 degrees. The doctor indicated she had a negative Faber and was neurologically intact. She also demonstrated full motor strength. Dr. Walsh indicated that Petitioner had an objectively normal physical examination. (RX3, p.5)

Dr. Walsh diagnosed Petitioner with status post arthroscopy with labral repair and resolution of her low back pain. Dr. Walsh opined that "[i]t was not likely at all the patient's diagnosis of a labral tear is causally related to the injury described. It is not likely at all the patient tore her right labrum as a result of the altercation in 2014 and went two years without any care or treatment to her hip..." He noted the imaging studies following the acute injury failed to demonstrate an acute labral tear and there was no finding of a labral tear until the arthroscopy with Dr. Antkowiak. The doctor provided that while Dr. Antkowiak had suspected a labral tear, imaging studies were negative. Dr. Walsh wrote "…[Petitioner] went into the surgical intervention with the diagnosis of a CAM deformity, which would be a congenital deformity. The acetabular labral tear was discovered at the time of the surgery." Dr. Walsh opined that "[i]f Petitioner tore her labrum in 2014, more likely than not she would have had significant pain and discomfort, and, in 2014, the MRI would have shown an acute effusion and the patient would have been diagnosed with a labral tear prior to 2016." (RX3, p.9) Dr. Walsh went on to explain that a labral tear can occur as result of trauma of typically the femoral head. He stated that it can sublux or partially come out of the hip socket resulting in a tear of the labrum, which deepens the socket and holds the ball in the socket. The doctor stated, "[c]learly with the injury described by the patient in 2014, this did not occur."

Dr. Walsh opined that it was not at all likely that the subsequent return to Dr. Antkowiak in August of 2016 was related to her work injury. He opined that the surgery performed in 2017 was not causally related to the work accident. He opined that Petitioner had reached maximum medical improvement when she was seen and he evaluated her in November of 2014 as she had an objective normal examination at that time. Lastly, Dr. Walsh provided an AMA impairment. The doctor provided that based on his opinion that Petitioner's causally related injury involves a contusion and other soft tissue lesions, her impairment rating would be a 0% of the lower extremity. He stated that for a non-operated tear or tear treated with a partial labrum excision or repair,

Petitioner's rating would be between 1%-3% of the lower extremity. He however stated that because Petitioner had no objective abnormalities, she would have a 1% impairment as a result of her acetabular labral tear. (RX3, p. 9)

Dr. Walsh authored an addendum report dated August 20, 2018, following his review of the narrative report of Dr. Antkowiak. Following his review of that narrative report, Dr. Walsh reported that there was no change in his prior opinions. (RX 4)

Lieutenant Rick Emerson testified on behalf of Respondent in this matter. Lieutenant Emerson testified that he has worked for the Village for 26 years. His current rank is Lieutenant and he has served in that role for 14 years. Lieutenant Emerson testified that Petitioner was a permanent part-time officer prior to her accident. The designation of a permanent part time officer has largely to do with the number of hours per year an employee could work. He confirmed that Petitioner returned to the role of permanent part-time officer in her pre-injury capacity. Lieutenant Emerson confirmed that Petitioner was subsequently promoted and is now serving in the role of a full-time police officer and has been doing so since June of 2018. He provided that Petitioner has been working in her capacity as a full-time police officer without issue. Lastly, he testified that Petitioner was a good employee.

In support of the Arbitrator's Decision relating to (F) Is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds the following:

There is no dispute that Petitioner sustained work-related injuries on February 22, 2014 when she apprehended a resisting arrestee. Petitioner's primary injuries were to her right shoulder, lower back and right hip. Petitioner received conservative medical care from Oak Orthopedics through December 11, 2014, which consisted of physical therapy, epidural injections to her lower back and intra-articular injections to her hip. As of December 4, 2014, Petitioner reported to Dr. Antkowiak that she continued to experience pain in her groin region and hip. (PX8, p.38) He felt that her clinical presentation was consistent with a possible labral tear. (Id. at p.39)

Petitioner was last seen on December 11, 2014 by Dr. Santiago-Palma, with regard to her lower back. On that visit she reported continued symptoms to her right shoulder and lower back. Dr. Santiago-Palma noted that extension of the right and left lateral rotation of the lumbar spine reproduced symptoms of her lower back. (PX8, p. 35) With respect to the shoulder, Dr. Santiago-Palma indicated that Petitioner's symptoms warranted another cortisone injection.

Respondent's examiner, Dr. Walsh who had seen Petitioner a month earlier had a completely different take than those of the treating physicians. Petitioner's reported symptoms were essentially the same, but after examining Petitioner and reviewing the diagnostic studies, it was Dr. Walsh's opinion that there were no objective abnormalities that substantiated her symptoms. (RX2, p.8) His conclusions were that Petitioner suffered a soft tissue injury to her hip, shoulder and low back. (Id.) He opined that her symptoms in November of 2014 were likely not related to her injury in February of 2014 and that she could return to work without restrictions. (Id.)

Thereafter, Petitioner's benefits were stopped. Petitioner's medical treatment for her lower back, right shoulder and right hip came to a halt. Other than a few visits to her personal physician in 2015 wherein she complained of back, right shoulder and right hip, Petitioner did not have any further medical care until 2016. In June of 2016, she complained to her personal physician, Dr. Harris Waheed, that her lower back was worse. In July of 2016, she revisited Dr. Waheed with primary symptoms of right hip pain. After undergoing an MRI, she was able to return to Dr. Antkowiak with her Medicaid insurance on August 24, 2016. Dr. Antkowiak noted that she had positive impingement signs and that her labral stress test was positive. After a course of

conservative care, which did not improve her symptoms, Dr. Antkowiak performed an arthroscopic surgery to right hip. Despite the diagnostic studies that did not reveal a tear, Dr. Antkowiak found a labral tear that extended approximately form the 10 o'clock position to the 1 o'clock position. (PX10)

Dr. Antkowiak stated that an acetabular tear can often be the result of an acute injury. He further indicated that Petitioner did not have any significant hip or groin issues prior to the injury date of February 22, 2014 and has had continued symptoms and pain thereafter. (PX10) He opined that it was reasonable to assume that her labral tear and injury occurred as a result of her reported injury. (Id.)

Petitioner returned to Dr. Walsh on June 25, 2018. On that visit he re-examined her and reviewed the medical records subsequent to his first examination including the operative report of the hip arthroscopy performed by Dr. Antkowiak. He opined that Petitioner's back and hip pain had resolved. He further stated that it was not likely at all that Petitioners right hip arthroscopy was the result of the February 2014 injury. (RX3, p.6) He added that it was not likely that Petitioner suffered an acute labral tear in 2014 and went two years without any care or treatment of the hip. (Id. at 7) Dr. Walsh seems to suggest that "...[Petitioner] went into the surgical intervention with the diagnosis of a CAM deformity, which would be a congenital deformity." Dr. Antkowiak addressed the diagnostic arthroscopy with evaluation of the labrum. The doctor noted that a labral tear was identified that extended from approximately the 10 o'clock position on the acetabular labral phase to the 1 o'clock position. Dr. Antkowiak indicated he performed a dynamic exam under arthroscopic visualization for evidence of Cam impingement. The doctor provided that he did not visualize any areas of significant Cam impingement and therefore, a Cam resection was not necessary "as we found primary pathology to be an acetabular labral tear." Dr. Walsh authored a third report on August 20, 2018 after reviewing the narrative report of Dr. Antkowiak. He indicated that his opinions remain unchanged. (RX4)

The Arbitrator has reviewed the medical documentation and finds that the opinions of Dr. Antkowiak are more persuasive that those of Dr. Walsh. Petitioner's complaints with regard to her hip have been consistent from the onset. The surgery and finding of a labral tear proved that Dr. Walsh was incorrect in his assessment that there were no abnormalities of the right hip. After the labral tear was repaired, Petitioner symptoms dissipated. Dr. Walsh's later opinions that the acute labral was not related to altercation have no support especially given the fact that Dr. Walsh acknowledged that a labral tear could occur as a result of trauma. (RX3, p.8) There is no evidence that Petitioner's symptoms ever resolved in the period of time she was unable to receive treatment or is there any evidence of an intervening injury. Consequently, the Arbitrator adopts the opinion of Dr. Antkowiak that it is reasonable to assume that Petitioner's labral tear occurred as a result of her reported injury.

Based on the foregoing, the Arbitrator finds that Petitioner's right hip condition of ill-being is causally related to the work injury of February 22, 2014. Furthermore, relying on the medical records submitted, the Arbitrator finds that Petitioner's low back and right shoulder conditions of ill-being were causally related to the work injury of February 22, 2014.

In support of the Arbitrator's Decision relating to (K) What temporary total disability benefits are due, the Arbitrator finds the following:

The parties stipulated that Petitioner is entitled to temporary total disability (TTD) through December 9, 2014. Benefits were stopped based on Respondent's reliance of the opinions of Dr. Walsh who examined Petitioner on November 6, 2014. A month later, both Drs. Antkowiak and Dr. Santiago-Palma indicated in their respective chart notes that Petitioner was unable to work due to the medical conditions of her right hip, lower back and right shoulder. As stated in the foregoing, the Arbitrator is not persuaded by the opinions of Dr. Walsh with regard to his assessment of Petitioner's right hip. As such, Petitioner's temporary total disability benefits should have continued.

Petitioner testified that after her stoppage of benefits she remained off work until December 28, 2015. On that date, she accepted a warehouse job with Metabolic Management. Petitioner's job required her to package supplements into small boxes. Petitioner's unrebutted testimony was that in the year of 2016, she earned $16,337.00, which equated to $314.17 per week.

Petitioner eventually reached maximum medical improvement on April 19, 2017 and was released to return to work without restrictions as of April 21, 2017.

Based on the foregoing, the Arbitrator finds Petitioner was temporarily totally disability for the period of February 23, 2014 through December 27, 2015 equaling 96-1/7 weeks. The Arbitrator further awards Petitioner temporary partial disability benefits (TPD) of $139.90 per week [($524.02 - $314. 17) x 66-2/3%] for the period of December 28, 2015 through April 20, 2017, representing 68-4/7 weeks. Respondent is entitled to a credit of $14,758.24 for amounts paid. (RX1)

In support of the Arbitrator's Decision relating to (J) Were the medical services that were provided to petitioner reasonable and necessary? Has respondent paid all appropriate charges for all reasonable and necessary medical services? the Arbitrator finds the following:

Petitioner has presented the following medical bills into evidence as Petitioners' Exhibit #2:

Provider	Dates of Service	Bill Amount
ATI Physical Therapy	1/16/17 – 3/3/17	$9,584.51
Franciscan St. Mary's	9/3/14 - 9/29/14	$5,112.00
Riverside Medical Center	1/13/17	$33,246.47
Riverside Medical Center	12/15/16	$2,247.00
Crete Fire Protection Dist.	2/22/14	$1,083.75
Oak Orthopedics	4/10/14 – 3/9/17	$30,958.00
North American Partners in Anesthesia	1/13/17	4,303.60
		$86,535.33

Having found the requisite causal relationship, the Arbitrator awards the submitted medical charges of each provider subject to the Illinois Medical Fee Schedule, per Section 8.2 of the Act. Respondent is entitled to a credit $26,676.51 for amounts paid. (RX1)

In support of the Arbitrator's Decision relating to (L) What is the Nature and Extent of the injuries? The Arbitrator finds the following:

In determining the level of permanent partial disability for injuries incurred on or after September 1, 2011, the Commission shall base its determination on the following factors: (i) the reported level of impairment pursuant to the most current edition of the AMA's "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; (v) evidence of disability corroborated by the treating medical records. (820 ILCS 305/8.1b)

No single enumerated factor shall be the sole determinant of disability. 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)

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

(a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but are not limited to: loss of range of motion; loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment.

(b) Also, the Commission shall base its determination on the following factors:

(i) The reported level of impairment;
(ii) The occupation of the injured employee;
(iii) The age of the employee at the time of injury;
(iv) The employee's future earning capacity; and
(v) Evidence of disability corroborated by medical records.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that Respondent submitted an impairment rating conducted by Dr. Walsh. The doctor provided that based on his opinion that Petitioner's causally related injury involves a contusion and other soft tissue lesions, her impairment rating would be a 0% of the lower extremity. He stated that for a non-operated tear or tear treated with a partial labrum excision or repair, Petitioner's rating would be between 1%-3% of the lower extremity. He however stated that because Petitioner had no objective abnormalities, she would have a 1% impairment as a result of her acetabular labral tear. (RX3, p. 9) No rating was provided regarding Petitioner's lower back and right shoulder injury. Because the AMA rating is incomplete and does not pertain to all of Petitioner's injuries, the Arbitrator therefore gives lesser weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that Petitioner was employed as a part-time police officer at the time of the accident. She was able to return to work in her prior capacity as a result of said injury and she now works for Respondent as a full-time police officer. The Arbitrator therefore gives no weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 34 years old at the time of the accident. Because of Petitioner's relatively young age, she enjoys a long work-life expectancy, which means that she will live with disability for a longer period than an older individual. The Arbitrator therefore assigns greater weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that Petitioner was able to return to her prior position and is now working for Respondent as a full-time police officer. Because Petitioner has secured a promotion, she is earning more money as a full-time police officer than she was as a part time police officer. It's clear the accident had no impact on her future earnings. The Arbitrator therefore gives no weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that Petitioner sustained injuries to her low back, right shoulder and right leg/hip. Petitioner treated conservatively for her low back and shoulder conditions with physical therapy and multiple injections. Petitioner was diagnosed with a contusion/strain of lumbar back and right shoulder. On January 13, 2017, Dr. Antkowiak performed 1.) right hip acetabular labral tear and 2.) capsular closure and plication. The post-operative diagnosis was hip femoral acetabular impingement and acetabular labral tear. Post surgey, Petitioner followed with Dr. Antkowiak through April 19, 2017. At that time, the doctor provided that she could

return to work with no restrictions effective April 21, 2017. Petitioner returned to her pre-accident position as a part-time police officer with Respondent in July of 2017. She was subsequently promoted to a full-time officer in June of 2018. Petitioner continues to work at that capacity. With respect to present complaints, Petitioner testified that she cannot drive for long periods of time without experiencing some pain discomfort. She experiences trouble sleeping when her pain occurs. She also stated that she sometimes experiences shoulder discomfort with activity. She stated that her hip, while not bothering her every day, would sometimes bother her if she picks up her daughter. She has not received any additional medical treatment for her claimed injuries in this case since her discharge from care by Dr. Antkowiak on April 19, 2017. The Arbitrator gives greater weight to this factor.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 7-1/2% disability to her person as a whole for her right shoulder and lower back per Section 8(d)(2) of the Act and 15% loss of use of the right leg per Section 8(e)(12).

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

BENJAMIN SPURLIN, II,

Petitioner,

vs. NO: 18 WC 11903

MILLER CONTRACTING SERVICES, INC.,

Respondent.

20IWCC0066

DECISION AND OPINION ON REVIEW

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

The Findings of Fact section reflects that after the August 9, 2018 visit with Dr. Gornet, "Petitioner immediately returned to work at a new job. (T. 14) While he was working, he was also studying and taking a class to get another position. (T. 21)." The Commission strikes that language and substitutes the following:

> On October 10, 2018, approximately two months after his release by Dr. Gornet, Petitioner started a new job at Tru-Built, which is a barn building company. Petitioner left Tru-Built's employ on February 22, 2019, and in March, he attended a week-long class to qualify for a position at an area mine. T. 20-21.

All else is affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 16, 2019, as modified above, is hereby affirmed and adopted.

50TMCC0068

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $720.00 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 a 15% loss of use of the person as a whole.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $54,100.00. 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: JAN 2 9 2020

L. Elizabeth Coppoletti

LEC/mck

D: 1/21/20

43

L. Elizabeth Coppoletti

Stephen Mathis

D. Douglas McCarthy

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SPURLIN II, BENJAMIN
Employee/Petitioner

Case# **18WC011903**

MILLER CONTRACTING SERVICES INC
Employer/Respondent

20IWCC0066

On 7/16/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.01% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in 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 RICH RICH & COOKSEY PC
THOMAS C RICH
6 EXECUTIVE DR SUITE 3
FAIRVIEW HTS, IL 62208

0734 HEYL ROYSTER VOELKER & ALLEN
JOHN FLODSTROM
120 W STATE ST 2ND FL
ROCKFORD, IL 61101

STATE OF ILLINOIS)
)SS.
COUNTY OF WILLIAMSON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

Benjamin Spurlin, II
Employee/Petitioner

v.

Miller Contracting Services, Inc.
Employer/Respondent

Case # 18 WC 11903

Consolidated cases: _____

20IWCC0066

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 **Edward Lee**, Arbitrator of the Commission, in the city of **Herrin**, on **May 14, 2019**. By stipulation, the parties agree:

On the date of accident, **March 26, 2018**, 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 **$62,400.00**, and the average weekly wage was **$1,200.00**.

At the time of injury, Petitioner was **20** years of age, ***single*** with **0** dependent children.

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

Respondent shall be given a credit of N/A for TTD, N/A for TPD, N/A for maintenance. The parties agree that Respondent shall be given a credit for any and all medical bills previously paid.

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 $ **720.00** /week for a further period of **75** weeks, as provided in Section **8(d)2** of the Act, because the injuries sustained caused the **15% loss of Petitioner's body as a whole as a result of serious and permanent injuries sustained to Petitioner's body as a whole.**

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.

Edward Lee — Signature of Arbitrator

7/14/19 — Date

ICArbDecN&E p.2

JUL 16 2019

FINDINGS OF FACT

The parties stipulated that Petitioner sustained an accident arising out of the course and scope of his employment on March 26, 2018 when he was struck in the neck and head by a flex hose on a concrete pump. (T. 8, 9) After the incident, Petitioner only remembers waking up in the hospital thirteen (13) days later, to the best of his recollection. (T. 9, 10) While he was in the hospital, Petitioner was treated with rest and medication. (PX6) He was also seen at CoxHealth Hospital and was advised that he may have memory difficulties, dizziness, headaches, double vision, hearing difficulties, depression, tiredness, weakness or difficulty with concentration. (PX7) He was also counseled concerning anxiety and panic attacks. *Id.*

Petitioner sought treatment with Dr. Winkleman at Southern Illinois Healthcare Harrisburg Primary Care Group in which Petitioner's mother asked that her son be referred to a neurologist at Washington University in St. Louis for his traumatic brain injury because Petitioner was being combative, rude, and disruptive. Dr. Winkleman noted that Petitioner "certainly seems to be experiencing cognitive/behavioral sequelae of the head injury..." (PX8, 4/9/18, 4/10/18) Prior to the accident, Petitioner had no prior injuries to his head, neck, or sustained any trauma to his brain. (T. 11, 12, 20) Southern Illinois Healthcare Harrisburg Primary Care Group noted that Petitioner's hard hat was shattered. (PX8, 4/10/18) Furthermore, Petitioner reported that his mind "will not shut off" and complained of severe headaches. *Id.* During this office visit, he was given multiple medications in an effort to assist in his memory restoration, anxiety, and depression. *Id.*

Dr. Matthew Gornet examined petitioner for the first time on April 30, 2018 for neck pain, headaches, bilateral trapezial pain and dizziness. (PX9, 4/30/18) Dr. Gornet stated the history of the injury as follows:

> History of Present Illness: This is the first visit and spinal examination for Benjamin Spurlin. The patient is a 20-year-old whose main complaint is neck pain, headaches, bilateral trapezial pain and dizziness. He states his current problem began on or about 3/26/18. He was working for Miller Construction. Apparently, according to the notes as well as his grandfather who accompanied him today, there was a concrete pump and he was struck in the head on the left side with the hose. There was loss of consciousness. He was covered in concrete. With the initial injuries, they were concerned that he was irritated or burned by the concrete as well as his head injury. He was listed as being combative. He was admitted to the hospital, initially at Kermit in Texas and then transported to University Medical Center in Lubbock. Again, he was there for multiple days. He was then discharged and asked to follow-up with local care. He lives in Illinois, where he was hired, and has worked for this company over the last year as well as prior to this, one year earlier. He returned home around 4/8/18. He has been off work since. He does not recall any previous problems of significance with his neck. His symptoms remain constant and worse with activity, reaching, pulling or lifting. It is worse in the morning. He denies significant radicular symptoms such as arm pain or numbness. *Id.*

Dr. Gornet's examination showed pain into Petitioner's neck and both trapeziuses and restricted range of motion in flexion/extension and rotation. *Id.* Petitioner's motor strength was normal as well as his reflexes in sensation. *Id.* At this office visit, Dr. Gornet ordered a MRI of the cervical spine to be performed at MRI Partners of Chesterfield. *Id.* The clinical findings revealed well-preserved disc height at all levels and no signs of degeneration or foraminal narrowing. *Id.* His findings also showed subtle central annular tears at C3-4, and more significant injuries at C4-5 and C5-6. *Id.* Dr. Gornet's working diagnosis impressions take into consideration that Petitioner's neck pain and headaches were from a disc injury from C3 to C6. *Id.* He also believed that Petitioner was suffering from concussion-like symptoms. *Id.* He placed Petitioner in physical therapy and prescribed medication. *Id.*

Petitioner followed up on June 9, 2018 and told Dr. Gornet that he felt better during physical therapy but the pain returned every evening particularly at night. (PX9, 6/9/18) Dr. Gornet referred him to Dr. Kaylea Boutwell for injections. *Id.* These were done at C4-5 on June 28, 2018 and C5-6 on July 12, 2018. (PX11, 6/28/18, 7/12/18) These resulted in improvement. (PX9, 8/9/18) Dr. Gornet stated: "He is still not pain-free. He has not returned to baseline, but he is definitely improved." *Id.*

In the interim, Petitioner was examined at Respondent's request by Dr. Richard Katz, a physiatrist. (RX1) Dr. Katz's report showed a picture of Petitioner with the words "say a little prayer for me" underneath the picture which did not resemble Petitioner. *Id.* Dr. Katz's examination was both mental and physical and largely normal. *Id.* In his report, Dr. Katz stated that Petitioner had neck pain with marked behavioral overlay and continued to have tension type headaches related to pain. *Id.* Despite no knowledge of Petitioner's previous condition, Dr. Katz stated it was likely that Petitioner had pre-morbid learning and behavioral problems that required investigation by school records, but arbitration, Petitioner testified that he graduated from high school. (T. 20) Although Dr. Katz believed Petitioner met the criteria for a major depressive order, he noted that Petitioner was not depressed during his examination. (RX1) Dr. Katz also stated that Petitioner did not need any disc replacement surgery. *Id.* He did not have the record from Dr. Boutwell which showed that Petitioner reported improvement after injections. *Id.* Dr. Katz believed that degenerative annular tears were not an infrequent finding in asymptomatic persons in Petitioner's age group. *Id.* Petitioner was 20 years old at the time of the accident. (AX2; T. 11) Dr. Katz also believed that Petitioner's neck pain started three weeks after his incident and therefore, it was difficult to "link the two when one had no symptoms for 3 weeks." (RX1) Despite not having the records of Dr. Boutwell which showed improvement from injections, Dr. Katz stated that improvement in his neck pain would not be achieved without addressing behavioral or psychiatric issues. *Id.*

Dr. Gornet reviewed Dr. Katz's report with Petitioner on August 9, 2018 and went through his report at the request of Petitioner because he was unclear about some of the issues raised by Dr. Katz. (PX9, 8/9/18) Dr. Gornet believed that Dr. Katz had to some extent distorted Petitioner's entire medical record. *Id.* Dr. Gornet noted that Petitioner had a very serious injury

to this head and he was life-flighted to the University Medical Center in Lubbock, Texas. *Id.* While Dr. Katz believed that Petitioner had no neck injury, Dr. Gornet noted that the initial practitioners at the scene had placed Petitioner in a cervical collar and that he was given a CT scan of his head and neck. *Id.* With regard to Dr. Katz's statement that Petitioner's neck pain was "degenerative," Dr. Gornet stated:

> He clearly has a mechanism of injury that would cause a neck injury. He is 20-years-old and to insinuate that this is preexisting disc degeneration is ludicrous. The fact that he has brought this other information in speaks for itself. It speaks for the fact that Dr. Katz has an agenda that is independent of any medical treatment in this case. I explained this to Mr. Spurlin and this seemed to reassure him. The fact of the matter is, is his treatment has helped him to some extent and the real issue is, as a 20-year-old, does he need further treatment as far as surgery is concerned. I would like him to try a stint of full duty no restrictions. All parties involved must understand that Mr. Spurlin still may require surgical intervention to cure and relieve the effects of his work related injury, but if he can work full duty and his symptoms are tolerable, then no surgery would need be performed. Exam is non-focal. At this point, he is in full agreement with this. I think he is strongly motivated to get his life back and get back to work, but, again, he understands that there is a distinct possibility that he may require surgical intervention as a direct result of his injury and his full duty release does not indicate that he is perfect, doing well or even at maximal medical improvement. I will see him back in six weeks' time for follow-up. *Id.*

After this visit with Dr. Gornet, Petitioner immediately returned to work at a new job. (T. 14) While he was working, he was also studying and taking a class to get another position. (T. 21) When he was finished with the course, the job he had studied for was gone. *Id.*

Petitioner testified at Arbitration. (T. 7) The Arbitrator had a chance observe Petitioner's demeanor for over 30 minutes and noted that Petitioner was polite and soft-spoken. Prior to the accident, Petitioner testified to no head, neck, migraine, or other upper body pain and had never suffered loss of consciousness. (T. 11, 12) He acknowledged that the epidural injections into his neck somewhat helped his pain and also testified that he would not be undergoing any surgery "unless it was his choice." (T. 12) Petitioner testified that he declined to have surgery at this time. (T. 13) Petitioner testified to a good range of motion; however, when he moves his head from side to side he gets a "creek" in his neck. (T. 13, 14) He testified to decreased strength and lifting and testified that when he was released, he immediately returned to work although "It was kind of rough at the start." (T. 14, 15) He testified to headaches which occur three times per week and although he took over-the-counter Ibuprofen it did not help. (T. 15, 16) Petitioner does not get a good night sleep and wakes up every one to two hours, goes to the bathroom, and tries to go back to sleep again. (T. 16, 17) His hobby of deer hunting had been adversely affected. (T. 17)

With regard to his memory, Petitioner testified he could still remember how to do concrete work. *Id.* Some of the "edges" on hunting and fishing are not there; however, his father was trying to reteach him. *Id.* Petitioner testifies to memory troubles which frustrated him. (T. 18) On cross-examination, Petitioner was asked about being struck in the head by his grandmother. (T. 23) Petitioner's grandfather was present in the room at the time the question was asked and Petitioner denied anything of the sort. *Id.*

CONCLUSIONS OF LAW

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

Pursuant to § 8.1b of the Act, permanent partial disability from injuries that occur after September 1, 2011 are to be established using the following criteria: (i) the reported level of impairment pursuant to subsection (a) of the Act; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. 820 ILCS 305/8.1b. The Act provides that, "No single enumerated factor shall be the sole determinant of disability." 820 ILCS 305/8.1b(b)(v).

(i) **Level of Impairment:** Neither Party submitted an AMA rating. Therefore, the Arbitrator appropriately used the remaining factors to evaluate Petitioner's permanent partial disability.

(ii) **Occupation**: Petitioner is currently unemployed and is searching for work. (T. 15) The Arbitrator places some weight to this factor.

(iii) **Age**: Petitioner was 20 years of age at the time of his injury. (AX2; T. 11) He is a younger individual and must live and work with his disability for an extended period of time. Pursuant to *Jones v. Southwest Airlines*, 16 I.W.C.C. 0137 (2016) (wherein the Commission concluded that greater weight should have been given to the fact that Petitioner was younger [46 years of age] and would have to work with his disability for an extended period of time). The Arbitrator places significant weight on this factor.

(iv) **Earning Capacity**: Petitioner is currently unemployed and is searching for work. (T. 15) Therefore, his earning capacity has been greatly reduced. The Arbitrator places significant weight to this factor.

(v) **Disability**: As a result of his accidents, Petitioner sustained a subarachnoid hemorrhage, a cerebral laceration and contusion, a second degree burn to his neck, concussion with loss of consciousness and a cervical disc injury at C3-4, C4-5, and C5-6 (PX4; PX6; PX9, 4/30/18) Petitioner was under inpatient care in the hospital for an extended period of time. (PX6) Petitioner's symptoms included

severe memory loss, insomnia, headaches, earaches, neck pain, trapezial pain and dizziness. (PX6; PX8, 4/10/18, 4/17/18; T. 9, 17, 18; PX9, 4/30/18) After his initial hospital visits, Petitioner received conservative care in the form of physical therapy and epidural steroid injections. (PX9, 6/9/18; PX11, 6/28/18, 7/12/18) Although this improved Petitioner's condition, Dr. Gornet noted that "...there is a distinct possibility that he may require surgical intervention as a direct result of his injury..." (PX9, 8/9/18) At Arbitration, Petitioner testified that he still often suffers from headaches, and although he takes ibuprofen for same, it does not seem to take the edge off. (T. 15, 16) He also "never" gets a good night's sleep and wakes up every hour or two. (T. 16, 17) His hobby of deer hunting has also been adversely affected because he can no longer pull a compound bow back. (T. 17) He still suffers from memory loss to the point where it has become necessary for his father to "reteach" him some of the edges of his hobbies of hunting and fishing. (T. 17) The Arbitrator places significant weight on this factor.

Based upon the foregoing evidence and factors, the Arbitrator finds that Petitioner sustained serious and permanent injuries that resulted in the 15% loss of Petitioner's body as a whole.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Christopher Ferrell,

Petitioner,

vs.

NO. 15WC 23359

20IWCC0067

The American Coal Company,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of notice, occupational disease, §1(d)-1(f), permanent disability, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 23, 2019 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: JAN 29 2020
SJM/sj
o-1/21/2020
44

Stephen J. Mathis

Deborah L. Simpson

Douglas D. McCarthy

Document Control

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

FERRELL, CHRISTOPHER Case# **15WC023359**

Employee/Petitioner

THE AMERICAN COAL COMPANY

Employer/Respondent

20IWCC0067

On 7/23/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.01% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in 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 & JORDAN
ROMAN P KUPPART
3 S MAIN ST SUITE 2
HARRISBURG, IL 62946

1662 CRAIG & CRAIG LLC
KENNETH F WERTS
115 N 7TH ST PO BOX 1545
MT VERNON, IL 62864

STATE OF ILLINOIS)
) SS
COUNTY OF **WILLIAMSON**)

20 IWCC0067

☐ 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

CHRISTOPHER FERRELL
Employee/Petitioner

v.

THE AMERICAN COAL COMPANY
Employer/Respondent

Case # **15** WC **23359**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Christina Hemenway**, Arbitrator of the Commission, in the city of **Herrin**, on **March 14, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☐ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☐ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☐ TTD
L. ☒ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☒ Other **Sections 1(d)-(f) of the Occupational Diseases Act**

20IWCC0067

FINDINGS

On **May 23, 2015**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

Timely notice of 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 $**95,580.16**; the average weekly wage was $**1,838.08**.

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

Petitioner claims no medical.

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

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

ORDER

As explained in the Arbitration Decision, Petitioner failed to prove by a preponderance of the evidence that he sustained an occupational disease that arose out of and in the course of his employment by Respondent and that his current condition is causally related to same. All benefits are denied. The Arbitrator makes no conclusions as to the remaining issues.

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

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the 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 22, 2019
Date

JUL 23 2019

STATE OF ILLINOIS) 20IWCC0067
) SS
COUNTY OF WILLIAMSON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

CHRISTOPHER FERRELL
Employee/Petitioner

v. Case #: **15 WC 23359**

THE AMERICAN COAL COMPANY
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Testimony of Petitioner

Petitioner lives in Galatia, Illinois. He was 59 years old at the time of arbitration and married with dependent children. He completed high school in 1979 and received an Associate Degree in mining technology. Petitioner testified that he worked for 32 years in coal mining, with all of that time being underground. He testified that he was regularly exposed to coal and rock dust while working in the mines. He also worked around a lot of diesel equipment for the last 15 years of his coal mining employment.

Petitioner testified that he last worked a shift in coal mining on May 23, 2015, for Respondent at its Galatia mine. He was 54 years old on that date. His job classification was mine manager. He testified that on that date he was exposed to and breathed coal dust. He testified that he had suffered a heart attack and had to have five bypasses. His health got to where he could not perform his job and they were shutting the mine down, so they gave him an early layoff due to his condition. He has not worked since leaving the coal mine. He applied for Social Security Disability due to his heart condition and before his disability was final, his kidneys went out. He was on dialysis as of the time of arbitration. Petitioner testified that he learned he had black lung after he applied for Social Security Disability. He that he knew he had breathing problems, as he could not get enough oxygen and was put on oxygen to sleep at night.

Petitioner testified that he worked at Brushy Creek Coal Company from September 1981 until 1999, when the mine shut down. From 1999 to 2001, he drove a truck for himself. In 2001, he went to work for Frontier Kemper sinking a slope at Kerr-McGee. He started working for Respondent in 2002 and stayed there until 2015. While at Brushy Creek he was a laborer for approximately a year, where he was required to rock dust and shovel. He spent two years as a roof bolter and 10 years in belt maintenance. In belt maintenance he worked on belt lines when

they were running, installed belt lines, and shoveled. He testified this was heavy manual labor. As a repairman at Brushy Creek, Petitioner worked on equipment at the face of the mine while they were mining coal. He had to carry parts and tools. He classified this as heavy work.

Petitioner testified that his first job classification with Respondent was as a face boss. In that job he worked at the mine face managing people who were mining coal. He rock-dusted and did whatever it took to train and to mine coal. Petitioner was a mine manager for a little over six years with Respondent. In that position he was responsible for everyone in the mine on that shift. He averaged walking two to three miles every shift that he worked, and he checked the ventilation in the coal mine. He testified that there was a lot of dust in the mine. He testified that the walking conditions were up and down. He walked in mud from his ankles to his knees, as well as in water. He testified that he wore a utility belt which weighed between 40 and 50 pounds. Petitioner considered most of his job duties to be heavy manual labor.

Petitioner testified that performing his job duties at the end of his coal mining career caused him breathing problems. In the last five years he worked, he could tell a big difference in his breathing. He also started having trouble with his balance. At the end of his career, when walking the whole mine, he would have to stop and catch his breath for five minutes at least. He testified that in the last mine that he worked there was a lot of mud and water and he got to where he could not do his job. He did not want to quit work, but he had to. Petitioner testified that currently he might be able to walk 300 feet on level ground at a normal pace before becoming short of breath and having to stop and catch his breath and rest a little. He testified that currently he could climb three steps. He also testified that he needed something to hold on to if he did not have his cane. Petitioner testified that from the time he first noticed his breathing problems until arbitration, they have worsened. Petitioner testified that he was to have a heart stent put in on March 25, 2019. He was hopeful that this would help, as he had been told he was not getting enough oxygen to his heart. Petitioner was not taking any breathing medications. He testified that he used oxygen at night. He was supposed to use it more often, but he had not looked in to getting a portable oxygen bag. Petitioner testified that he felt better when he was on oxygen all the time.

Petitioner testified that his breathing affects his activities of daily life. He is not able to go and do like he used to. He does very little physical work around the house. He testified that he tries to use his riding lawnmower to mow the yard, but his wife has to do most everything else. Petitioner testified that when he goes to the store with his wife he sits in the car or he pushes the cart because it will keep him from falling down. He testified that he did not want to retire at the time he did, and that if it was not for his health conditions, he would still be working in a coal mine somewhere. Petitioner testified that he would have worked until he could not work anymore because that is the way he has always been. He testified that he had a heart attack and it "all fell down" when that happened. As of the date of arbitration, he was on dialysis three days a week and was waiting on a kidney transplant. He testified that he had been on that list for almost two years. Petitioner testified that Dr. Rider prescribed oxygen for him. Petitioner testified that he has never smoked. Other medical conditions include diabetes, high blood pressure as well as GERD and other stomach issues.

Petitioner testified that he suffered a heart attack on January 31, 2014, in the evening after he got home from work. While he was off work, he had a five-vessel bypass. He returned to work too quickly and had to be off again. He testified that it was a struggle following his heart attack and that he never picked back up with his work after that. Petitioner applied for Social Security Disability in May 2015, which was the month that he left work. He testified that he has vision problems and takes shots in his eyes every month due to diabetes. Petitioner's wife completed a Function Report for Social Security dated June 15, 2015. In that report she mentioned that Petitioner suffered from fatigue, nausea, constipation, diarrhea, dizziness, blackouts and blurred vision. He testified that he had those conditions for quite some time. Petitioner is in renal failure and because of that he immediately qualified for Medicare. Petitioner testified that he also had bowel problems related back to when he was last at work. He had his gallbladder removed and that cured those problems pretty well.

Petitioner testified he has never held a desk job and has never done anything other than manual labor. He cannot use a computer and cannot type. He had to have his assistant do all the paperwork at the mine because he never messed with a computer.

Petitioner testified he has never smoked. In addition to his breathing and kidney issues, he has had five bypasses and was due to get a stent within a couple of weeks from the date of hearing. He is a diabetic, has high blood pressure, GERD and other stomach issues. He testified that he has diabetes now due to his stomach issues, and that his feet go numb as part of that.

Petitioner testified that he did not complete his job as a coal miner for the last three months he was employed by Respondent. He had to more or less give it up because of all the walking he had to do for the job. He testified he had to have help getting out of the mine and was unable to stand on his feet, but he did not want to give up. However, he ultimately had to retire. He testified that as of the day of arbitration, he could not do his last coal mining job.

Petitioner testified that there were over 150 people laid off along with him on May 22, 2015. He talked with his superintendent about how he could not perform his job, and his superintendent went ahead and laid him off. He testified that if he had not been sick, he would not have been laid off. He noted that the mine where he was working was headed for closure.

Petitioner testified that he collected unemployment benefits, which ended when he was awarded Social Security Disability. He was approved for Social Security Disability in October 2015, once his kidneys quit. He testified that when applying for Social Security Disability, he was honest with them about the conditions that prevented him from working, and that Social Security Disability also reviewed his medical records. Petitioner testified that he was having difficulty at the time of arbitration with his feet, due to neuropathy. He testified that the neuropathy was a hindrance to him with walking because he cannot feel his feet.

Petitioner acknowledged that while employed in the coal mines, from time to time he took the opportunity to have a chest x-ray taken and read by NIOSH. After the x-ray was taken, NIOSH would write to him and tell him what the chest x-ray revealed. He testified that he did not bring any of those letters with him to arbitration. Petitioner testified that he had a chest x-ray

taken on June 15, 2015, that was interpreted by Dr. Henry K. Smith in a report dated July 5, 2015. Petitioner testified that is when he found out that he had black lung.

Medical Records

Dr. Suhail Istanbouly

Dr. Suhail Istanbouly examined Petitioner on September 22, 2015, at the request of his counsel. He testified by way of deposition on August 11, 2017. Dr. Istanbouly is a physician specializing in pulmonary medicine and critical care medicine. He testified that roughly 30% of his patient census deals with the care and treatment of coal miners. He conducts black lung examinations for the U.S. Department of Labor. He has been the Medical Director of the Pulmonary Department of Herrin Hospital since approximately 2005. Dr. Istanbouly performs five to seven examinations, such as that performed on Petitioner, every month. Those exams are always at the request of a claimant's attorney. PX1.

Dr. Istanbouly noted that Petitioner was a coal miner for 34 years, that in the last year of employment he was a mine manager, that he never smoked, and that he did not recall being diagnosed with asthma or COPD in the past. Petitioner reported to Dr. Istanbouly that he had chronic daily cough for four years, which was moderate in intensity and triggered by strenuous activity and dust inhalation. The cough was productive of a half a cup of white-yellow sputum per day. He further reported exertional dyspnea and becoming short of breath with walking half a block. PX1.

Dr. Istanbouly testified that Petitioner's spirometry testing revealed a moderate, non-specific ventilatory limitation with no good response to bronchodilator treatment. Petitioner's chest x-ray revealed bilateral tiny, round opacities consistent with simple coal workers' pneumoconiosis. He testified that when a person has simple coal workers' pneumoconiosis radiographically, he would expect chronic respiratory symptoms, including chronic cough, sputum production, shortness of breath on exertion, wheezing and recurrent respiratory infections. Dr. Istanbouly testified that a person with a positive chest x-ray for coal workers' pneumoconiosis could also be asymptomatic, especially if it is in early stage. Dr. Istanbouly testified that his examination of Petitioner's chest was normal, but noted that a person does not necessarily have to have an abnormal physical exam of the chest to be diagnosed with coal workers' pneumoconiosis. He testified that the results of Petitioner's pulmonary function test showed a moderate non-specific ventilatory limitation, and that the meaning of those results was unclear. It could indicate obstructive, restrictive or mixed obstructive/restrictive defect. He testified that when a patient has no good response to bronchodilator treatment, it means the airway damage is irreversible, and rules out certain conditions or underlying conditions like asthma. He testified that the main culprit of Petitioner's moderate non-specific ventilatory limitation was coal dust inhalation. PX1.

Dr. Istanbouly diagnosed Petitioner with coal workers' pneumoconiosis caused by long term coal dust inhalation. This diagnosis was based on Petitioner's history, his chest x-ray and his pulmonary function test findings. Dr. Istanbouly described coal workers' pneumoconiosis as fine particles being inhaled into the deep parts of the airways ending in the alveoli creating a

local irritation or inflammation that ends up with a tiny scar which is seen as small, round opacities on the x-ray. The tiny scars replace the normal lung tissue and affect the gas exchange to the vascular parenchymal barrier. The scarring and fibrosis of coal workers' pneumoconiosis are permanent. By definition, if one has coal workers' pneumoconiosis, he has impairment of the function of his lungs at least at the site of the scar or fibrosis. PX1.

Dr. Istanbouly testified that Petitioner had significant pulmonary impairment from his chronic cough, his sputum production, and his exertional and nocturnal dyspnea. He opined that Petitioner had damage to his lungs as a result of his occupational exposure to coal mine dust. He testified that Petitioner should be restricted from ever returning to work at a coal mine. He noted that Petitioner had already retired from the coal mine by the time he saw him. Petitioner did not relate to him that he left the mine when he did due to respiratory problems, nor did he relate an inability to do the duties of his last job at the mine. PX1.

Dr. Istanbouly testified that Petitioner reported a runny nose and post-nasal drip, which may be associated with cough. He testified that there are other possibilities for dyspnea on exertion other than pulmonary disease, and noted that a heart condition is high on that list. He testified that the symptoms of being a heavy snorer and awakening at night short of breath are suggestive of sleep apnea. He noted that Petitioner was not taking any breathing medications and did not relate to Dr. Istanbouly ever having done so. PX1.

Dr. Istanbouly testified that he is not an A-reader or B-reader of films. He did not provide a profusion rating for the June 15, 2015, film that he interpreted of Petitioner. He testified that when he interprets a film for black lung, he determines whether it is positive or negative. If it is positive in his system of classification, then he indicates whether it is mild, moderate or severe. He classified Petitioner's film as mild. Dr. Istanbouly could not say whether the profusion was a 0/1 or 1/0. He testified that the chest x-ray was of good quality. If he would have found the film to be deficient in quality, he would have put that in his report. He testified that film quality is important to get an accurate diagnosis. He explained that poor film quality can lead to misinterpretation of the film and affect the accuracy of the interpretation if the reader does not recognize the deficiency. PX1.

Dr. Henry K. Smith

Dr. Henry K. Smith testified by way of deposition on December 5, 2018. He is a diagnostic radiologist and has been board certified in radiology since 1973. He took the B-reader exam for the first time in 1987, and has been continually certified as a B-reader since that time. Dr. Smith testified that he failed the B-reading recertification exam twice somewhere around 1999 due to his overreading of the films which, he explained, meant that he was finding more disease than was present on the standard film.

Dr. Smith received his Doctor of Osteopathic Medicine in 1968 from Kirksville College of Osteopathic Medicine. He confirmed this was a D.O., and not an M.D. He did a rotating general internship at Carson City Hospital in Carson City, Michigan and a radiology residency at Memorial Osteopathic Hospital in York, Pennsylvania. He operated his own private radiology

practice from 1988 to 2016. Since closing his practice, he has been doing consulting work in the field of radiology including a lot of B-readings. PX2.

Dr. Smith testified that in performing a B-reading, he starts with determining the quality of the film. The next step is to determine if there are any small opacities present. If opacities are present, he determines if there are enough to be called pneumoconiosis. If so, then he determines whether they are round or linear opacities and categorizes them by size. Dr. Smith testified that with coal workers' pneumoconiosis, the preponderance of small opacities are round. He testified that with other kinds of pneumoconiosis, such as asbestosis related, they are linear or irregular opacities. In coal workers' pneumoconiosis, opacities occur primarily in the upper to mid lung zones. With asbestosis, they predominantly occur in the mid to lower lung zones. Dr. Smith described an opacity as a small, abnormal density that one would not see on a normal chest x-ray. It is often seen with people that have occupational lung disease or pneumoconioses. The next thing the B-reader considers is the profusion, which is the concentration or density of the findings in the lungs. Dr. Smith testified that the profusion tells the reader what degree of involvement is present. The last thing included in completing the B-reading form is the obligatory findings, which are things that need to be recorded other than the findings of black lung. Dr. Smith testified that mottle on a film is a pixely type of look. He explained that it may look like there is disease present, but the reader is getting a false sense of there being opacities present because of the mottled appearance. PX2.

Dr. Smith reviewed a chest x-ray of Petitioner dated June 15, 2015, at the request of Petitioner's counsel. He testified that the film was slightly underinflated and gave it a quality 2 rating. He interpreted the film as having small opacities size P/P in all lung zones, profusion 1/0. He also noted mild thickened interlobar fissure and a calcified granuloma in the right middle lobe. He noted that Petitioner had a previous open-heart surgery, likely a coronary artery bypass. He testified that, based on his review of the chest x-ray, Petitioner had coal worker's pneumoconiosis and had damage to his lung as a result of the disease. PX2.

Dr. Smith testified that from 1988 to 2016, Smith Radiology was a freestanding diagnostic, walk-in medical facility that was netting $1.25 million in annual income after expenses. He testified that, of that income, maybe 5% was for medical legal exams or interpretations. Dr. Smith testified that over time he was interpreting chest x-rays for black lung for over 20 different law firms, and that 80% of these firms represented claimants. He testified that presently he is reviewing films for black lung for five firms that represent claimants, and one of those firms is Petitioner's counsel. He has also reviewed films for Culley & Wissore. He testified that he has read more than 345 films for Petitioner's counsel or Culley & Wissore. He testified that when he received films from Petitioner's counsel, he would get two or three films at a time on a frequency of twice a month, or perhaps slightly more. The medical/legal interpretations he is performing at this time are primarily for the claimant. He testified that at his peak he was interpreting 2,000 films a year for law firms. Presently he is interpreting about 1,500 films a year. PX2.

Dr. Smith testified that has never sat on any committee with NIOSH. He has not held any office in any capacity with either the College of Osteopathic Medicine or the Osteopathic Board of Radiology. He testified that the syllabus he uses to study for the B-reading exam he

"pretty much takes as gospel", and that the panel that puts the syllabus together are the peers that he aspires to be. He noted that the leaders in the field have been chosen to put the syllabus together. He testified that a new syllabus has been authored by NIOSH, and that Dr. Cris Meyer was one of the authors of that syllabus. He testified that he agrees with the current B-reading syllabus, that small opacities associated with the exposure to silica and coal dust are usually rounded. He agreed with the B-reading syllabus that the small rounded opacities usually involve the upper lung zones first and as the dust exposure continues, all the lung zones may become involved. He testified that has been his experience as well. PX2.

Dr. Smith testified that simple pneumoconiosis is unlikely to progress once the exposure ceases. He testified that pulmonary impairment is determined by appropriate valid pulmonary function testing and not by chest x-ray. He explained that when he was deliberating, he considered the film he interpreted of Petitioner as negative for pneumoconiosis. He testified that there was no lower profusion rating that film could have been given and still be positive for pneumoconiosis. PX2.

Dr. Smith did not know whether the monitors he uses for interpreting chest x-rays meet the guidelines that are set forth in the Code of Federal Regulations. He did not know whether the equipment complied with the DICOM standard that is set forth in the Code of Federal Regulations. PX2.

Dr. Cristopher Meyer

Dr. Cristopher Meyer testified by way of deposition on July 15, 2016. He reviewed the PA chest x-ray for Petitioner dated June 15, 2015, from Ferrell Hospital. He testified that the film was diagnostic quality, although it was quality 3 due to low lung volumes or underinflation and mottle. Dr. Meyer testified that mottle gives the radiograph an overall granular appearance and that very fine, sort of grain of sand, granularity is typical of P opacities. The distinction between mottle and P opacities is best made by looking at the entire examination and not just the lung fields, because mottle is a representation of image noise that involves the entire image. That same granularity will be seen in the soft tissue and even in the outside of the chest over the air surrounding the patient. Dr. Meyer testified that the best way to know whether the reader recognized its presence is whether the reader indicated same on the B-reading form. He testified that the film he reviewed was on a CD obtained from the medical provider and noted that anyone obtaining a copy of the CD would be provided with the same data. He testified that he uses a system compliant with all of NIOSH's requirements for the Coal Workers' Health Surveillance Program to interpret chest x-rays. He uses monitors that have a resolution in excess of 2K and that display the full digital DICOM data set. RX1.

Dr. Meyer testified that underinflation results from someone failing to take a full and complete breath. He explained that with digital examinations one can window and level the examination to make it as visually acceptable as possible. With low lung volumes one cannot really do anything other than mentally compensate for same. When a patient does not take a full breath, all of the lung vessels get crowded together, especially the lower lung zones. Dr. Meyer testified that Petitioner's lung volumes were low. There was a single calcified granuloma in the

right upper zone, but no small or large opacities. Dr. Meyer testified that there were no radiographic findings of coal workers' pneumoconiosis. RX1.

Dr. Meyer has been board certified in radiology since 1992, and has been a B-reader since 1999. He testified that he was asked to take the B-reading exam by Dr. Jerome Wiot, who was part of the original committee that designed the teaching course which is called the B-reader program. Dr. Meyer has recently been asked to have a more academic role in the B-reader program. He is on the American College of Radiology Pneumoconiosis Task Force, which is engaged in redesigning the course and submitting cases for the B-reader training module and exam. Dr. Meyer testified that radiologists have a 10% higher pass rate on the B-reading exam than other specialties. He believed it was because radiologists have a better sense of what the variation of normal is. He testified that one of the most important parts of the B-reader training and examination is making the distinction between a 0/1 and 1/0 film. RX1.

Dr. Meyer testified that to become a B-reader one takes a weekend course which includes a series of lectures describing the B-reading classification system. The teachers of the course go through standard examples of the various components of the B-reading system. The course participants then review a series of practice examples, with mentors overseeing the practice examples. Dr. Meyer testified that the faculty is typically experienced senior level B-readers. Generally, one takes the B-reading exam after taking the course. Dr. Meyer testified that the certifying exam is six hours long, with 120 chest x-rays to be characterized. The pass rate of the examination runs roughly 60%. RX1.

Dr. Meyer testified that the B-reader looks at the lungs to decide whether there are any small nodular opacities or linear opacities and, based on the size and appearance of those small opacities, they are given a letter score. He testified that specific occupational lung diseases are described by specific opacity types. Coal workers' pneumoconiosis is characteristically described by small round opacities. Diseases that cause pulmonary fibrosis, like asbestosis, will be described by small linear opacities. The distribution of the opacities is also described, as different pneumoconioses are seen in different regions of the lung. Coal workers' pneumoconiosis is typically an upper zone predominant process. Idiopathic pulmonary fibrosis or asbestosis is a basilar or linear process. The last component of the interpretation is the extent of lung involvement or the so-called profusion. Dr. Meyer testified that the profusion is basically trying to define the densities of the small opacities in the lung. RX1.

Dr. James R. Castle

Dr. James R. Castle testified by way of deposition on June 21, 2018. Dr. Castle is a pulmonologist and is board certified in internal medicine and the subspecialty of pulmonary disease. He practiced in Roanoke, Virginia for 30 years. His practice was limited to pulmonary disease and chest disease, which encompassed critical care medicine, and included treating patients with occupational lung disease. He had some patients in his practice who had coal workers' pneumoconiosis. He was continuously certified as a B-reader from 1985 until June 30, 2017, when he voluntarily let his B-reading certificate lapse. RX2.

At the request of Respondent's counsel, Dr. Castle reviewed medical records and Petitioner's chest x-ray from Ferrell Hospital dated June 15, 2015. Dr. Castle testified that the chest x-ray did not show any findings indicating the presence of coal workers' pneumoconiosis. There was evidence of previous coronary artery bypass grafting and poor inspiration, and he described a calcified granuloma in the right upper lobe. Dr. Castle testified that for a proper reading of a chest x-ray for pneumoconiosis, one first looks at the quality of the film. He explained that grading a film for quality is important, because a lesser quality film may pose more of a challenge in interpretation. In Petitioner's case, Dr. Castle graded the film as a quality 3 because of severe underinflation, which is failure to take a full and complete deep breath. Underinflation makes the film appear too light and makes the film sometimes unclear as to pleural changes that may or may not be present, or may aggravate any pleural changes that are present. It also causes crowding of all the structures in the chest, which tends to highlight the pulmonary vasculature. Grading a film for quality also allows those reviewing the ILO form to know whether the interpreter recognized the film as having quality deficiencies and took those things into account in interpretation of that film. He noted that a poor-quality film can lead to misinterpretation. RX2.

Dr. Castle testified that the reader looks for any parenchymal abnormalities, compares the film to the standard ILO films, and classifies the abnormalities as small, round and regular, or as linear and irregular. Then the reader locates the areas of the lung that are involved. The reader then determines the profusion, which is the density of the lesions in the lung. Dr. Castle testified there is a 12-category profusion scale, so that physicians and epidemiologists and others can talk to each other about a film and know what they are specifically talking about with precision. Under Section 4a of the ILO form, the reader indicates whether there are any other abnormalities on the film. Dr. Castle testified that profusion is important because it tells one the severity of the abnormality. The profusion of 0/1 means that the interpreter found that there were some possible increased opacities that could have been small, round regular, or linear and irregular and that he considered that the film might be abnormal, so he compared it to the 1/1 standard film. If the reader classified the film as 0/1, it meant that he felt it more closely represented 0/0 film, but he also considered the 1/1 film. If the film was classified as a 1/0, then it meant that the reader felt there were more opacities present on the claimant's film than on the 0/0 film. Dr. Castle testified that 0/1 is a negative reading of the film for pneumoconiosis. A reading of 1/0 would be a film of the lowest profusion that could be classified as positive for pneumoconiosis. RX2.

Dr. Castle testified that it was not very likely for simple pneumoconiosis to progress once the exposure ceased. He agreed with the position of the American Thoracic Society that an older worker with a mild pneumoconiosis may be at low risk for working in currently permissible dust exposure levels until he reached retirement age. Dr. Castle testified that the medical records he reviewed for Petitioner did not reveal any pathologic evidence of pneumoconiosis. He testified that there is basically no clinical significance to sub-radiographic pneumoconiosis. RX2.

Dr. Castle concluded that, based upon his review of the data he had, Petitioner did not suffer from any pulmonary disease or impairment occurring as a result of his occupational exposure. Petitioner worked in the mining industry for 34 years and retired in May 2015. Petitioner indicated to Dr. Istanbouly that his last job in mine management required significant physical effort. Dr. Castle testified that it was noteworthy that Petitioner's attending cardiologist

indicated that he should retire because of generalized cardiovascular disease and diabetes which resulted in significant weakness, fatigue, and angina pectoris. Dr. Castle testified that Petitioner's exposure to coal mine dust was sufficient enough to have caused him to develop coal workers' pneumoconiosis if he were a susceptible host. Dr. Castle noted that Petitioner was a lifelong non- smoker. RX2.

Dr. Castle testified that another risk factor for the development of pulmonary symptoms and disease is that of cardiac disease. Petitioner had a very significant degree of coronary artery disease. He underwent coronary artery bypass grafting times five and had a somewhat difficult postoperative course which resulted in bilateral pleural effusions. He also had very significant bilateral atelectasis and/or pneumonia during the postoperative period. He required removal of more than 800 ML of fluid from his left chest. Subsequent chest x-rays showed evidence of reduced volume as well as possible pleural scarring. Dr. Castle testified that these findings were all quite significant, indicating that this would likely be a cause of dyspnea. Petitioner had a mildly reduced left ventricular systolic function with an ejection fraction of about 50%. He had periods of vascular congestion consistent with congestive failure while hospitalized. Dr. Castle testified that the complications from his surgery could certainly result in significant problems with shortness of breath, paroxysmal nocturnal dyspnea, as well as restrictive lung disease. The fluid that occupied the chest could result in scarring and thickening in and around the pleura, which results in a reduction on spirometric findings. Petitioner did not demonstrate any consistent findings indicating the presence of an interstitial pulmonary fibrosis. RX2.

Dr. Castle testified that there were two valid pulmonary function studies in the data set that he reviewed. There was no obstruction noted on either study. There was a reduction of both the forced vital capacity and FEV1 with a normal FEV1 percent. The finding was highly suggestive of a restrictive pulmonary process. The diffusing capacity was essentially normal after correction for alveolar volume. Dr. Castle testified that if there was a significant restrictive process due to coal workers' pneumoconiosis, it would be expected to result in a reduction in the diffusing capacity after correction for alveolar volume. He also testified that if a restrictive process such as seen in Petitioner's case were due to coal workers' pneumoconiosis, there would be a very marked degree of interstitial fibrotic changes on chest x-ray. Those findings were not present in this case. Dr. Castle testified that the fact that the diffusing capacity after correction for alveolar volume was essentially normal, indicates that the restriction was due to an extrinsic process rather than a process occurring in the lung parenchyma or tissue. The restriction that is present is due to scarring from his previous cardiac surgery with resultant pleural effusions that did not totally resolve occurring with probable pneumonia. Dr. Castle testified that it is also possible that Petitioner developed scarring related to congestive changes postoperatively. He that the restrictive changes present on Petitioner's pulmonary function studies were not due to the coal mine dust induced disease, but rather to severe cardiac disease with previous thoracotomy and complications of bilateral pleural effusions with atelectasis. He testified that Petitioner's diffusing capacity performed at Methodist Hospital was reduced, but once it was adjusted for alveolar volume, it was normal. He testified that Petitioner cannot expand his lung because of the things that have been happening around the lungs, but when it is corrected for that volume, the lung itself has a normal capacity to exchange gas. RX2.

Dr. Castle testified that from his review of the medical records, Petitioner did not suffer from chronic bronchitis. He did not see a diagnosis of chronic bronchitis in the medical records that he reviewed. Dr. Castle testified that cough is not considered an objective determinant of pulmonary impairment. Dr. Istanbouly obtained an oral history for Petitioner of his physical capacity declining gradually over the past few years. Dr. Castle testified that was consistent with what was revealed in the treatment records regarding Petitioner's heart disease. RX2.

Dr. Castle described coal workers' pneumoconiosis as a chronic dust disease brought about by the inhalation of coal mine dust over a period of working in or around coal mines. He testified that it is manifested by the presence of an abnormal chest x-ray with small, round regular-type opacities primarily in the upper lung zones but, depending upon the severity, may involve the middle and occasionally the lower lung zones. The disease may or may not be symptomatic. Coal workers' pneumoconiosis is a type of interstitial lung disease. Along with that disease process there is scarring and fibrosis that can occur in the lungs. Dr. Castle testified that the scar tissue cannot carry on the function of normal healthy lung tissue, and that the scarring and fibrosis that occurs with pneumoconiosis is permanent and irreversible. RX2.

Dr. Castle testified that when coal workers' pneumoconiosis manifests itself on pulmonary function, it is usually obstructive, and it can cause a restrictive defect. He testified that one can have coal workers' pneumoconiosis and have a normal chest x-ray. RX2.

Dr. Castle testified that Section 2.3 of the *Guides to the Evaluation of Permanent Impairment, Sixth Edition*, states that the *Guides* are a value only if the medical diagnosis is correct. An incorrect diagnosis leads to an incorrect impairment rating. Dr. Castle testified that with the impairment that the Petitioner has, based on his medical records and testing, Table 5-4 would not be the appropriate table to use for evaluation of the degree of his impairment. He testified that the correct table to use for Petitioner's impairment rating would come under cardiac impairment. He did not know the exact table as he does not provide ratings for cardiac disease very often. RX2.

Primary Care Group

Medical records of Primary Care Group were admitted into evidence. Petitioner was seen on July 23, 2007, regarding his high blood glucose. Review of systems respiratory showed no chronic cough, decreased exercise tolerance or wheezing. On November 19, 2007, Petitioner's review of systems respiratory was negative. His physical examination of the lungs remained normal with no adventitious sounds. On that date he also noted some visual changes. Petitioner was seen regarding elevated blood sugar on December 1, 2009. His review of systems respiratory showed no cough. Physical examination of the lungs was normal. Petitioner underwent a chest x-ray on February 1, 2010, because of cough. A small band of atelectasis was noted in the left lung base. There was no active cardiopulmonary disease. Petitioner was seen in the office that same date reporting that he had had cough for the past several weeks which had been much worse at night. He was also having some chest tightness and mild discomfort. His cough was described as productive of mucoid sputum. Symptoms were associated with chest pain, night sweats and runny nose. Review of systems respiratory showed cough and wheezing. His oxygen saturation was 94% on room air. Physical examination of the chest revealed normal

breath sounds on auscultation and no adventitious sounds. Petitioner was started on Levaquin for acute bronchitis. Petitioner followed up with a cough on February 4, 2010. He reported that he could not stop coughing. Physical examination of the chest was normal. The assessment remained acute bronchitis. Petitioner was seen on March 31, 2010, for follow up of diabetes. He reported that the cough was still present and was characterized as dry. On review of systems respiratory cough was noted, but he did not have difficulty breathing, sputum production or wheezing. Breath sounds were normal on examination. He was again diagnosed with acute bronchitis. When seen on June 30, 2010, and September 29, 2010, Petitioner did not have any pulmonary complaints. His physical examination of the chest was normal on those dates. RX9.

Petitioner was seen on July 12, 2011. Physical examination of the chest was normal. He denied difficulty breathing on exertion. Petitioner was seen on October 11, 2011, with complaints of numbness in the left arm from his hand to his elbow. Physical examination of the chest was normal. Petitioner was seen on March 9, 2012, for recheck of his diabetes. He was complaining of burning above his ankle in both legs. He was receiving shots in his eyes for visual problems due to diabetes. On review of systems he did not have any difficulty breathing or a cough. His lung examination was normal. His diagnosis on that day included diabetes, neuropathy, hyperlipidemia, intermittent claudication and peripheral vascular disease. Petitioner was seen on July 6, 2012, for follow up on hyperlipidemia. His review of systems revealed no difficulty breathing or a cough. His lung examination was normal. On this date he was treated for allergic rhinitis. Petitioner was seen on October 30, 2012, regarding sinus issues. He reported post-nasal drip, sneezing, and nasal stuffiness associated with cough. Review of systems respiratory showed no difficulty breathing or cough. Physical examination of the chest remained normal with no adventitious sounds. He was diagnosed with allergic rhinitis and maxillary acute sinusitis. RX9.

Petitioner was seen on March 6, 2013, with a dry cough. The onset of the cough had been gradual over two months. His review of systems respiratory remained negative. Physical examination of the chest was normal. He was continued on medication for acute maxillary sinusitis. Petitioner was seen on January 23, 2014, regarding his diabetes. He also described an onset of a dry cough that had been gradual and occurring for a couple weeks. Petitioner was seen on March 6, 2014, for transition into care from hospitalization related to his CABG. He did not have any coughing, wheezing or difficulty breathing on exertion. Breath sounds were normal on examination. Petitioner was seen on March 25, 2014, for cold symptoms including sneezing, nasal congestion, runny nose and productive cough. His symptoms did not include wheezing or shortness of breath. Physical examination of the chest was normal with no adventitious sounds. Petitioner was given an antibiotic for sinusitis. Petitioner returned on May 9, 2014, with complaint of acute onset of cough for four days. The cough was productive of mucoid sputum. Same was associated with chest pain. His review of systems respiratory was otherwise negative. Physical examination of the chest showed normal breath sounds. Chest x-ray were performed that day, which showed poor inspiratory effort with mild bi-basilar subsegmental atelectasis and no acute cardiopulmonary process. Petitioner presented with complaint of dry cough on May 28, 2014, which had been occurring in intermittent pattern for two months. He did not have any difficulty breathing. Physical examination of the chest was normal. The assessment was pneumonia involving the left lung. Petitioner underwent a chest x-ray on May 28, 2014, which

revealed no significant change from May 9, 2014. Petitioner had a stable tiny benign calcified granuloma in the right upper lung zone and no acute cardiopulmonary process. RX9.

Petitioner was seen on March 18, 2015, for abdominal pain which included nausea and vomiting with sudden onset three weeks prior. His review of systems respiratory showed no difficulty breathing or cough. Physical examination of the chest was normal with no adventitious sounds. Petitioner was seen on August 25, 2016, with complaints of upset stomach, constipation, and fatigue. His review of systems respiratory was negative for difficulty breathing and cough. His examination of the lungs was normal. His pulse oximetry was 97% on room air. The assessments were acute-on-chronic renal failure, hyperkalemia, diabetes mellitus and hypertension. Petitioner was seen on October 15, 2016, with cough, dyspnea, wheezing and pleuritic chest pain. His review of systems respiratory was negative for any difficulty breathing. His pulse oximetry was 96% on room air. Physical examination of the chest revealed quiet, even, and easy respiratory effort. Assessment was bronchitis. RX9.

Petitioner was seen on February 6, 2017, with hypertension. He had headache, dizziness and shortness of breath. His review of systems respiratory was negative for difficulty breathing and cough. His pulse oximetry was 96% on room air. Physical examination of the chest revealed rales in both lung fields. The assessment was hypertension, arteriosclerotic heart disease and cardiac insufficiency. He was referred to Prairie Heart Cardiology for testing, and EKG done on that day was abnormal. Chest x-ray on that date revealed mild pulmonary edema. Petitioner was seen on March 27, 2017, with flu-like symptoms, including body aches and productive cough. He had no difficulty breathing. His pulse oximetry was 92% on room air. Physical examination of the chest revealed breath sounds were normal. The assessment was influenza. Petitioner was seen on April 21, 2017, for hospital follow up. He had been in the hospital for 20 days for pneumonia/flu and renal failure. On this day, review of systems respiratory was negative for any difficulty breathing and cough. His pulse oximetry was 93% on room air. Physical examination of the chest showed rales in both lung fields. He was on dialysis for his chronic kidney disease. RX9.

Petitioner was seen on January 30, 2019, for sinusitis symptoms including chills, congestion, coughing and sinus pressure. His review of systems was negative for shortness of breath. Productive cough had been present for seven days and had gradually been worsening. His oxygen saturation was 96%. Physical examination pulmonary showed normal effort with no respiratory distress. No wheezing was noted, but he did have some rhonchi. Assessment was acute non-recurrent maxillary sinusitis, bronchitis and acute upper respiratory infection. Petitioner was seen on February 12, 2019, for follow up regarding his diabetes. It was noted that the disease course had been worsening. His review of systems respiratory was negative for cough, shortness of breath and wheezing. Physical examination pulmonary revealed normal breath sounds with no respiratory distress or wheezes. Testing was also ordered for pre-transplant evaluation for kidney transplant. Chest x-ray taken that day revealed cardiomegaly without acute disease in the chest. RX11.

Harrisburg Medical Center

Medical records of Harrisburg Medical Center were admitted into evidence. Petitioner underwent a chest x-ray on January 10, 2003, which was interpreted by Dr. Youssef as having a profusion rating of 0/0. Petitioner had a chest x-ray on June 24, 2008, which showed no active cardiopulmonary disease. Chest x-ray taken February 1, 2010, was compared to the film of June 24, 2008, and again showed no active pulmonary disease. Indication for the chest x-ray was cough. A history and physical dated September 25, 2013, included review of systems respiratory, which revealed no cough or wheeze. On physical examination, the lungs were clear to auscultation. Chest x-ray performed on January 31, 2014, was interpreted as revealing pulmonary hypoaeration, otherwise it was negative. RX5.

Petitioner was seen on September 14, 2016, by Dr. Patrick Riley for epigastric pain. He had a history of coronary artery disease and chronic kidney disease, stage IV. Review of systems respiratory was positive for cough. Physical examination of the chest was positive for rhonchi. Petitioner's O2 saturation was 97%. The assessment was epigastric pain, coronary artery disease, diabetes, influenza type A and B, chronic kidney disease, hyperkalemia, acute kidney injury and DVT. Petitioner was hospitalized from March 30, 2017, to April 3, 2017, for evaluation of epigastric pain. Petitioner had a history of coronary artery disease and coronary artery bypass graft times five in 2014. He declined ischemic evaluation with stress test or cardiac catheterization during this hospitalization. Due to bradycardia, temporary pacemaker was ordered. Petitioner had presented to his primary care provider on the day prior with report of epigastric pain as well as loss of appetite with nausea and vomiting on and off. Other associated symptoms included shortness of breath, dizziness and palpitations. He tested positive for the flu. His review of systems respiratory was positive for cough. On examination his chest was clear to auscultation. His chest x-ray of March 29, 2017, demonstrated new small left basilar infiltrate consistent with pneumonia. Petitioner's discharge diagnoses were epigastric pain resolved, left lobe pneumonia with influenza A and B, coronary artery disease, intermittent bradycardia, hypertension, chronic kidney disease stage IV, left kidney nodule, severe untreated sleep apnea with hypoxia and anemia. Petitioner was noted during the hospitalization to have intermittent and profound hypoxia with apneic episodes. CPAP was prescribed and with same he had no hypoxic events. Petitioner qualified for home oxygen. RX5.

Petitioner underwent a chest CT scan on August 3, 2017. His lungs were clear of active infiltrate. There were small bands of atelectasis versus fibrosis in both lung bases. He had minimal left pleural effusion. There was no pneumothorax or focal lung mass. PX3.

Memorial Hospital of Carbondale

Medical records of Memorial Hospital of Carbondale were admitted into evidence. Petitioner was transferred from the Harrisburg Emergency Department for evaluation of NSTEMI (heart attack) and possible need for intervention on February 1, 2014. Upon arrival at Memorial Hospital of Carbondale, Petitioner reported that he had developed lower extremity edema for the past week which had progressed gradually and also noted facial puffiness as well as mild abdominal distention. Petitioner also mentioned that he was coughing in the middle of the night and producing whitish thin expectoration. He denied any shortness of breath. Physical examination of the lungs showed air entry equal bilaterally and crepitations in the bilateral bases with no wheezes or rhonchi. Petitioner was seen by Dr. Watson, cardiac surgeon, for evaluation

for a myocardial surgical revascularization. On review of systems Petitioner admitted shortness of breath. On examination, his lungs were clear to auscultation. Dr. Watson noted that Petitioner had three vessel coronary artery disease as well as left main coronary artery disease. He had elevated left ventricular and diastolic pressure. Surgical revascularization was recommended. RX6.

On February 3, 2014, Petitioner underwent a coronary bypass graft times five. On February 5, 2014, Petitioner was seen by Dr. Randy Cowart regarding management of acute kidney failure and fluid overload. He had no shortness of breath at that time. Dr. Cowart's assessment was acute renal failure of multifactorial etiology. He noted that Petitioner's initial presentation suggested that he might have some chronic kidney disease. He had diabetes of sufficient duration to put him at significant risk for diabetic neuropathy. Chest x-ray performed on February 6, 2014, showed persistent left lung consolidation and possible pleural effusion. Chest x-ray of February 7, 2014, revealed overall increase in central infiltrates suggesting worsening congestion and atelectasis. Chest x-ray taken on February 8, 2014, showed worsening of pulmonary edema and interval accumulation of minimal pleural fluid. He had bibasilar atelectasis, pneumonia and/or edema. Petitioner's chest x-ray of February 14, 2014, showed increasing density in the left lung suggesting increasing pleural fluid and atelectasis. Pneumonia was not excluded. On the same date, Petitioner underwent ultrasound-guided, left thoracentesis with removal of 860 ccs of maroon fluid. He underwent chest x-ray on February 15, 2014, which revealed slightly improved aeration of the left lung with decreasing pleural fluid and consolidation. Petitioner was discharged to Herrin Acute Rehab in stable condition on February 15, 2014. His principal diagnosis was multi vessel coronary artery disease. Secondary diagnoses were uncontrolled diabetes mellitus, diabetic peripheral neuropathy, hypertension and dyslipidemia. RX12.

Petitioner underwent a cardiac catheterization at Memorial Hospital at Carbondale on August 6, 2015. It was noted that he was well revascularized and had diffuse distal disease that would be treated medically. Indication for the catheterization was history of coronary artery disease and abnormal stress test. Petitioner was hospitalized from April 4, 2017, to April 8, 2017, for weakness, unsteadiness and shortness of breath. It was noted he had recently been hospitalized for respiratory distress and was treated for influenza and pneumonia, and was diuresed where he lost 14 pounds. He was treated for irregular heart rate and was discharged home the previous day on supplemental oxygen via nasal cannula. In the emergency room on this date, his pulse oximetry was in the low to mid 80s on three liters of oxygen which went up to the low 90s after supplemental oxygen was increased to four liters. His review of systems respiratory was positive for cough and shortness of breath. Physical examination respiratory showed coarse breath sounds. Petitioner underwent a chest x-ray on April 4, 2017. The impression was enlarged cardio mediastinal silhouette with pulmonary vascular indistinctness and small effusions suggestive of congestive heart failure exacerbation of mild pulmonary edema. Atypical infection/pneumonia was also considered. Petitioner was seen on April 4, 2017, for nephrology management. Petitioner reported that he had lung disease but there was no documentation of same in his records and Petitioner was not seeing a pulmonologist. His review of systems respiratory was positive for cough and shortness of breath. Physical examination of the lungs showed breath sounds that were diminished throughout with no wheezes, crackles or rales. The discharge diagnoses were acute-on-chronic kidney disease, uncontrolled diabetes

mellitus, bilateral lower lobe pneumonia, acute decompensated heart failure, elevated troponin level, essential hypertension, gastroesophageal reflux disease, anemia secondary to chronic kidney disease and hyperkalemia. Examination of the lungs showed they were clear to auscultation with no wheeze or crepitations. RX12.

Petitioner was seen on April 27, 2017 for construction of a permanent dialysis access. Review of systems respiratory was negative for dyspnea. His examination respiratory showed normal auscultation and effort. Chest x-ray on June 2, 2017, showed no acute cardiopulmonary findings. Petitioner was admitted to the hospital from September 16, 2017, to September 27, 2017. The history and physical noted that two weeks prior he underwent an uneventful laparoscopic cholecystectomy. A few days later, he developed abdominal pain, with evidence of abdominal fluid on CT scan, and was transferred to St. Louis University. He underwent an ERCP which showed a cystic stump leak, and a stent was placed. He returned to Memorial Hospital that date with abdominal pain, elevated white count, diaphoresis and a mesenteric edema and small fluid collections in the right abdomen on CT scan. His review of systems respiratory was negative for apnea, shortness of breath and stridor. On examination, his respiratory effort was normal, as were his breath sounds. He was in no respiratory distress. Infectious disease was consulted and an antibiotic was prescribed. Petitioner was also having some episodes of delirium and hallucinations and confusion, which was worse on pre-dialysis and post-dialysis days. RX12.

Petitioner was admitted to the hospital again from October 3, 2017, to October 6, 2017, with abdominal pain. He had a mid-abdominal drain in place. A second drain was placed to drain what appeared to be infected bile from the right lower quadrant. Petitioner's condition improved with antibiotics. His discharge diagnoses included intraabdominal abscess, chronic anemia, chronic obstructive lung disease, end stage renal disease, type II diabetes mellitus, essential hypertension, mixed hyperlipidemia, GERD and status post CABG times five. RX12.

Petitioner was admitted to the hospital overnight on October 14, 2017. He had multiple intraabdominal abscesses resulting from bile leak and pancreatitis as well as bloodstream infections. He was seen by his doctor on this date and was sent to the emergency room due to severe hyperglycemia. He did not have any shortness of breath or new cough. He underwent chest x-ray on October 15, 2017, which showed marked cardiomegaly. Atelectasis could not be excluded in the left lung base. PX12.

Petitioner was hospitalized from October 18, 2017, to October 20, 2017, with a chief complaint of abdominal pain. Review of systems respiratory was negative for apnea, shortness of breath or stridor. His oxygen saturation was 96%. Physical examination pulmonary showed normal effort and breath sounds. He had no respiratory distress. Petitioner was noted to have end stage renal disease. Petitioner underwent a cardiac stress test on February 27, 2018, as part of his preoperative evaluation for kidney transplant. RX12.

SIH Medical Group

Medical records of SIH Medical Group were admitted into evidence. Petitioner was seen on February 25, 2014, for post op visit. He was status coronary artery bypass graft times five.

His respiratory review of systems was positive for cough and dyspnea. On examination his lungs were clear to auscultation and his respiratory effort was normal. It was noted that Petitioner was doing well overall. Petitioner was seen again on March 11, 2014, for follow up from his CABG. Petitioner was doing well overall and had no dyspnea. On physical examination his lungs were clear to auscultation and his respiratory effort was normal. He was seen on August 26, 2014, complaining of a small hernia at the distal end of sternotomy incision. His physical examination respiratory was normal. Petitioner was scheduled for surgery to repair the hernia. RX7.

Prairie Cardiovascular Consultants

Medical records of Prairie Cardiovascular Consultants were admitted into evidence. Petitioner underwent a heart catheterization study and intravascular ultrasound of the LAD on February 1, 2014. Based on these studies, cardiovascular surgery consultation for coronary artery bypass graft surgery was recommended. He was seen on March 28, 2014, for follow up on coronary artery disease. He had been enrolled in cardiac rehab and was doing well with that. He was released to return to work in mid-April 2014. On review of systems respiratory he denied chronic cough. His chest was clear to auscultation. Petitioner was seen on July 11, 2014. He had developed cough that the doctor suspected was probably secondary to ace inhibitors. He also had an area that protruded in the bottom part of his incision from the cardiac surgery. Review of systems respiratory revealed that Petitioner complained of cough at night. His O2 saturation was 98%. Chest was clear to auscultation. Dr. Falcone discontinued the Lisinopril because it was producing cough. Petitioner returned to Dr. Falcone on August 8, 2014. He denied shortness of breath. He was continuing to complain of cough at night. His O2 saturation was 96%. Physical examination respiratory showed a clear chest. Petitioner was referred back to Dr. Watson for evaluation of the hernia in the lower part of his sternum. RX4.

Petitioner was seen on June 2, 2015. He reported that he had recently been let go from his job due to severe weakness and fatigue. He reported episodes where he would wake up in the night with shortness of breath and chest pain. Review of systems respiratory continued to show complaint of cough at night. His chest was clear to auscultation. Dr. Falcone ordered a treadmill stress test and echocardiogram. He was seen on September 11, 2015, in follow up to the cardiac catheterization performed on August 6, 2015. All bypasses were noted to be patent, but he had severe diffuse distal disease that was not amenable to percutaneous intervention. Dr. Falcone noted that he had compromise of his kidneys and eyes from uncontrolled diabetes, that he was constantly tired, and that he had angina with minimal activities. He was not able to continue working and was planning for disability. On review of systems respiratory he denied chronic cough. Physical examination respiratory revealed the chest to be clear to auscultation. His diagnoses included coronary artery disease, diabetes mellitus, status post CABG, dyslipidemia, hypertension and carotid disease/stenosis. RX4.

Petitioner was seen on March 22, 2017, for complication regarding his coronary artery disease. Petitioner reported that he had been having significant amount of shortness of breath, nausea and some chest tightness and pressure. He reported that the shortness of breath had worsened over the past couple weeks. He was also working with his nephrologist due to stage IV renal disease. On this date his review of systems was positive for shortness of breath and negative for coughing and wheezing. Petitioner underwent a CT of the abdomen and pelvis on

April 5, 2017. It revealed bilateral pleural effusions with overlying atelectasis and developing consolidation in the lung bases, left greater than right. Image findings were consistent with pneumonia. Petitioner was seen for a cardiac consultation on April 5, 2017, for evaluation of congestive heart failure and elevated troponin. The plan was to continue with medical therapy with no plans for immediate left cardiac catheterization. RX4.

Petitioner was seen on August 30, 2017, for preop examination prior to GI surgery. Review of systems respiratory was negative. His oxygen saturation was 98%. On examination his breath sounds were normal, and he had no respiratory distress. He was seen for six-month follow up on April 19, 2018. It was noted that from a cardiology standpoint, he was doing quite well. He was seeking a kidney transplant at Barnes Jewish in St. Louis. Review of systems respiratory remained negative. Petitioner was seen on October 18, 2018. He was noted to have renal failure and was on dialysis three days per week. Review of systems was positive for shortness of breath but negative for cough. His oxygen saturation was 98%. Physical examination pulmonary showed normal effort and normal breath sounds. There was no respiratory distress. He was to continue with optimal medication therapy for his coronary artery disease. Petitioner was seen on February 26, 2019, for an echocardiogram for preoperative transplant evaluation. This was noted to be an abnormal Dobutamine stress echocardiogram, suggestive of coronary artery disease. RX4.

Dr. Carlos Rendon

Medical records of Dr. Carlos Rendon were admitted into evidence. Petitioner was seen on September 22, 2014, for post op follow up from open repair of an incisional ventral hernia and implantation of mesh on September 17, 2014. His review of systems respiratory was negative for cough and dyspnea. His respiratory examination was normal. Petitioner was released to return to work as of September 29, 2014, with no lifting over 20 pounds. Petitioner was seen for another post-op visit on October 9, 2014. His activity level was back to preoperative level. Review of systems respiratory showed no cough or dyspnea. He was released to follow up as needed. RX8.

Social Security Disability

Petitioner's Social Security Disability file was admitted into evidence. In his Disability Report, Petitioner listed physical or mental conditions that limited his ability to work as follows: diabetes, hypertension, problems standing/pass out, shingles, heart problems/prior heart attacks/surgeries, abdominal hernia, macular degeneration, fall asleep frequently any time of day, neuropathy in feet, borderline kidney failure and stomach problems. Petitioner indicated that he stopped working on May 23, 2015, because of these conditions. In the same report it was indicated that he was fired due to these conditions. He also stated that he could not lift anything over four pounds because of his heart attack. On the Disability Determination and Transmittal, the primary diagnosis was listed as chronic ischemic heart disease with or without angina. With regard to a secondary diagnosis, none was listed, and it was noted "none established". The disability was stated to have begun on May 23, 2015. RX10.

CONCLUSIONS OF LAW

The Arbitrator hereby incorporates by reference the above Findings of Fact, and the Arbitrator's and parties' exhibits are made a part of the Commission's file. After review of the evidence and due deliberations, the Arbitrator finds on the issues presented at trial as follows.

In support of the Arbitrator's decision relating to issue (C), whether an occupational disease occurred that arose out of and in the course of Petitioner's employment by Respondent, and issue (F), whether Petitioner's current condition is causally related to the injury, the Arbitrator finds the following:

To recover compensation under the Workers' Occupational Diseases Act, a claimant must prove that he suffers from an occupational disease and that a causal connection exists between the disease and his employment. An occupational exposure need not be the sole or principal causative factor, as long as it was a causative factor in the condition of ill-being. *Bernardoni v. Industrial Comm'n*, 362 Ill.App.3d 582, 596 (3rd Dist. 2005).

In this case, the Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that he suffers from coal workers' pneumoconiosis. In so concluding, the Arbitrator finds the B-reading interpretations and opinions of Drs. Meyer and Castle to be more persuasive than the B-reading by Dr. Smith. The Arbitrator gives no weight to Dr. Istanbouly's chest x-ray interpretation, because in his testimony he did not properly describe the findings of the x-ray to be a useful interpretation, and failed to recognize the quality deficiency recognized by all others who interpreted same.

The only chest x-ray interpreted by the experts retained by the parties to this case was taken on June 15, 2015. Dr. Meyer and Dr. Castle found this chest x-ray to be quality 3. Both noted underinflation. Dr. Meyer also noted mottle. Dr. Smith found the film to be quality 2 due to underinflation. Dr. Smith, however, did not take into account the mottle which appeared on the chest x-ray. Dr. Meyer testified that mottle can simulate small round opacities which was what Dr. Smith described as seeing on Petitioner's chest x-ray.

Dr. Meyer's expertise as a B-reader has been recognized by his peers, as he has been asked to have a more academic role in the B-reader training course. Dr. Meyer testified that the faculty for the B-reading course are generally senior-level B-readers. Furthermore, Dr. Meyer is on the College of Radiology Pneumoconiosis Task Force which is engaged in redesigning the course and submitting cases for the B-reading training module and exam. Dr. Smith has never sat on any committee with NIOSH or held any office in any capacity with either the College of Osteopathic Medicine or the Osteopathic Board of Radiology. Dr. Smith testified that the panel that puts together the syllabus for the B-reading exam are the peers that he aspires to be. He testified that the leaders in the field are chosen to put the B-reading syllabus together. Dr. Meyer is one of the authors of that syllabus. The B-readings of Dr. Meyer and Dr. Castle of the x-ray of June 15, 2015, are consistent with the chest x-ray interpretations contained in the treatment records. Petitioner's treatment records contained a number of chest x-ray interpretations throughout the years. None of these chest x-rays were ever interpreted as positive for coal workers' pneumoconiosis. There was nothing in the treatment records indicating that Petitioner

suffered from an occupational disease. Petitioner's current condition of ill-being is caused by his cardiac disease and chronic renal failure which are not causally related to his coal mine dust exposure.

Dr. Istanbouly testified that the results of the pulmonary function tests performed as part of his examination showed a moderate non-specific ventilatory limitation. He testified that the meaning of those results was unclear, but he related this moderate non-specific ventilatory limitation to coal dust inhalation. There were two pulmonary function studies in the data set that Dr. Castle reviewed. He testified that both studies appeared to be valid, and that no obstruction was revealed on either study. The diffusing capacity was essentially normal after correction for alveolar volume. The test results were highly suggestive of a restrictive pulmonary process. Dr. Castle testified that if there was a significant restrictive process due to coal workers' pneumoconiosis, it would be expected to result in a reduction of the diffusing capacity after correction for alveolar volume. Dr. Castle testified that the fact that the diffusing capacity after correction for alveolar volume was essentially normal, indicates that the restriction was due to an intrinsic process rather than a process occurring in the lung parenchyma. Dr. Castle related the restriction to the scarring from Petitioner's previous cardiac surgery.

Based upon the foregoing and the record in its entirety, the Arbitrator finds that Petitioner failed to prove by a preponderance of the evidence that he suffers from coal workers' pneumoconiosis and/or reduced pulmonary capacity or symptoms that arose out of and in the course of his exposure in the coal mine, and that his current condition of ill-being is causally related to his employment. All benefits are denied. The remaining issues are moot, and the Arbitrator makes no conclusions as to these issues.

STATE OF ILLINOIS)
) SS.
COUNTY OF MCLEAN)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JoAnn Ferguson,

Petitioner,

20IWCC0068

vs.

NO. 14WC 27182

Exelon Corporation,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petitions for Review having been filed by the parties herein and proper notice given, the Commission, after considering the issues of causal connection, 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 March 4, 2019 is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $75,000.00.

Bibliography

20IWCC0068

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

DATED: JAN 29 2020
SJM/sj
o-1/21/2020
44

Stephen J. Mathis

Deborah L. Simpson

Douglas D. McCarthy

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

FERGUSON, JoANN
Employee/Petitioner

Case# **14WC027182**

EXELON CORPORATION
Employer/Respondent

20IWCC0068

On 3/4/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.45% 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:

1608 MOSS & MOSS PC
DAVID MOSS
122 WERNER CT
CLINTON, IL 61727

0264 HEYL ROYSTER VOELKER & ALLEN
DANA J HUGHES
PO BOX 6199
PEORIA, IL 61601-6199

20IWCC0068

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

JoAnn Ferguson
Employee/Petitioner

v.

Exelon Corporation
Employer/Respondent

Case # **14** WC **27182**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Bloomington**, on **January 24, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **July 15, 2014**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did*** 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.

Per the *Stipulation to Amend Arbitrator's Exhibit 1*, in the year preceding the injury, Petitioner earned **$65,445.12**; the average weekly wage was **$1,258.56**.

On the date of accident, Petitioner was **58** years of age, ***single*** 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 **$26,006.83** for TTD, **$0** for TPD, **$0** for maintenance, **$20,162.10** in non-occupational indemnity disability benefits (*i.e.*, long term disability benefits) and **$0** for other benefits, for a total credit of **$46,168.93**.

Respondent is entitled to a credit for medical bills paid in the amount of **$ALL AMOUNTS PAID** through its group medical plan for which credit may be allowed under Section 8(j) of the Act.

The Arbitrator finds that Petitioner ***has not*** exceeded her choice of physicians under Section 8(a) of the Act.

ORDER

Respondent shall pay the reasonable and necessary medical services as included in **Petitioner's Exhibit 13** as provided in Sections 8(a) and 8.2 of the Act. Respondent is to hold Petitioner harmless for any claims for reimbursement from any health insurance provider and shall provide payment information to Petitioner relative to any credit due. Respondent is to pay unpaid balances with regard to said medical expenses directly to Petitioner. Respondent shall pay any unpaid, related medical expenses according to the fee schedule and shall provide documentation with regard to said fee schedule payment calculations to Petitioner. Respondent is entitled to a credit for all benefits paid under its group health plan under Section 8(j) of the Act.

Respondent shall pay Petitioner temporary total disability benefits of **$839.04/week** for **67 3/7 weeks**, for the timeframe of **July 16, 2014 through October 31, 2015,** as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of **$735.37/week** for **150 weeks**, because the injuries sustained caused **30% loss of the person-as-a-whole**, as provided in Section 8(d)2 of the Act.

Respondent shall be given a credit of **$26,006.83** for TTD, **$0** for TPD, **$0** for maintenance, **$20,162.10** in non-occupational indemnity disability benefits (*i.e.*, long term disability benefits) and **$0** for other benefits, for a total credit of **$46,168.93**.

Respondent is entitled to a credit for medical bills paid in the amount of **$ALL AMOUNTS PAID** through its group medical plan for which credit may be allowed under Section 8(j) of the Act.

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

20IWCC0068

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

Melinda M. Rowe-Gillivan
Signature of Arbitrator

2/28/19
Date

ICArbDec p. 2

MAR 4 - 2019

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

JoAnn Ferguson
Employee/Petitioner

Case # **14** WC **27182**

v.

Consolidated cases: **N/A**

Exelon Corporation
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that on July 15, 2014, she was employed by Respondent and that she had been employed by Respondent since August of 1989. Petitioner testified that her job duties involved the cleaning of tools and equipment in a decontamination process.

Petitioner testified that on July 15, 2014, she was working in the decontamination room. She testified that she was lifting a piece of equipment from a bin and that the equipment being lifted from the bin was that of a "RAD" gun. Petitioner described the RAD gun as a pneumatic drill-like device, which was attached to wire leads and a control box. She testified that the equipment she was lifting at the time of the accident was contained in a decontamination bag, and she estimated the weight of the bag to be approximately 70-75 pounds. She testified that the bag containing the RAD gun, lead and control box was in a bin which was approximately waist-high. She testified that she reached into the bin and that as she was pulling the bag up and straightening her back and lifting the approximately 75-pound weight, she felt a pop on the right side of her low back and pain radiating into her right buttocks and right leg.

Petitioner denied having ever injured her low back while working for Respondent prior to the accident at issue. Petitioner denied having received any treatment or having had any problems or complaints with her low back prior to the accident at issue. Petitioner further denied having been injured in any other kind of accident like a slip and fall.

Petitioner testified that after the Section 12 IME with Dr. deGrange, she stopped receiving temporary total disability benefits as of February 28, 2015. She testified that with the termination of temporary total disability benefits, she began receiving long-term disability benefits through Respondent. She testified that in July 2015, she received a letter from the Social Security Administration indicating that she was being awarded Social Security Disability benefits. She further testified that she was not immediately eligible for Medicare, and that she was unable to recall the date on which she became eligible for Medicare. Petitioner further testified that she retired from Respondent on October 31, 2015.

Petitioner testified that following surgery by Dr. Butler, she could finally lay in bed instead of on the floor. She testified that she felt better. When asked if she was suffering from any other medical conditions or physical ailments recently, Petitioner responded in the affirmative and stated that she underwent shoulder surgery in October 2017, that in April of 2018 she underwent additional shoulder surgery and that in October of 2018, she underwent a right knee replacement.

Petitioner testified that she is currently receiving Social Security Disability benefits. Petitioner testified that she is not working, nor has she looked for work since she retired from Respondent. Petitioner testified that she can do all activities of daily living, but can no longer go backpacking. Petitioner complains of pain in her back, which she associates with an unrelated knee condition.

The Photograph of Bin/RAD Gun was entered into evidence at the time of arbitration as Petitioner's Exhibit 1.

The medical records of DMH Corporate Health Services were entered into evidence at the time of arbitration as Petitioner's Exhibit 2. The records reflect that Petitioner was seen on July 15, 2014, at which time it was noted that she was lifting something from a bin when she felt a pop/pain in the bottom area of her butt. It was noted that Petitioner worked for Clinton Power Station where she worked as a support worker decontaminating equipment, that she reported an injury occurring that day at 9:00 a.m., that she reported that she was working in the decontamination room and was getting a piece of equipment weighing 75 pounds out of a bin waist-high so she had to bend over and get the equipment out of the bin and that she reported that as she was doing this, she went to pull up/straighten her back lifting the equipment and that she felt a pop on her right side of her low back and into the right buttocks. It was noted that Petitioner's daughter was with her at the visit and that she reported that while she went to the restroom that she was also having pain in the hamstrings, though maybe she meant the quadriceps muscles, and that Petitioner denied this pain, reporting the main area of pain in the right buttocks with radiation of pain in the low back and hip/thigh region, right side only, but pinpointed significant pain in the right buttocks over the gluteus maximus making a simple muscle strain most likely. It was noted that some findings at the visit were concerning for symptom magnification with significant pain despite stable blood pressure and that the pain story kept changing to different areas. It was noted that Petitioner was not agreeable at first to just having a simple muscle strain so further imaging and use of an anatomy book to show her components of pelvic/hip area had to be demonstrated. It was also noted that after showing Petitioner diagrams she seemed to understand and agreed to the plan of care for a muscle strain, but was not in agreement with returning back to regular work duties due to injury. It was noted that no follow-up was necessary and that it may be appropriate to review with Petitioner the proper ergonomics of lifting heavy objects again to avoid future injuries related to lifting. It was noted that x-rays of the sacrum coccyx performed on July 15, 2014 were interpreted as revealing no fracture and degenerative joint disease; similarly, x-rays of the lumbar spine also performed on July 15, 2014 were interpreted as revealing no fracture and diffuse degenerative joint disease. The diagnosis was noted to be that of right-side hip strain/right-sided muscle strain of the gluteus maximus. Petitioner was given a prescription for Ibuprofen and was recommended to use ice/heat for up to 20 minutes up to 2-3 times per day. It was noted that no follow-up was recommended and that Petitioner's symptoms should improve over the next 1-2 weeks. Petitioner was allowed to return to work regular duty. (PX2).

The medical records of Clinton Internal Medicine/Dr. Kureishy were entered into evidence at the time of arbitration as Petitioner's Exhibit 3.[1] The records reflect that Petitioner was seen on July 19, 2014, at which time it was noted that the chief complaint was that of low back pain, that she pulled a hamstring at work on Tuesday, that she felt tingling and numbness on the foot and a lot of pain in the back of the leg, and that she was seen at DMH and the diagnosis was right side muscle strain of gluteus maximus. It was also noted that Petitioner had buttock pain and right hamstring pain, that she said she was reaching into a bin to pull a rad gun out that was in a bag and felt a pop and was in severe pain, and that she strained her lower buttock/upper leg. It was noted that Petitioner stated that the pain was radiating to the back of the knee and that her toes were numb. The assessment was noted to be that of right lower back pain. Petitioner was given Dexa and Toradol injections and started on Celebrex. It was noted that Petitioner was to be off work for one week, that she was to take Hydrocodone, Diazepam and Prednisone, and that she was

[1] Any highlighting that appears in the exhibit was not made by the Arbitrator.

suggested to undergo physical therapy. A work slip was issued on July 19, 2014, indicating that Petitioner was to be off work July 19, 2014 through July 25, 2014. (PX3).

The records of Clinton Internal Medicine reflect that Petitioner was seen on July 25, 2014, at which time it was noted that she was seen in follow-up for low back pain. It was noted that Petitioner was seen by a worker's compensation physician in Joliet and had been released to return to work on Tuesday and that she was in a lot of pain and was unable to sit straight. The assessment was noted to be that of right low back pain. Petitioner was recommended to undergo physical therapy and to remain off work for a week. It was noted that an MRI of the lumbosacral spine was under consideration. A work slip was issued on July 25, 2014, indicating that Petitioner was to be off work July 25, 2014 through August 1, 2014. At the time of the August 1, 2014 visit, it was noted that Petitioner had had an MRI done on July 31, 2014 and that the results were not back. It was noted that Petitioner was in a lot of pain, that she was unable to sit straight, that the pain was radiating to the back of the knee, and that her toes were numb. The assessment was noted to be that of right lower back pain. Petitioner was recommended to continue medications, to undergo physical therapy and to remain off work for another week. A work slip was issued on August 1, 2014, indicating that Petitioner was to be off work August 1, 2014 through August 8, 2014. At the time of the August 8, 2014 visit, it was noted that the MRI showed mild degenerative disk disease and mild foraminal stenosis. It was noted that Petitioner was in a lot of pain more with sitting, that she was unable to sit straight and that she sat on the left buttock. The assessment was noted to be that of right lower back pain. It was noted that physical therapy had not been started and that Petitioner was recommended to continue her medications. A work slip was issued on August 8, 2014, indicating that Petitioner was to be off work August 8, 2014 through August 18, 2014. (PX3).

The records of Clinton Internal Medicine reflect that Petitioner was seen on August 18, 2014, at which time it was noted that she was in a lot of pain, that she was unable to sit straight and sat on the left buttock, and that she stated there was radiation to the back of the knee and that her toes were numb. The assessment was noted to be that of right lower back pain. Petitioner was recommended to continue medications. It was noted that physical therapy had not been started. It was also noted that Petitioner was referred to Dr. Rehman [*sic*], a neurosurgeon. A work slip was issued on August 18, 2014, indicating that Petitioner was to be off work August 18, 2014 through August 25, 2014. At the time of the August 25, 2014 visit, it was noted that Petitioner was seen for low back pain and that she also needed her "regular med refills." It was noted that Petitioner continued to be in a lot of pain, that she was unable to sit straight, and that she sat on the left hip with the right leg outstretched. It was noted that Petitioner stated that the pain medication and muscle relaxants helped and that she was seeing the company doctor the following Tuesday. It was noted that Petitioner was recommended to consult with Dr. Rehman [*sic*]. It was also noted that Petitioner was also recommended to call for physical therapy approval and that she was to undergo an MRI of the right thigh for her hamstring. A work slip was issued on August 25, 2014, indicating that Petitioner was to be off work August 25, 2014 through September 8, 2014. (PX3).

The records of Clinton Internal Medicine reflect that Petitioner was seen on August 26, 2014 for hypertension and a "med check." Petitioner was recommended to monitor her blood pressure and to lose weight. Included within the records of Clinton Internal Medicine was an interpretive report for an MRI of the lumbar spine performed on July 31, 2014 at Eastland Open MRI, which was interpreted as revealing multilevel degenerative bulging/protruding discs accompanying facet degeneration; moderate central canal compromise greater eccentric to the right at L4-5; moderate foraminal compromise bilaterally L4-5 and L5-S1. At the time of the September 8, 2014 visit, it was noted that Petitioner had thigh pain and was awaiting an MRI of the right thigh to be done on September 12th, that she had right-sided back pain radiating down to the right hamstring to the back of the knee, and that her toes were numb. It was noted that Petitioner continued to be in a lot of pain, that she was unable to sit straight, that she sat on the left hip with the right leg outstretched, and that her back burned if she sat straight for 10 minutes. It was noted that physical therapy was to start on Friday, that Petitioner was recommended to call for approval for a consultation with

a neurosurgeon, and that she was to undergo an MRI of the right thigh. A work slip was issued on September 8, 2014, indicating that Petitioner was to be off work September 8, 2014 through September 22, 2014. (PX3).

Included within the records of Clinton Internal Medicine was a note dated September 9, 2014 from HSHS Medical Group/Neurosurgical & Orthopedic Surgery, at which time it was noted that Petitioner was seen for evaluation of low back pain that radiated down her right posterior lower extremity. It was noted that complained of numbness in the right foot, that she was injured at work lifting items out of a bin and that she was to start physical therapy that week. It was noted that Petitioner had not tried epidural injections and that she was taking Norco, Diazepam and Celebrex for pain. It was noted that Petitioner's pain started on July 15, 2014, that her symptoms had not improved and that her main complaint was right lateral thigh pain. The assessment was noted to be that of lumbago and lumbar radiculopathy. It was also noted that Petitioner's pain was in the right L5/S1 distribution, that her symptoms had been present for the past two months, and that it had been progressively getting worse. It was noted that Petitioner had tried multiple medications without any benefit and that her symptoms suggested a disc herniation, but that her MRI did not reveal any gross surgical pathology. Petitioner was recommended to undergo another MRI of the lumbar spine as it was possible that she had had a new ruptured disc since her previous MRI. (PX3).

Included within the records of Clinton Internal Medicine was a note dated September 16, 2014 from HSHS Medical Group/Neurosurgical & Orthopedic Surgery, at which time it was noted that Petitioner was seen to review her recent MRI. It was noted that Petitioner continued to report low back pain that radiated down the right posterior lower extremity, that she denied any changes since she was evaluated last week, and that she had not tried any physical therapy or injections. It was noted that Petitioner was currently taking Norco for pain. The assessment was noted to be that of (1) lumbar radiculopathy; (2) lumbago. It was noted that the repeat MRI showed no gross surgical pathology, that there was no disc herniation, that Dr. Rahman did not see any surgical pathology, and that he recommended referral to pain management for epidural and transforaminal injections. It was noted that physical therapy would not help Petitioner and that if injections failed to relieve her symptoms, she may be a candidate for decompressive exploratory foraminotomy at L4-L5 and L5-S1 on the right. (PX3).

The records of Clinton Internal Medicine reflect that Petitioner was seen on September 22, 2014, at which time it was noted that she had seen Dr. Rehman [*sic*] and was seeing pain management at St. Mary's Hospital on October 13, 2014. It was noted that Petitioner had undergone a repeat MRI and was not a candidate for surgery at that time, and that if pain management did not help she may be a candidate for exploratory lumbar foraminectomy at L4-L5 and L5-S1 levels. Petitioner was also given a flu shot on that date. At the time of the October 7, 2014 visit, it was noted that Petitioner's back pain was increasing that day and that she was seeing the company doctor the next week. It was noted that Petitioner was waiting to be seen at the pain clinic. It was noted that Petitioner had right-sided back pain radiating down to the right hamstring to the back of the knee, and that her toes were numb. Petitioner was instructed to continue her medications. At the time of the October 21, 2014 visit, it was noted that Petitioner had been seen in the pain clinic and had been scheduled for steroid injections on November 4, 2014 in Decatur. A work slip was issued on October 21, 2014, indicating that Petitioner was to be off work October 21, 2014 through November 4, 2014. (PX3).

The records of Clinton Internal Medicine reflect that Petitioner was seen on November 4, 2014, at which time it was noted that she was to go to the pain clinic on that date to get steroid injections in Decatur. It was also noted that Petitioner noticed a lump in her right thigh posterolaterally in the lower third of the thigh. It was noted that Petitioner continued to be in a lot of pain, that she was unable to sit straight, that she sat on the left hip and leaned back with the right leg outstretched, and that she had been told that she did not need physical therapy. A work slip was issued on November 4, 2014, indicating that Petitioner was to be off work November 4, 2014 through November 18, 2014. At the time of the November 18, 2014 visit, it was noted that Petitioner stated that she had had two "shots" in the back with the pain clinic and

that she stated that it made it worse for her. It was noted that Petitioner had right-sided back pain radiating down to the right hamstring to the back of the knee, and that her toes were numb. Petitioner was recommended to continue her medications and was given a prescription for Hydrocodone. A work slip was issued on November 18, 2014, indicating that Petitioner was to be off work November 18, 2014 through December 1, 2014. (PX3).

The records of Clinton Internal Medicine reflect that Petitioner was seen on November 25, 2014 for a regular check-up. It was noted that Petitioner's blood pressure was high on that date. At the time of the December 1, 2014 visit, it was noted that Petitioner stated that she had had three "shots" in the back with the pain clinic and that the next series was to start in the morning. It was noted that the "shots" did not help and made it worse for her. A work slip was issued on December 1, 2014, indicating that Petitioner was to be off work December 1, 2014 through January 2, 2015. At the time of the January 6, 2015 visit, it was noted that Petitioner was status post three "shots" in the back with the pain clinic and that there was no improvement. A work slip was issued on January 6, 2015, indicating that Petitioner was to be off work January 5, 2015 through February 6, 2015. At the time of the January 19, 2015 visit, Petitioner was seen for pre-operative clearance. It was noted that Dr. Rehman [*sic*] was to do the surgery and that they had been waiting on worker's compensation for approval. It was also noted that there had been no improvement in the pain. At the time of the February 5, 2015 visit, it was noted that Petitioner awaited surgery and needed to be "okayed" with worker's compensation. A work slip was issued on February 5, 2015, indicating that Petitioner was to be off work February 5, 2015 through March 6, 2015. (PX3).

The records of Clinton Internal Medicine reflect that Petitioner was seen on February 23, 2015, at which time she was seen for hypertension and a three-month check-up. At the time of the March 6, 2015 visit, it was noted that Petitioner was seen for a check-up and that her worker's compensation had been stopped. A work slip was issued on March 6, 2015, indicating that Petitioner was to be off work March 6, 2015 through April 7, 2015. At the time of the April 7, 2015 visit, it was noted that Petitioner had been in a lot of pain and was unable to sit upright. It was noted that surgery had been declined and that Petitioner was to do physical therapy for three months. It was noted that Petitioner had had two "shots" in the back with the pain clinic, that she continued to be in a lot of pain, that she was unable to sit straight and that she sat on the left hip and leaned back with the right leg outstretched and extended. It was also noted that physical therapy was to be started at John Warner Hospital. Petitioner was given a prescription for Hydrocodone. A work slip was issued on April 7, 2015, indicating that Petitioner was to be off work April 7, 2015 through May 6, 2015. At the time of the April 23, 2015 visit, it was noted that Petitioner needed referrals. It was noted that Petitioner's surgery had been declined twice, that she was unable to sleep well, that she did physical therapy for three weeks with worsening of symptoms, and that she had had two "shots" in the back with the pain clinic. It was noted that Petitioner wanted a second opinion and that she was to be sent to Dr. Espinoza in Springfield or Dr. Nardoni in Bloomington. It was noted that Petitioner was checking with insurance and her lawyer, and was to let Dr. Kureishy's office know to schedule. (PX3).

The records of Clinton Internal Medicine reflect that Petitioner was seen on May 6, 2015, at which time it was noted that she had chronic back pain following an injury at work in July 2014, that she continued to be in a lot of pain, that she was unable to sit upright and that she sat on her left hip and leaned back with the right leg extended. It was noted that surgery had been declined twice by the insurance company, that Petitioner could not sleep well, that she did physical therapy for three weeks with worsening of her symptoms, and that she had had two "shots" in the back with the pain clinic. It was also noted that Petitioner had been off work for the last 10 months. It was noted that Petitioner wanted a second opinion and that she would be sent to Dr. Nardoni in Bloomington for a second opinion regarding surgery. A work slip was issued on May 6, 2015, indicating that Petitioner was to be off work May 6, 2015 through June 9, 2015. At the time of the June 9, 2015 visit, it was noted that Petitioner was seeing Dr. Amin to get a second opinion regarding surgery. A work slip was issued on June 9, 2015, indicating that Petitioner was to be off work June 9, 2015 through July 9, 2015. At the time of the July 9, 2015 visit, it was noted that Petitioner had a

second opinion on surgery, that she saw Dr. Amin and had further testing done, and that they were awaiting the results. It was noted that they would consider a back brace for Petitioner. A work slip was issued on July 9, 2015, indicating that Petitioner was to be off work July 9, 2015 through August 7, 2015. (PX3).

The records of Clinton Internal Medicine reflect that Petitioner was seen on August 7, 2015, at which time it was noted that she stated that Dr. Amin agreed with Dr. Rehman [*sic*] to go ahead and do the surgery, and that surgery had been declined by the insurance company. It was noted that Petitioner could not sleep well, that she got 2-4 hours of sleep, and that physical therapy resulted in worsening of her symptoms. Petitioner was given a prescription for Norco. A work slip was issued on August 7, 2015, indicating that Petitioner was to be off work August 7, 2015 through September 7, 2015. At the time of the September 1, 2015 visit, it was noted that Petitioner saw Dr. Amin and Dr. Rehman [*sic*] and had been tentatively approved for surgery. It was noted that Petitioner had been off work for the last 13 months. A work slip was issued on September 1, 2015, indicating that Petitioner was to be off work September 1, 2015 through October 7, 2015. At the time of the October 7, 2015 visit, it was noted that Petitioner had been waiting on insurance to get her approved for surgery. A work slip was issued on October 7, 2015, indicating that Petitioner was to be off work October 7, 2015 through October 30, 2015. At the time of the November 6, 2015 visit, it was noted that Petitioner had been using the back brace and stated that it did not work very well. It was noted that Petitioner had been waiting on insurance to get her approved for surgery, and that they had denied surgery for a second time. It was noted that Petitioner had retired from work. (PX3).

The records of Clinton Internal Medicine reflect that Petitioner was seen on December 4, 2015, at which time it was noted that she had been denied by the insurance company to get surgery. At the time of the February 3, 2016 visit, it was noted that Petitioner had been denied by the insurance company to get surgery. At the time of the April 1, 2016 visit, it was noted that Petitioner had been denied by the insurance company to get surgery. At the time of the June 1, 2016 visit, it was noted that Petitioner had seen three neurosurgeons and was now going to see Dr. Butler who came from Chicago to Champaign. It was noted that Petitioner had right-sided back pain radiating down to the right hamstring to the back of the knee and shooting down to the sole of the foot, and that her toes were numb. At the time of the July 20, 2016 visit, it was noted that Petitioner was seen for a pre-procedural cardiovascular examination/pre-operative clearance. It was noted that Petitioner had been approved to have surgery with Dr. Butler in Chicago at Covenant Hospital in Champaign. (PX3).

The medical records of Physicians Immediate Care were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. The records reflect that Petitioner was seen on July 22, 2014, at which time it was noted that she presented with a chief complaint of constant (but worse at times) pain in the right thigh since July 15, 2014. It was noted that Petitioner reported that it was the result of an injury which was work-related and which had a sudden onset, that she had no similar problems in the past, that this was not the result of a motor vehicle accident, and that she denied any non-work related event or illness possibly contributed to or is related to the development of symptoms. It was noted that Petitioner reported that the pain/pressure radiated to the right lower extremity and that she was bending over to pick up a heavy object at the bottom of a container and felt pain in the low back, buttocks and the right leg. It was noted that Petitioner also reported muscle pain as an abnormal symptom related to the complaint. It was noted that Petitioner reported muscle pain located over the right thigh, that the pain was 7/10, that she had pain in the buttocks and right thigh, and that her right foot was numb. The diagnosis was noted to be that of sprain/strain to the hip/thigh. Petitioner was issued work restrictions. (PX4).

The records of Physicians Immediate Care reflect that Petitioner was seen on July 29, 2014, at which time it was noted that her pain was unchanged since the last visit. It was noted that Petitioner's primary care physician had her off work, that he would be ordering an MRI very soon and that she was taking multiple medications. The diagnosis was noted to be that of sprain/strain of the hip/thigh, stable/improved. Petitioner was issued work restrictions and was recommended to return on August 12th for a re-check. At the time of the August 15, 2014 visit, it was noted that Petitioner had had an MRI that

showed mild arthritis in the spine. It was noted that Petitioner's pain was still in one single area of the proximal hamstring muscle group. Petitioner was issued work restrictions and was recommended to return on September 2, 2014. At the time of the September 2, 2014 visit, it was noted that Petitioner had had no change in symptoms, that the pain medications helped as prescribed by Dr. Kureishy, and that she was awaiting neurology referral approval. It was noted that Petitioner stated that the back pain felt like it was burning. Petitioner was issued work restrictions and was recommended to return on September 19, 2014 for a re-check. (PX4).

The records of Physicians Immediate Care reflect that Petitioner was seen on September 19, 2014, at which time it was noted that she described the severity of her pain as 10/10 and that she was still with lots of pain in the proximal sciatic area of the right leg. It was noted that Petitioner was set with pain management for trial injections. Petitioner was issued work restrictions and was recommended to return on October 6, 2014 for a re-check. At the time of the October 6, 2014 visit, it was noted that Petitioner described the severity as 5/10 which had improved since the last office visit, that there were no changes, that she had a history of two MRIs, and that she was due to have a procedure done on October 13th but was not sure what it was. Petitioner was issued work restrictions and was recommended to return on November 3, 2014 for a re-check. At the time of the November 3, 2014 visit, it was noted that Petitioner described the severity as 6/10, that she was due to start spinal injections the next day, and that she was under the care of pain management. Petitioner was issued work restrictions and was recommended to return on December 8, 2014 for a re-check. At the time of the December 8, 2014 visit, it was noted that Petitioner was still the same and that she had had injections in the back and was not sure why, except she knew that they were not working. Petitioner was issued work restrictions and was recommended to return on January 5, 2015 for a re-check. (PX4).

The records of Physicians Immediate Care reflect that Petitioner was seen on January 12, 2015, at which time it was noted that she had been coming there since July 22, 2014, that she had had almost all of her care through private resources, that the case was discussed with Dr. Koehler, and that she was to be released to Lori Huber, RN and was to be suspended from being seen for this condition unless requested to do so in the future. Petitioner was issued work restrictions and was released to Ms. Huber pending further plans of Exelon. (PX4).

The transcript of the deposition of Dr. Mohammed Rahman dated January 21, 2016 was entered into evidence at the time of arbitration as Petitioner's Exhibit 5. Dr. Rahman testified that his practice is that of neurosurgery and that he is board-certified in neurosurgery. (PX5).

Dr. Rahman testified that he first saw Petitioner on September 9, 2014 and that she had been referred by her primary care physician, Dr. Kureishy. He testified that Petitioner was seen because she was having low back pain and pain down her right lower extremity. He testified that Petitioner was injured at work lifting items out of a bin. He testified that Petitioner had an MRI of her lumbar spine on July 31, 2014 that showed arthritis and foraminal stenosis. He testified that he diagnosed Petitioner as having acute low back pain and lumbar radiculopathy, and that he recommended an updated MRI of her lumbar spine. He testified that they did not discuss return to work. (PX5).

Dr. Rahman testified that the follow-up MRI was performed on September 11, 2014, which he interpreted as showing foraminal stenosis at L4-5 and L5-S1 with degenerative disk disease. He testified that foraminal stenosis and degenerative disk disease was synonymous with arthritis and wear and tear in the lower back. He testified that he next saw Petitioner on September 16, 2014, at which time she continued to have radicular symptoms and leg pain in the right lower extremity. He testified that the treatment recommendations made on that date was that of a referral to pain management for injections. He testified that he recommended injections because he did not see any new disc herniation. He testified that he also indicated that physical therapy would not be of help to Petitioner. He testified that he recommended that if

Petitioner did not improve with injections then she may be a candidate for surgery, which was that of a decompressive laminectomy and foraminotomy at L4-5 and L5-S1 on the right. (PX5).

Dr. Rahman testified that when he stated that there was no surgical pathology, he meant that there was no urgent or emergent issue. He testified that because Petitioner's pain was so intense, he recommended an exploratory foraminotomy if she did not improve with injections. He testified that Petitioner mentioned that she did attend pain management. He testified that at the time of the visit on September 16, 2014, they did not discuss Petitioner's ability to work. He testified that he did not have any recollection of why there were two work notes dated September 16, 2014 and September 19, 2014 stating the opposite work status. (PX5).

Dr. Rahman testified that he next saw Petitioner on January 15, 2015, at which time she had followed-up after having had two injections. He testified that the injections did not provide Petitioner with any relief and that she continued to have low back pain and had pain down her right lower extremity to her toes. He testified that the physical examination revealed the same right lower extremity paresthesias in the L5-S1 distribution. He testified that his diagnosis was that of lumbar radiculopathy, acute low back pain, spinal stenosis and degenerative disk disease. He testified that he recommended surgery at L4-5 with decompressive laminectomy and possible fusion. When asked the basis of prescribing surgical treatment, he responded that he had seen Petitioner over the past four months, that he did not see any significant improvement with medications or with the injections, and that he recommended surgery at that point. He agreed that he authored a narrative report dated March 25, 2015 and that his opinions were the same as set forth in the letter. (PX5).

Dr. Rahman testified that he believed that the incident that was related to him by Petitioner might or could have caused the underlying medical condition necessitating the surgery that he prescribed, that she sustained an injury at work and prior to this was asymptomatic, and that it seemed like her symptoms were exacerbated due to this injury. When asked to assume that on July 15, 2014 Petitioner reported that she was working in the contamination room at the Clinton Power Plant and was getting a piece of equipment weighing 75 pounds out of the bin which was waist-high so that she had to bend over and get the equipment out of the bin, that as she was doing this she went to pull or straighten up and with lifting the equipment she felt a pop on the right side of the low back and into the right buttocks and asked whether the surgical treatment that he prescribed might or could have been necessitated by her engaging in that work activity, Dr. Rahman agreed that the activity could have exacerbated her symptoms. When asked what the nature of the aggravation was or what had occurred that would require surgery, Dr. Rahman responded that usually one would see a disc herniation and that sometimes one would get irritation of the nerve without any disc herniation, and that this could explain Petitioner's symptoms. (PX5).

Dr. Rahman testified that he most recently saw Petitioner on August 20, 2015, at which time she reported that she continued to experience low back pain with radiation of pain down to the right lower extremity, that she had numbness in her toes on the right side, and that she denied any symptoms on the left side. He testified that Petitioner was seen by Dr. Amin in Springfield for a second opinion and that he also had recommended surgery. He testified that Petitioner's symptoms had not improved, that she was taking pain medications, that her pattern of pain was in the same distribution as the previous three visits, and that he recommended surgery. He testified that Petitioner had exhausted physical therapy and had tried injections, that both modalities did not help her, and that he recommended surgery. He testified that he recommended decompressive lumbar laminectomy at L4-5, L5-S1 along with a fusion at L5-S1. He testified that a laminectomy would address compression of the nerve or impingement of the nerve at L4-5 and L5-S1, and that the fusion would address instability of the lower back. He testified that there were no future appointments scheduled for Petitioner. (PX5).

When asked whether he was able to render any opinions as to whether Petitioner was able to work regardless of the conflicting notes that were discussed, Dr. Rahman responded that in his opinion she would

not be able to work because her pain was quite intense and had not improved in the nearly one year that he had seen her. He agreed that this would be true from the first time that he saw Petitioner on September 9, 2014 and would extend to her last visit on August 20, 2015. He further testified that he felt that the medical treatment he had rendered to Petitioner was reasonable and necessary to treat her condition of ill-being. (PX5).

On cross examination, Dr. Rahman agreed that when he first saw Petitioner she had recently undergone an MRI of her lumbar spine and that he had the July 2014 MRI available to him for his review. He agreed that he recommended an additional MRI on his first visit with Petitioner. When asked if it was fair to say that he recommended the additional MRI because he thought that he might see something different on a new one than that depicted on the July 2014 MRI, Dr. Rahman responded that Petitioner's pain was quite intense, that the findings on the MRI did not make sense, and that he assumed that an updated MRI would show some surgical pathology. He agreed that the MRI from September 11, 2014 was essentially depicting the same findings as those in July of 2014 and that the condition was degenerative disk disease. (PX5).

On cross examination, Dr. Rahman agreed that the findings on the MRI were not inconsistent with someone of Petitioner's age (*i.e.*, 59). He agreed that it was typical for him to address work restrictions when he thought that they were appropriate for his patient. He agreed that his treatment records for Petitioner did not address her work capabilities. He testified that usually primary care physicians addressed return to work and that he thought that he previously mentioned that Petitioner was off work, so that may have been the explanation for not addressing her work situation. (PX5).

On cross examination, Dr. Rahman agreed that the next time that he saw Petitioner after September 2014 was in January 2015. He testified that Petitioner's clinical presentation was essentially the same at that time. He testified that he did not know Dr. deGrange. When asked if Dr. deGrange noted on examination in February 2015 that there were no neurologic deficits and that Petitioner's examination was clinically consistent with some mild stiffness and whether those findings would not be inconsistent with what he was appreciating on his examination of her, Dr. Rahman responded that part of the statement was consistent and that part was not and that Petitioner did not have deficits but did have radicular symptoms. He agreed that Petitioner had no neurologic deficits, which would be that of weakness in the lower extremities. He testified that low back pain would suggest that Petitioner had instability in the spine. When asked whether Petitioner's pain complaints were primarily in the right leg as opposed to the back, Dr. Rahman responded that the majority of her pain was in the right leg, but that she also had low back pain. (PX5).

On cross examination, Dr. Rahman testified that a protrusion or bulging of a disc could be a normal variant for an individual of Petitioner's age and that it could be asymptomatic. He agreed that the condition would be a chronic issue as opposed to something that was acute. He agreed that a herniation was acute and that Petitioner did not have a herniation. He testified that Petitioner's MRI findings were chronic and longstanding. He agreed that it was not his testimony that the work incident actually caused the condition that was seen on the MRI. (PX5).

On cross examination, Dr. Rahman agreed that when he initially saw Petitioner and reviewed the July 2014 MRI, he felt that her condition was non-surgical. He agreed that the condition that was depicted on the July 2014 MRI was essentially the same condition that was depicted on the MRI of July 2015. He agreed that he could not state to a reasonable degree of medical and surgical certainty that the work incident that Petitioner described really caused an acute condition in the lumbar spine, but further testified that her symptoms were definitely symptomatic after the incident. He agreed that there was nothing that could quantify what the injury really was to Petitioner's lumbar spine. (PX5).

On redirect, Dr. Rahman agreed that from his history and examinations of Petitioner, she had not suffered any back complaints, back pain or radiculopathy into her legs prior to this incident. He agreed that in his review of the MRIs, he had not seen a surgical pathology. He agreed that he testified that the disc protrusions which were identified on the MRIs were chronic in nature. He agreed that he testified that even though there was no surgical pathology, there was a surgical necessity. He testified that in spite of having tried conservative treatment, Petitioner still continued to progress and that her symptoms were very classic for a particular nerve being irritated, which was the L5-S1 nerve. He testified that because they could not help Petitioner with conservative treatment and they could not see any pathology, he recommended exploration of the L4-L5 nerve. He testified that Petitioner's pain had progressed and that her back pain also became more prominent, which was why surgery became an option for her. (PX5).

On redirect, Dr. Rahman testified that if Petitioner's primary care physician did not address work restrictions, then he would address it. When asked if there was any medical or physiological effect for Petitioner in not having the surgery done, Dr. Rahman responded that the worst-case scenario would be that she would get weakness of her right lower extremity. He testified that if Petitioner was still symptomatic from her right lower extremity paresthesias and low back pain, then he did not see her beginning to return to work in the same kind of setting at the power plant. (PX5).

On redirect, Dr. Rahman testified that the MRI findings had not changed due to the incident. He testified that he thought that the symptoms were exacerbated by the work accident. He testified that usually one saw radiographic evidence of a disc herniation or a bone spur that was causing compression of the nerve, but that in Petitioner's case it was not seen. He testified that if one looked at the EMG results, it would tell you that there was a particular nerve that was being injured or irritated. He testified that they had the symptoms that matched the EMG, and that the only missing piece of the puzzle was the MRI which did not show anything. (PX5).

On redirect, Dr. Rahman agreed that there was a third MRI done at the request of Dr. Amin. He agreed that when he referred to Dr. Trudeau's EMG, he was talking about an EMG that was prescribed by Dr. Amin. When asked whether the subsequent diagnostic tests changed his opinion, Dr. Rahman responded that it reinforced his opinion that there was compression of the L5 nerve. He agreed that the surgical procedure that he had proposed was to eliminate the impingement and that by eliminating the impingement, it would hopefully relieve Petitioner's symptomatology. (PX5).

The medical records of St. Mary's Pain Medicine Center/Pain Consultants of Central Illinois were entered into evidence at the time of arbitration as Petitioner's Exhibit 6. The records reflect that Petitioner was seen on January 6, 2015, at which time it was noted that the injections had not helped, that her primary care physician was providing Hydrocodone, and that she did not want to continue with injections. The diagnosis was noted to be that of low back pain and right lower extremity radiculopathy. Petitioner was referred back to Dr. Rahman. The records reflect that Petitioner underwent an intralaminar lumbar epidural steroid injection with fluoroscopic guidance L5-S1 right on December 2, 2014 for a pre- and post-operative diagnosis of lumbar radicular pain. The records further reflect that Petitioner underwent a transforaminal lumbar epidural steroid injection with fluoroscopic guidance L5-S1 right on November 4, 2014 for a pre- and post-operative diagnosis of lumbar radicular pain. (PX6).

The records of St. Mary's Pain Medicine Center/Pain Consultants of Central Illinois reflect that Petitioner was seen on October 13, 2014, at which time it was noted that she was referred to the pain clinic by Dr. Rahman's office for further diagnostics and evaluation of her back pain. It was noted that Petitioner started to experience lower back and right lower extremity pain on July 15, 2014 after she injured herself at work, that the pain radiated to her right posterior lower extremity, and that she also complained of numbness in the right foot. It was noted that Petitioner had taken Norco, Diazepam, and Celebrex which provided about 10-20% pain relief, and that her symptoms had not improved. The assessment was noted to be that of low back pain and right lower extremity pain, nocioceptive, with significant neuropathic

component, as well as right L5-S1 radiculopathy. Petitioner was to be scheduled for right L5-S1 transforaminal epidural steroid injections. (PX6).

The medical records of Dr. John Warner Hospital were entered into evidence at the time of arbitration as Petitioner's Exhibit 7. The records reflect that Petitioner underwent an MRI of the lumbar spine on September 11, 2014, which was interpreted as revealing small right paracentral disc protrusion at L4-5 with mild right lateral recess narrowing; otherwise, no spinal stenosis or foraminal narrowing any level. The records reflect that Petitioner underwent pre-operative chest x-rays on January 19, 2015. The records further reflect that Petitioner underwent a Physical Therapy Initial Evaluation on March 25, 2015, at which time it was noted that she was hurt at work on July 15, 2014 and that she was lifting a 70# piece of equipment and felt a pop at the glut and had pain in the back of her leg. It was noted that Petitioner had glut pain to foot pain and that numbness that was constant. The Progress Report dated March 25, 2015 noted that Petitioner did not tolerate physical therapy well and that she was very guarded with exercises and showed signs of pain and discomfort throughout treatment. The Communication Tracking entry dated April 10, 2015 noted that Dr. Rahman wanted Petitioner to be discharged secondary to making her worse and pushing for insurance to approve surgery. The Physical Therapy Initial evaluation dated November 14, 2016 noted that Petitioner' rehab potential was guarded secondary to the length of time since the injury. The Progress Report dated December 30, 2016 noted that Petitioner had made good progress with physical therapy, that her range of motion had improved, and that her pain had decreased significantly. It was noted that Petitioner was able to do all her daily activities and that it was felt to be appropriate to discharge her a home exercise program secondary to having met her goals. (PX7).

The transcript of the deposition of Dr. Devin Amin dated January 22, 2016 was entered into evidence at the time of arbitration as Petitioner's Exhibit 8. Dr. Amin testified that he practiced medicine exclusively in neurosurgery and that he is board-certified. (PX8).

Dr. Amin testified that he first saw Petitioner on June 12, 2015 and that she indicated on her initial paperwork that she was a second opinion consult for symptoms of pain in the right leg and back. He testified that Dr. Kureishy was indicated in the "referring" section of the initial paperwork. He testified that Petitioner described a time course of approximately a year in the time that he was seeing her to lifting a 70-pound object and that since that point, she described back and leg pain which was specifically right-sided which had been treated with physical therapy as well as epidural injections without relief. He testified that on physical examination he found the strength to be symmetric, that he found the reflexes to be symmetric and present in the lower extremities, that the rest of the neurologic exam was within normal limits, that the straight leg raise on the lower extremities on the left did not show any exacerbation of her symptoms and that on the right at about 45 degrees Petitioner had a pain that she would describe as an L5 dermatome distribution (*i.e,* the side of the leg going to the top of the foot). He testified that the MRI performed in September 2014 described the lateral recess stenosis at the L4-5 level that would impinge upon the L5 nerve root, which was consistent with the symptoms Petitioner was having. (PX8).

Dr. Amin testified that he wanted to see a picture of the anatomy that was concurrent with the patient and the examination, so he wanted an updated MRI without contrast of the lumbar spine. He testified that a CT of the lumbar spine could also add information to a diagnostic work-up, and that he also wanted an EMG/nerve conduction study because he had already examined Petitioner and found findings consistent with an L5 radiculopathy. He testified that the three studies were performed. He testified that the July 1, 2015 MRI showed a moderate disk bulge with some left foraminal narrowing and mild to moderate spinal stenosis. He testified that the left foraminal stenosis was not of much significance because Petitioner did not have complaints on the left leg. He testified that the more advanced facet and ligamentous hypertrophy was contributing to what he had assessed the original problem to be (*i.e.*, a compression of the nerve root as it traversed the L4-L5 disk space that was within the L5 nerve root on the right side). He testified that as to the CT scan performed on July 1, 2015, the scan at the L4-5 level demonstrated disk height loss, endplate sclerosis, vacuum disk phenomenon, and osteophytes, which would contribute to the lateral recess

stenosis. He testified that it also found mild to moderate spinal stenosis and no left foraminal narrowing. He testified that it was a different picture of the same process and that there was both bone and collapsed disk that was narrowing the lateral recess of the L4-5 level. (PX8).

Dr. Amin testified that the vacuum disk phenomenon was a sign of a degenerative change of the disk such that there was air within the disk material, and that the finding of air was for him a pretty particular finding to show that there was an advanced degenerative process at the L4-5 level. He testified that Dr. Trudeau performed an EMG/nerve conduction study of the bilateral lower extremities, which showed a right L5 radiculopathy moderately severe in electrophysiological terms, a right S1 radiculopathy mild in electrophysiological terms, and no other evidence of radiculopathy. He testified that in his experience the S1 radiculopathy being mild was not something that he would typically include in a conservative treatment plan, and that moderately severe L5 radiculopathy refractory to conservative measures would be an indication for surgical decompression of the L5 nerve root. (PX8).

Dr. Amin testified that he saw Petitioner again on July 20, 2015, at which time a discussion was had as to what had been found on testing and a very likely explanation for the pain that she was having in her back and right leg, and what may be a reasonable treatment plan after she had failed conservative measures of physical therapy and injections. He testified that the surgical plan for Petitioner he described in terms of a lumbar laminectomy and bilateral foraminotomy. (PX8).

After having been asked to assume that Petitioner worked at the Clinton Power Plant, was working in the decontamination room and was getting a piece of equipment weighing 75 pounds out of the bin that was waist-high so that she had to bend over and get the equipment out of the bin and that, as she was doing this and as she went to pull up or straighten up her back, while lifting the equipment, she felt a pop on the right side of her low back and into her right buttocks, and having been asked to opine whether the accident might or could have caused the findings of the MRI, CT scan and EMG, Dr. Amin responded that he thought that it might or could have, but that he was unable to reach a degree of medical certainty greater than 50% likely. He testified that he thought that the imaging that they had over a time course left it up to something where it was suggestive, but not certain. (PX8).

Dr. Amin testified that the event could have aggravated Petitioner's underlying conditions causing the pain symptoms that ultimately brought her to see him, but that he was unable to state that with a reasonable degree of medical certainty that that was what caused it. He agreed that the surgical treatment that he had prescribed was designed to alleviate the symptoms of pain that Petitioner was presenting with, and that it was to relieve an L5 nerve compression on the right side. (PX8).

Dr. Amin testified that his final status with Petitioner when he saw her on July 20, 2015 was that, upon outlining a surgery that should have a high likelihood of relieving her pain, she still wished to pursue surgical intervention closer to home. He testified that he did not have any appointments scheduled to see Petitioner. He testified that he thought that the course of treatment that he offered to Petitioner was reasonable given the pain complaints and findings that she presented with, and that he thought it was reasonable and had a high likelihood of achieving pain relief for her. He testified that the prescription for surgery was necessary to cure Petitioner of the conditions and symptoms of ill-being that she presented to him with. (PX8).

On cross examination, Dr. Amin testified that he is board-certified by the American Board of Neurological Surgery. When asked whether the July 2015 MRI that he ordered depicted a different picture of Petitioner's lumbar spine than was depicted in September 2014, Dr. Amin responded that he did not find an acute difference, but that it was more of a continuity along a spectrum with more advanced changes of the same type. He agreed that the condition that was depicted on the September 2014 MRI would be described as degenerative in nature. He agreed that the advanced picture as depicted on the July 2015 MRI

was something that could advance and change just in the natural course of progression of the disease. (PX8).

On cross examination, Dr. Amin agreed that he could not state to a reasonable degree of medical certainty that the activity at work as alleged by Petitioner aggravated the condition seen as depicted on the MRI images. He agreed that it was fair to state that he could not state to a reasonable degree of medical certainty that the need for surgery was causally connected to the work incident described. (PX8).

On cross examination, Dr. Amin agreed that he ordered some testing specifically to assess whether there was any instability in the spine and that the testing that he ordered (*i.e.,* x-rays) revealed no evidence of instability. He agreed that if he did appreciate some instability in the lumbar spine, his treatment recommendations would be different because a procedure like a lumbar fusion was indicated by the instability. He agreed that that was the reason that he did not find that fusion was medically reasonable and necessary in this case. (PX8).

On redirect, Dr. Amin agreed that Petitioner's underlying physiological conditions might have caused or contributed to the nerve impingement that had caused her pain. He agreed that the physiological findings as demonstrated in the MRI were preexisting and would have developed over time. When asked whether the incident of lifting the 75-pound object might or could have aggravated the underlying physiological conditions, Dr. Amin responded that they could or possibly exacerbate or aggravate the L5 radiculopathy, but that he could not reach a degree of medical certainty that that was what happened most likely to bring Petitioner to medical attention at the time that he was seeing her. He testified that while it was certainly possible that the event could have exacerbated it, it was another step to say that it was the most likely. He testified that in speaking with Petitioner and in his review of the medical records, he had not seen any indications where she had experienced this symptomatology prior to July 15, 2014. (PX8).

On further cross examination, Dr. Amin agreed that it was still his opinion to a reasonable degree of medical and surgical certainty that he could not state that the work accident had a causal connection to the need for the surgery that he had prescribed. (PX8).

The transcript of the deposition of Dr. David Fletcher dated October 6, 2017 was entered into evidence at the time of arbitration as Petitioner's Exhibit 9.[2] Dr. Fletcher testified that his practice area is that of occupational medicine and that he is board-certified. (PX9).

Dr. Fletcher testified that he saw Petitioner as an examining physician and then became a treating physician. He testified that he first saw Petitioner in May 2016 and that he last saw her earlier that week, when she had a one-year follow-up following her fusion surgery in August of 2016. (PX9).

Dr. Fletcher testified that he saw Petitioner on May 16, 2016 at her attorney's request. He testified that Petitioner's history was that she was a 61-year-old white female who had worked for multiple decades as a laborer at the Clinton Power Plant, that she described a very acute injury that occurred at the workplace, that she stated that she was getting a RAD gun which weighed approximately 75 pounds out of a biohazard bin that was waist-high, that she said she was leaning into the bin and that when she was on her tippy toes, she bent over the bin to get the 75-pound object to lift out and heard a pop and felt immediate pain from her lower back going down her right leg. He testified that he thought that Petitioner had actually lifted the object out and was removing it when she noticed the pop in her back. He testified that Petitioner reported the immediate onset of symptomatology, that she had classic developmental lumbar radiculopathy and that based on his review of the medical records, she had consistent symptomatology from the date of injury until she was examined in May 2016. (PX9).

[2] Any highlighting that appears in the exhibit was not made by the Arbitrator.

Dr. Fletcher testified he diagnosed that Petitioner structurally had multiple images of her lumbar spine that showed a combination of pathology at L4-L5, L5-S1 that would explain her persistent symptoms of right leg pain that she reported consistently since her injury in July of 2014. He testified that Petitioner presented with classic L5 and S1 nerve root radiculopathy. He testified that Petitioner's pain drawing conformed the symptoms she presented to him, and that her physical examination correlated with those subjective complaints. He testified that Petitioner's complaints followed a recognized dermatomal pattern and that the EMG that was performed by Dr. Trudeau correlated with his physical examination of her. When asked of the significance of the EMG, Dr. Fletcher responded that it provided an objective diagnostic test that Petitioner had lumbar nerve root irritation in those enervated muscles at both the L5 and S1 levels and provided support for the physical examination findings. He testified that it also provided some help in the decisionmaking of going forward and doing a surgical procedure. (PX9).

Dr. Fletcher testified that he reviewed a report from Dr. deGrange dated July 14, 2017 and that he disagreed with his position on the performance of an EMG in a case like Petitioner's. He testified that he believed that the EMG testing was accurate and that Dr. Trudeau was highly qualified and a well-respected physical medicine specialist. He testified that on performing a physical examination on May 16, 2016 Petitioner displayed no evidence of any embellishment of her symptoms and that she was not a drug seeker. He testified that Petitioner had no Waddell's non-organic back pain signs. He testified that Petitioner's physical examination was classic for lumbar radiculopathy at the L5-S1 level which correlated with her subjective complaints, her electrical studies and her imaging. (PX9).

Dr. Fletcher testified that he diagnosed Petitioner with a right L5 radiculopathy and right S1 radiculopathy. When asked if he had any indication that there had ever been any prior complaints or back pain prior to the work injury of July 15, 2014, Dr. Fletcher responded that he found nothing in the records to suggest that Petitioner had had prior treatment for her low back or any lumbar radiculopathy. When asked whether the complaints that had been presented by Petitioner were consistent with a strain injury approximately two years after her reported injury of July 15, 2014, Dr. Fletcher responded in the negative and further stated that it was ridiculous to think that it was a lumbar strain and that she had persistent lumbar radiculopathy since the date of accident. He testified that Petitioner's presentation and complaints were longlasting and chronic. He testified that a lumbar strain would normally resolve within a few weeks, and that that was not the case for Petitioner. (PX9).

When asked what physiologically was causing Petitioner's low back pain, Dr. Fletcher responded that she had degenerative disk disease and that she had an inflammatory process that caused lumbar radiculopathy from a combination of degenerative changes, stenosis and disk protrusions at the L5 and S1 nerve root. When asked whether Petitioner's injury in lifting the RAD gun on July 15, 2014 might or could have caused the findings which were identified in the multiple MRIs, CT scan and EMG, Dr. Fletcher responded that he believed "without any shred of doubt" that the injury in July of 2014 personally aggravated and accelerated those preexisting conditions, and that also based on his review of the September 14th MRI there appeared to be "some aspect of acuteness on top of some chronic changes." (PX9).

Dr. Fletcher testified that he felt that Petitioner would benefit and do well if she had a two-level fusion at L4-L5. He testified that he also felt that Petitioner would benefit from some treatment for some secondary depression that she had from her chronic pain, and that he also recommended that she would benefit with some neuropathic pain medications like Lyrica. He testified that he thought that the best thing that he suggested was that Petitioner really needed a cane to make sure that did not fall and break her hip, and that she needed to see Dr. Butler. (PX9).

Dr. Fletcher testified that he referred Petitioner to the care of Dr. Butler and that he ultimately performed surgery on August 5, 2016. He testified that he was aware of the surgery that was performed by Dr. Butler because he was the surgical intern, and that because of his experience in surgical management of patients post-operatively he was Petitioner's doctor and did all of her post-operative care. He testified

that Petitioner had a two-level posterior lateral fusion from L4 to S1. He testified that he saw Petitioner for three visits in the hospital after surgery. He testified that Petitioner did very after the surgery and that she did not have any complications. He testified that he talked to Petitioner a few times when she was seen in follow-up with Dr. Butler. He testified that he also did Petitioner's one-year post-operative visit including films which showed integrity of the fusion, and that she did not have any leg pain. (PX9).

Dr. Fletcher testified that as of October 4, 2017, he considered Petitioner to be at maximum medical improvement and that she would not need any further treatment for her July 2014 injury. He testified that Petitioner had satisfactorily completed one year of post-operative care that showed that she had a solid fusion, that she was not seeking any additional treatment, that she did not have any right leg pain anymore, and that she still had some back pain but was extremely thankful how well she had done following her surgery. He testified that Petitioner indicated to him that she thought she was 70% better because of the surgery. He testified that he recommended that Petitioner try to not lift more than 20 pounds occasionally, but that he did not do a formal FCE as he did not think it was necessary. (PX9).

Dr. Fletcher agreed that in his initial report he noted that even before surgery Petitioner was on Social Security Disability. When asked if he made any recommendations as to whether there was any kind of future medical care that Petitioner may expect, Dr. Fletcher responded that he did not and that she had had a great result. He testified that he felt that the treatment was reasonable and necessary to cure Petitioner of the condition of ill-being that she had presented with. He testified that because she was receiving Social Security and also because of her age, neither he nor Dr. Butler were aggressive in trying to get Petitioner back to her former level of employment as a laborer at Clinton and that they did not recommend work hardening. (PX9).

On cross examination, Dr. Fletcher agreed that the first time that he saw Petitioner was on May 20, 2016 at the request of her attorney and that he had since become a treating physician. He testified that at the time of the report he had only seen the films of the MRI performed on September 11, 2014, but that subsequently he had seen three of the four lumbar MRIs. He testified that he had not seen the films for the CT. When asked if he would agree that the findings were essentially the same across the board, Dr. Fletcher responded that there was some variability as they were done on different machines, but that he would agree that there was not too much difference. (PX9).

On cross examination when asked whether a protrusion was not a herniation, Dr. Fletcher responded that it was somewhat debatable. He testified that he thought that protrusion was less of an expulsion of the herniated nucleus of a disk, and that he considered with a herniated disk a lot more disk material got out as compared to a protrusion. He testified that he would not call the findings on Petitioner's MRIs a disk herniation and that he never had. (PX9).

On cross examination, Dr. Fletcher agreed that at the time of the MRIs Petitioner was 59 years old, and he further agreed that the findings were consistent with a person of her age. He testified that the L4-5 disk protrusion could be a normal variant for someone 59 years of age. He testified that he felt that the stenosis was likely preexisting and that the disk protrusion was probably preexisting. When asked what findings he believed might be acute in nature, Dr. Fletcher responded the eccentric aspect of the disk protrusion at L4-L5 as opposed to the stenosis and foraminal encroachment, which had been longstanding in his opinion. (PX9).

On cross examination, Dr. Fletcher agreed that he reviewed the deposition transcripts of Drs. deGrange, Rahman and Amin, and that they all stated that they could not find any acute changes in the MRIs. When asked if he would agree that none of those doctors found any objective findings to support a surgical pathology, Dr. Fletcher responded that two of them were recommending surgery so he would disagree. When asked about his reference in his report as to the disk pathologies that corresponded to Petitioner's radicular complaints, Dr. Fletcher responded that it was the fact that she had eccentric disk

protrusions to the right symptomatic side. When asked if he would agree that there was no new nerve root impingement on any of the MRI studies, Dr. Fletcher responded that there was no obvious encroachment that was advanced, but that the lumbar nerve roots were inflamed which caused the symptomatology that was present. He agreed that it was his opinion that the findings on the EMG were corroborated by the findings on the MRI. (PX9).

On cross examination when asked of the surgical pathology based on Petitioner's diagnostic images, Dr. Fletcher responded that she had disk protrusions, spinal stenosis, lateral nerve root encroachment and osteophytes, in addition to disk collapse. He agreed that all of those findings were consistent with someone of Petitioner's age. When asked if he would agree that his causation opinion was based on Petitioner's subjective reporting of the injury and her subjective complaints post-accident, Dr. Fletcher responded that that was one factor, but that another big factor was that they did not have any evidence of any prior treatment. When asked if there was objective medical evidence to support that the work accident caused any furthering of Petitioner's degenerative condition, Dr. Fletcher responded that unless one had an MRI from the day before her injury to compare, it was not possible. When asked whether there would be any objective medical evidence to support that the surgery was necessitated by the reported work accident, Dr. Fletcher responded that it was all based on the history and the subsequent course of her symptomatology and medical treatment. (PX9).

On cross examination, Dr. Fletcher agreed that he was not an orthopedic surgeon. He testified that he did not perform surgeries but was a surgical intern. He testified that he would not defer his opinion regarding treatment recommendations to an orthopedic surgeon, and that he felt very competent to manage lumbar spine pain. When asked would or could Petitioner have needed the surgery given her degenerative condition, Dr. Fletcher responded that it was possible. (PX9).

On redirect, Dr. Fletcher agreed that because he was not a surgeon he referred Petitioner to Dr. Butler's care. He agreed that two previous orthopedic doctors examined Petitioner and concluded that she was in need of surgery, and that the surgery performed by Dr. Butler was the surgery that had been prescribed by other doctors. (PX9).

On redirect, Dr. Fletcher agreed that to say that, absent the work injury, Petitioner would have needed the surgery was speculation. He agreed that the symptoms that Petitioner presented with and were documented in his initial examination were the same symptoms that were being presented to other physicians from the day of accident onward and that they were consistent. He agreed that they did not vary, alter or change over the course of the approximate two years between Petitioner's accident and his examination of her in May of 2016. He testified that the pain drawing that was done by Dr. deGrange for his examination on January 24, 2015 was identical to the pain drawing that Petitioner did for him in May 2016. (PX9).

On redirect, Dr. Fletcher agreed that Petitioner's symptomatology existed through an extensive course of conservative treatment. He agreed that Petitioner failed conservative treatment for a period of approximately two years. He agreed that when he indicated that Petitioner's degenerative condition was in part preexisting but permanently aggravated by the work injury, he was indicating that her underlying preexisting condition was aggravated, accelerated, or exacerbated by her work injury of lifting a 75-pound RAD gun out of a bin. He agreed that he thought that the L4-L5 disk protrusion could be an acute finding and that the acute finding and aggravations necessitated the surgery that Dr. Butler ultimately performed. He agreed that the surgery that Dr. Butler performed was designed to relieve Petitioner of the pain symptoms being caused by inflamed lumbar nerve roots, and that "the proof was in the pudding" because the surgery did that. (PX9).

The transcript of the deposition of Dr. Jesse Butler dated July 13, 2018 was entered into evidence at the time of arbitration as Petitioner's Exhibit 10. Dr. Butler testified that he practiced orthopedic spine surgery. (PX10).

Dr. Butler testified that he first saw Petitioner on May 27, 2016. He testified that Petitioner was referred to him by Dr. Fletcher. He testified that Petitioner reported an injury at work on July 15, 2014, that she recalled bending over to reach inside a bin to grab an object, that she stated that she had lower back pain with radiation to the right leg affecting primarily the thigh, and that this all occurred after that activity. He testified that his diagnosis was that of spinal stenosis and lumbar degenerative disk disease from L4 to the sacrum. He testified that from his review of the CT scan of July 1, 2015 and the MRI of July 1, 2015, on both of those studies, particularly with the MRI, it showed collapse of the disc at both the L4/5 and L5/S1 levels. He testified that the central canal showed minimal narrowing, that Petitioner had significant foraminal stenosis and lateral recess stenosis at both L4/5 and L5/S1, and that there were inflammatory changes affecting the endplates of the vertebral bodies at both of those levels. He testified that as to the CT scan, it showed vacuum degeneration at both L4/5 and L5/S1 that was manifested by the presence of air within the disc space, that there was loss of disc height and advanced arthritic changes of the facet joints, and that the facet degeneration produced marked stenosis of the lateral recess in the foraminal region both at L4/5 and L5/S1. He testified that from an anatomic standpoint, it gave an objective basis for the subjective complaints Petitioner had of back pain radiating to the legs. He testified that it also had an impact on the treatment options that were available in that when one went in and decompressed the lateral recess and foramen extensively one could create iatrogenic instability, which was why they had to do a fusion as opposed to just a laminectomy. (PX10).

Dr. Butler testified that from his review of the diagnostic tests that preceded the July 2015 MRI, these findings were consistent throughout the diagnostic tests. He further testified that the physical examination and diagnostic findings were consistent with the pain complaints that Petitioner was presenting with. He testified that from his review of the medical records or medical testimony that he had prior to seeing her, there was no indication, nor did he later learn, that Petitioner had complained or back pain or suffered from back pain or radiculopathy prior to her accident on July 15, 2014. He testified that based on the duration of her conservative treatment and the ongoing level of pain that she described as a 7/10, he felt that Petitioner had essentially done everything from a conservative standpoint and that surgery could be an option for her. He testified that he felt that a laminectomy and fusion from L4 to the sacrum would be the most appropriate treatment. (PX10).

Dr. Butler testified that on August 5, 2016, he did a laminectomy at L5 and L4 with a spinal fusion from L4 to the sacrum and that he also performed an interbody fusion at L4/5, did an iliac crest bone graft on the right side and performed nerve monitoring throughout the procedure. He testified that there were no acute findings in surgery and that by the time he had seen her, Petitioner was two years into her post-injury treatment course and that none of her imaging studies really showed an acute process. (PX10).

Dr. Butler testified that he saw Petitioner on August 19, 2016 for a two-week follow-up visit. He testified that Petitioner had resolution of her pre-operative pain in the legs, that she noted that her low back pain was better than before surgery and that overall she was pleased. He testified that it was his opinion that Petitioner was off work and needed to be off work from the time that he saw her until the time that they had completed her surgical follow-up. He testified that at the time of the August visit, he gave Petitioner a home exercise program and asked her to return in one month. He testified that at the time of the September 23, 2016 visit, Petitioner's midline incision was healed, her neurologic exam was normal and she no longer had tenderness to palpation. He testified that Petitioner was to continue her home exercise program and they were going to discontinue the brace in about six weeks. He testified that Petitioner had been in quite a bit of therapy and that she wanted to advance her activities on her own and do some walking and leg-stretching exercises. He testified that he next saw Petitioner on November 11, 2016, at which time she was noted to have been walking 2½ miles a day, that her leg complaints were stable and that she was finally

fitted for her bone stimulator. He testified that the physical examination was unchanged and that the x-rays showed progressive healing of the fusion. He testified that they recommended removal of the back brace and that she start physical therapy. (PX10).

Dr. Butler testified that he next saw Petitioner on February 10, 2017, at which time she noted some increased pain with the performance of therapy. He testified that Petitioner completed therapy and was now walking three miles a day and taking a rare Hydrocodone for pain. He testified that Petitioner's physical examination was unchanged and that x-rays showed continued progress of the spinal fusion. He testified that throughout his treatment of Petitioner he felt that her presentations were valid, and that he did not see any indication of malingering or symptom magnification. He testified that he next saw Petitioner on April 14, 2017, at which time she stated that she was doing well, that she had some tingling in the bottom of the foot at times, that she was walking 3-4 miles a day and that she had recently cut her hand changing the string trimmer cable and was taking medication as needed. He testified that Petitioner's x-rays showed solid fusion from L4 to the sacrum and no adjacent level of degeneration, and that he recommended that she continue activities as tolerated and continue to follow-up on an annual basis. He testified that this was the last time that he saw Petitioner. (PX10).

Dr. Butler testified that it was his opinion that the work injury on July 15, 2014 aggravated Petitioner's underlying degenerative condition and ultimately resulted in the need for her conservative treatment and ultimately the surgical treatment performed on August 5, 2016, and that the lifting of a 75-pound object was causally related to the ultimate need for surgery and post-operative care performed. He testified that Petitioner's conditions of stenosis and degenerative disk disease were not caused by the lifting incident of July 15, 2014. When asked to explain how these preexisting conditions were aggravated, accelerated or exacerbated by the lifting injury, Dr. Butler responded that it seemed as though Petitioner was working in her occupation without incident and that there had not been records provided of concurrent or significant preexisting treatment for back issues. He testified that subsequent to that, Petitioner began treating for back and leg pain and continued to do so on a consistent frequency from the date of injury up until the time that he saw her, and that she had gone through conservative treatment with medication, therapy, spinal injections and ultimately surgical consultation. He testified that Petitioner had variable opinions for treatment but nonetheless had recommendations for surgical treatment from two different specialists, and an EMG with Dr. Trudeau that documented appropriate findings of radiculopathy on the right side that correlated with her subjective complaints. He testified that based on this, he felt that Petitioner had had an aggravation of her underlying degenerative condition. (PX10).

Dr. Butler testified that Petitioner picked up a 75-pound object and as a result, it created nerve inflammation that never subsided up until the point where he surgically decompressed those nerves. He testified that Petitioner's response to the surgery was appropriate and consistent with what the diagnostic tests pre-operatively would indicate and that in some cases where there was a two-year delay in completion of treatment one may not get results, but that Petitioner responded very well. When asked whether the positive outcome confirmed or emphasized the need for surgery, Dr. Butler responded that a good outcome from an unindicated surgery did not warrant or support the indication for that procedure but that in this case, Petitioner had pathology, diagnostics and a good outcome and that, in some respect, it reinforced the indication for the procedure. (PX10).

Dr. Butler testified that his formal assessment of Petitioner's work capacity had not been done and that typically they were not able to get any type of functional capacity evaluation or formal work assessment from patients treated through a commercial insurance carrier, so based on her activity level she was likely to be able to function in the light physical demand level with lifting restrictions probably in the 15-pound range with occasional bending and stooping. He testified that he believed that his billing was reasonable given the other doctors in the area and that he believed that they were "the best bargain in town now." He testified that it was his opinion that the treatment that he rendered to Petitioner was necessary given the complaints and findings that she presented with. (PX10).

On cross examination, Dr. Butler testified that he rented office space with SafeWorks in Champaign. He testified that he received 2-3 referrals from Dr. Fletcher per month and that most were workers' compensation claims, but not all. He testified that the referrals were either Dr. Fletcher's patients or people that had come to him having been cared for in other circumstances from other providers in the area. He agreed that Petitioner came to him on a referral from Dr. Fletcher. (PX10).

On cross examination, Dr. Butler agreed that Petitioner had seen three physicians before she saw him in 2016, including Dr. Rahman, Dr. Amin and Dr. deGrange. He testified that he was not familiar with any of those physicians, but that he had their records available for his review. He agreed that he had an understanding as to what their opinions were as to Petitioner's condition at the time that they saw her and that condition's causal relationship to the work event. He testified that he disagreed with Dr. deGrange's opinion, that Dr. Amin's opinion was somewhat confusing and that Dr. Rahman's opinions were unclear to him. He testified that he disagreed with Dr. Amin's opinion as he felt that Petitioner's need for surgery was related to the work injury and that he could definitely state that. (PX10).

On cross examination, Dr. Butler agreed that his testimony was that the pathology as depicted on the radiology images supported the need for surgery that he recommended. He testified that Petitioner had surgical pathology at any time on her imaging studies and that what ultimately placed her at a point where surgery was the most appropriate recommendation was once she had failed conservative treatment. He testified that Petitioner's findings were fairly non-specific, that she had spinal stenosis, and that there were many patients who had that who had no symptoms or had tolerable symptoms. He testified that what made Petitioner a surgical candidate based on the imaging studies was not just the imaging studies, but also the failure of the response to treatment and an appropriate level of pain and impairment that made surgery an option. (PX10).

On cross examination, Dr. Butler agreed that the pathology that was identified in July of 2014 at L4/5 and L5/S1 was significant enough to warrant surgery. He agreed that the condition that existed in Petitioner's spine at the time of the work event was that which was depicted on the MRI of July 2014. Dr. Butler agreed that it was possible that lifting one item on one occasion for a woman like Petitioner who had existing pathology in her spine could cause or produce an exacerbation of pain, but not necessarily aggravate the underlying condition from a pathological standpoint. When asked whether one would expect to see on MRI a progression of the disease radiographically if the lifting injury had aggravated a condition in the lumbar spine, Dr. Butler responded that one usually did not and that the changes took years to develop. He agreed that it took years to develop because it was a natural progression of an underlying condition. (PX10).

On cross examination, Dr. Butler agreed that in this case the lifting event did not cause a change in Petitioner's condition in July of 2014 until at least September of 2014. He testified that he did not know when Petitioner was taken off work following the lifting event. When asked whether he had any idea what Petitioner was doing from the time of the work event until the time that he saw her two years later in 2016, Dr. Butler responded that he had nothing other than what was documented in her medical records. He agreed that Petitioner was about 60 years of age at the time of the work injury. He agreed that it was possible that a person like Petitioner who was 60 and had similar findings in the lumbar spine could be experiencing symptoms of pain in her activities of daily living separate and apart from whatever they were doing at work. (PX10).

On cross examination when asked if it was possible that since it was two years from the time of the work event to the time that he saw her that Petitioner's pain complaints could be associated with something other than the work event, Dr. Butler responded that based on the history he did not find anything to suggest that there was a break in the chain of causation. When asked if it was possible that Petitioner's pain complaints were related to something other than the work event when he saw her two years later, Dr. Butler replied that he did not see anything in the records to suggest that. He testified that anything was possible,

but that he did not find a gap in treatment and did not find any other historical variance that would change his causation opinion. (PX10).

On cross examination, Dr. Butler testified that he did not have any documentation of treatment from when Petitioner saw Dr. Trudeau for the ten-month period of time in July of 2015 to May of 2016 when she saw Dr. Fletcher. When asked whether he had any indication otherwise that she was seeking treatment during those ten months, Dr. Butler responded that he thought Petitioner was at a point of her case being denied and that she was essentially waiting for depositions to be completed. (PX10).

On redirect, Dr. Butler agreed that he would have classified Petitioner's injury from the lifting incident to have been a sprain/strain type of injury. He further testified that initially one would classify this as a sprain or strain and that Petitioner did not improve. He testified that Petitioner picked up a 75-pound object at the age of 59 and developed back and leg pain that did not go away until she had surgery to fix it. He agreed that Petitioner's pain complaints that she expressed from July 15, 2014 remained the same pain complaints throughout the two years of conservative treatment until he saw her and ultimately performed surgery. He agreed that if this were a sprain/strain injury, one would expect it to have resolved within two years. He testified that there were patients who had subjective pain complaints that did not correlate with objective findings and that they complained "until the end of time," and that this was not the impression that he had of Petitioner. He testified that Petitioner responded better than anticipated following surgery. (PX10).

On further cross examination, Dr. Butler agreed that there were no documented pain complaints from July 2015 to May 2016. (PX10).

The Notice of Award of the Social Security Administration was entered into evidence at the time of arbitration as Petitioner's Exhibit 11. The TTD Payment List from PMA Management was entered into evidence at the time of arbitration as Petitioner's Exhibit 12. The Medical Bills Exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibit 13.

The office notes of Dr. Butler dated April 5, 2018 were entered into evidence at the time of arbitration as Petitioner's Exhibit 14. The records reflect that Petitioner was seen for a one-year follow-up of her lumbar fusion done at Presence. It was noted that Petitioner's symptoms were aggravated by sitting. It was noted that Petitioner overall was doing quite well, that she was having multiple issues with her right shoulder, that she had recent carpal tunnel surgery, and that she was also contemplating her right knee to be replaced. It was noted that Petitioner was having intermittent left-sided back pain and that there were no radicular symptoms in the lower extremities. It was noted that radiographs showed solid fusion from L4 to the sacrum with good hardware position, and that there was no loosening or adjacent level degeneration. Petitioner was recommended to follow-up in one year for an annual check-up. (PX14).

The Benefits Payment Documentation was entered into evidence at the time of arbitration as Respondent's Exhibit 1. The Job Description was entered into evidence at the time of arbitration as Respondent's Exhibit 2. The Short Term/Long Term and Group Health Benefit Documentation was entered into evidence at the time of arbitration as Respondent's Exhibit 5.

The transcript of the deposition of Dr. Donald deGrange dated August 25, 2015 was entered into evidence at the time of arbitration as Respondent's Exhibit 6. Dr. deGrange testified that he is a board-certified orthopedic surgeon, that he is a fellow at the American Academy of Orthopedic Surgeons and that he is also a fellow of the North American Spine Society. He testified that his medical practice has been almost exclusively the diagnosis, treatment and surgery of the adult spine. (RX6).

Dr. deGrange testified that he saw Petitioner on February 10, 2015, at which time she gave a history that she as working as what she described as a support worker for Exelon Corporation, and that she stated

that on or about July 15, 2015 she had a piece of radioactive equipment called a RAD gun, that she said it weighed about 70 pounds, that she was lifting it and that she felt a pop in her low back followed by immediate onset of pain in that area radiating into the buttock. He testified that Petitioner reported the incident on the date, was sent to the on-site nurse, and was then referred for further consultation to the local urgent care center. He testified that Petitioner's current chief complaint was that of low back pain that radiated into the right lower extremity with some pain, numbness and tingling into the right ankle and into the right foot. He testified that Petitioner stated those symptoms were present on a daily basis and were characterized as frequently mild in terms of their severity and occasionally moderate with prolonged sitting and standing, repeated bending and twisting, and walking for more than 15-20 minutes at a time. He testified that Petitioner stated that she was not able to lift more than about 15-20 pounds comfortably and that, as of February 10, 2015, she was taking Hydrocodone on a regular basis, usually 2-3 times per week. (RX6).

Dr. deGrange testified that on physical examination, Petitioner had a normal neurologic examination with some mild stiffness, and that the range of motion called for input, cooperation and effort. He testified that there was nothing that he could really detect and that it was all up to the patient how much they wanted to move. He testified that for all intents and purposes, Petitioner had a normal neurologic examination with some mild stiffness. He testified that his own reading of the MRI of July 31, 2014 was that there was a normal alignment of the spine both from the front and side views, that the top three of the five lumbar intervertebral discs were normal, that L4-5 revealed some mild degeneration with what was referred to as a mild dessication and a broad-based disc bulge, and that there was no clinically significant spinal stenosis or nerve root compression. He testified that at L5-S1 he remarked that there were similar findings with some mild disc dessication, loss of signal, a little bit of a disc bulge and some mild to moderate arthritis in the facet joints, but no clinically significant spinal stenosis or lateral recess compromise. (RX6).

Dr. deGrange testified that his diagnosis of Petitioner's lumbar spine was that of a lumbar strain, and that the basis of that impression was that of the self-described mechanism, that it was what he would refer to as a low-level injury, that it was a soft tissue injury, and that it was consistent with a lumbar strain. When asked to explain the findings on MRI in the clinical picture with Petitioner, Dr. deGrange responded that he referred to those as normal and age-appropriate. He testified that in his opinion this was not a surgical case and that they would reserve surgery in cases of neurologic deficits. He testified that in the absence of neurologic deficit, if a patient had a cancer, an infection, or an impending fracture or progressive deformity, they would not need a neurologic compromise. He testified that in a case like this there where it was just a strain and one found the normal age-related degenerative changes, this was "really where spine surgery has run into problems" and that he understood a lot of it was done because patients had pain that was refractory to other means. He testified that it did not mean at all that simply because they were not getting better that surgery was going to make them better, and that over the course of his 18 years he had seen many patients made significantly worse with this approach. He testified that in the absence of any demonstrable pain source, he would not recommend surgery. He further testified that there was no obvious pain generator in this case, that there was disc degeneration that he would normally expect to see in a 59-year-old person, and that he thought that Dr. Rahman initially felt the same way. (RX6).

When asked if he had an opinion as to what an outcome would be like for Petitioner if she did undergo a decompressive lumbar spine surgery, Dr. deGrange testified that the best one could hope for was that she was the same after surgery as she was before, and that unfortunately there was no way to predict if that outcome would occur. He testified that the three possibilities were that of the pain getting better, the pain getting worse, or the pain staying the same, and that he did not see a great chance for success in this case. He testified that if Petitioner were only taking the pain medications 2-3 times per week, most spine surgeons would consider that successful. (RX6).

When asked whether an abnormal finding of a positive straight leg raise at 45 degrees replicated an L5 dermatome, Dr. deGrange responded that a straight leg raise did not replicate any dermatome

specifically and that it was a measure of the irritation of the sciatic nerve. He testified that the L5 dermatome consisted of the myotome (*i.e.*, muscle) and the dermatome (*i.e.*, sensory), and that the typical myotome or muscle groups one was talking about with the L5 nerve root were the extensors of the great and lesser toes and that the dermatome was on the dorsum of the foot as well as the lateral aspect of the foot. He testified that when one was straightening out the leg and the sciatic nerve was irritated by that maneuver, one could not say it was the L4, the L5, the S1, the S2 or the S3. (RX6).

When asked whether he found anything on his physical examination or in his review of any of the materials that would make decompression of any of those nerves reasonable and necessary for Petitioner, Dr. deGrange responded that he did not according to his physical examination, his review of the MRI, not according to the radiologist's review of the MRI and apparently not according to Dr. Rahman's original evaluation of Petitioner as well as her diagnostic studies. When asked if he found that any additional treatment was reasonable and necessary for Petitioner, Dr. deGrange responded that at six or seven months post-injury one typically had what one had at that point in time. He testified that he found that Petitioner was at maximum medical improvement for the July 15, 2014. He further testified that he did not find that Petitioner's condition required work restrictions as determined by the incident itself, and that he did not think her age-related degenerative changes necessitated any restrictions. (RX6).

On cross examination, Dr. deGrange testified that as part of his examination and as part of the history that he took from her, there was no history that Petitioner had experienced any prior low back pain. He testified that he did not recall in the medical records that he reviewed any indication that Petitioner had treated for low back pain or expressed low back pain before the accident on July 15, 2014. He denied having been provided with any surveillance video or films depicting Petitioner in her general activities. (RX6).

On cross examination, Dr. deGrange agreed that Petitioner reported to him that she had low back pain radiating into the right lower extremity with pain, numbness and tingling into the right ankle and the right foot. He agreed that this would be characterized as radiculopathy. When asked from his review of the medical records and from his history from Petitioner whether he would consider those pain complaints to have been consistent, Dr. deGrange responded in the negative based on his physical examination. He testified that this was a subjective complaint and that it was Petitioner's subjective complaint not reinforced or substantiated by objective findings, either on exam or diagnostic study review. (RX6).

On cross examination, Dr. deGrange agreed that he did not have available to him a CT of the lumbar spine or an MRI dated July 1, 2015. He agreed that the findings on the CT and MRI dated July 1, 2015 seemed consistent with the prior tests given the difference in machines and the radiologists' readings. He testified that there were certain cases where a CT or MRI scan was absolutely definitive, and that an MRI scan could show cancers or an epidural abscess and that the CT could show a bad fracture. When asked whether different machines were going to demonstrate different intensities on findings, Dr. deGrange responded that there would be some variance with mild findings, but that he did not see "severe" in any of the reports or the verbiage. (RX6).

On cross examination when asked whether the findings on diagnostic testing would have caused Petitioner's symptoms, Dr. deGrange responded that he did not see a clear correlation between the two. He testified that one would expect some mechanical back pain, but none of the radicular complaints that Petitioner referred to. When asked whether he believed that the treatment that Petitioner had was reasonable and necessary to cure her of the condition of ill-being she was presenting with, Dr. deGrange responded that Petitioner's description to him of the incident indicated a lumbar strain and nothing more than that. He testified that these were typically treated with a short course of medication and some physical therapy, and would usually resolve after approximately 1-2 months depending on the patient's circumstances, their age, their morbidity and any pre-existing issues. He testified that anything beyond two months he would not consider reasonably medically necessary or causally related to the incident of July 2014. (RX6).

On cross examination, Dr. deGrange agreed that he did not find any basis for permanent partial disability based on Petitioner's injury. He testified that he was not aware that Petitioner had been found to be disabled by the Social Security Administration. He agreed that it was quite a disparity of opinion. When asked whether he was aware that another surgeon had recommended surgical treatment, Dr. deGrange responded that he did not have any records. (RX6).

On redirect, Dr. deGrange agreed that it was his testimony that essentially the diagnostics showed pretty much consistently the same condition from the July 31, 2014 MRI through the July 1, 2015 MRI. He further agreed that if there was no gross surgical pathology on the initial MRI, it was a fair statement that there was no gross surgical pathology on the last MRI. (RX6).

The IME Report of Dr. deGrange dated February 10, 2015 was entered into evidence at the time of arbitration as Respondent's Exhibit 7. The report reflects that Petitioner stated that on or about July 15, 2014, she was taking a "RAD" gun out of a metal bin, that the tool weighed approximately 70 pounds and that as she was lifting it, she felt a pop followed by pain in her low back radiating into the right buttock. It was noted that Petitioner's current chief complaint was that of low back pain radiating into the right lower extremity with pain, tingling and numbness into the right ankle and the right foot, that her symptoms were present daily and by her description were best characterized as frequently mild and occasionally moderate with prolonged sitting and standing, repeated bending and twisting, and walking for more than 15-20 minutes at a time. It was noted that Petitioner stated that she was not able to lift more than 15-20 pounds without discomfort, and that she was taking Hydrocodone prescribed by her primary care physician 2-3 times per week. (RX7).

The report reflects that as Petitioner described and enacted the incident, it was consistent with a lumbar strain. It was noted that Petitioner was afforded immediate attention in terms of medical evaluation and diagnostic testing and was eventually referred shortly after the incident to Dr. Rahman on September 9, 2014 for evaluation and consultation. It was noted that Dr. Rahman indicated in his note of September 9, 2014 that Petitioner's symptoms suggested a disc herniation but that the MRI did not reveal any gross surgical pathology, and that he recommended obtaining another MRI to further evaluate the cause of her symptoms. It was noted that when Dr. Rahman saw Petitioner after the second MRI, he noted that there was no gross surgical pathology noted, that there was no gross herniation, and that he did not see any surgical pathology and recommended referral to pain management for epidural and transforaminal injections. It was noted that a recommendation for an L4-5 decompression and posterior fusion had been made and that the recommendation was given despite the lack of evidence of any surgical pathology as discussed by Dr. Rahman looking at two different MRIs on two different occasions, and that there was no explanation in the medical records of the apparent discrepancy. It was noted that Dr. deGrange had also looked at the same studies and concluded that there were no surgical indications, which was in line with Dr. Rahman's findings. (RX7).

The report reflects that it was the opinion of Dr. deGrange that Petitioner sustained a lumbar strain as she described her mechanism and that it had not resulted in any acute or gross surgical pathological lesion that required surgery. It was noted that Dr. deGrange agreed with Dr. Rahman regarding his conclusions after reviewing both MRIs. It was also noted that Dr. deGrange opined that Petitioner had reached maximum medical improvement regarding her work-related incident, did not require any further diagnostic testing or medical treatment, and could be returned to her usual and customary job duties, and that he further found no basis for permanent partial disability. (RX7).

The Records Review Report of Dr. deGrange dated July 14, 2017 was entered into evidence at the time of arbitration as Respondent's Exhibit 8. The report reflects that Dr. deGrange was given additional medical evidence to review, including the deposition of Dr. Rahman, the deposition of Dr. Amin, the IME report of Dr. Fletcher, the medical records of Dr. Fletcher, the medical records of Dr. Butler, radiology reports and films, and a consultation report of Dr. Trudeau dated July 1, 2015. The report notes that his

review of the medical records did not cause him to change, amend or alter his previous expressed opinion but that he was "struck" by the findings of the two neurosurgeons, Dr. Amin and Dr. Rahman, who both concluded that they could find no acute changes that would serve as a reasonable medical basis for concluding that there was a permanent aggravation of Petitioner's preexisting degenerative changes. It was noted that there was no medical evidence that the subject incident was medically causally related to or caused the need for the subsequent surgery performed by Dr. Butler, and that it was Dr. deGrange's opinion that there was no medical causal relationship to the subject incident and the subsequent surgery performed by Dr. Butler. (RX8).

The BlueCross BlueShield of Illinois Letter dated October 7, 2015 was entered into evidence at the time of arbitration as Respondent's Exhibit 9. It was noted that a medical policy review determined that the service provided was not covered based on corporate medical policy criteria and that a decision was made that the lumbar spinal fusion proposed by Dr. Rahman was denied as not medically necessary. (RX9).

CONCLUSIONS OF LAW

At the outset, the Arbitrator notes that the parties submitted a *Stipulation to Amend Arbitrator's Exhibit 1* so as to reflect the parties' post-arbitration agreement to an amended Request for Hearing Form number 5 to indicate that Petitioner's earnings during the year preceding the injury were $65,445.12 and that the average weekly wage, calculated pursuant to Section 10 of the Act, was $1,258.56.

With respect to disputed issue (C) pertaining to the issue of accident, the Arbitrator finds that Petitioner did sustain an accident that arose out of and in the course of her employment with Respondent on July 15, 2014.

Petitioner testified without rebuttal that on July 15, 2014, while working at her regular job duties for Respondent in the decontamination room, she was lifting a piece of equipment out of a bin. Petitioner testified that while she was in the act of lifting the equipment out of the bin, she noticed the onset of pain in her low back, which radiated into her right buttock and right hip. The Arbitrator notes that a similar history of accident appears throughout the entirety of the medical records in this matter. In light of the undisputed facts as testified to by Petitioner at the time of arbitration and as recorded in the medical records, the Arbitrator concludes that Petitioner sustained an accident arising out of and in the course of her employment with Respondent on July 15, 2014.

With respect to disputed issue (F) pertaining to the issue of causation, the Arbitrator finds that Petitioner has met her burden of proving that her current condition of ill-being is causally related to the accident of July 15, 2014.

The Arbitrator notes that the medical evidence revealed that Petitioner remained symptomatic in her low back and right lower extremity from the date of accident throughout the entirety of her medical treatment, without any documented intervening accidents or incidents to account for her symptoms. According to Petitioner's testimony she experienced no symptoms in her low back prior to the accident at issue, and the Arbitrator notes that no medical evidence was proffered at the time of arbitration by Respondent demonstrating otherwise.

While the Arbitrator acknowledges that Dr. deGrange testified that his diagnosis of Petitioner's lumbar spine was that of a lumbar strain, and that the basis of that impression was that of the self-described mechanism, that it was what he would refer to as a low-level injury, that it was a soft tissue injury, and that it was consistent with a lumbar strain, the Arbitrator in this case places greater reliance upon the opinions

proffered by both Dr. Rahman and Dr. Butler. Related thereto, the Arbitrator notes that Dr. Rahman testified that he believed that the incident that was related to him by Petitioner might or could have caused the underlying medical condition necessitating the surgery that he prescribed, that she sustained an injury at work and prior to this was asymptomatic, and that it seemed like her symptoms were exacerbated due to this injury. (PX5).

The Arbitrator further notes that Dr. Butler testified that it was his opinion that the work injury on July 15, 2014 aggravated Petitioner's underlying degenerative condition and ultimately resulted in the need for her conservative treatment and ultimately the surgical treatment performed on August 5, 2016, and that the lifting of a 75-pound object was causally related to the ultimate need for surgery and post-operative care performed. He testified that Petitioner's conditions of stenosis and degenerative disk disease were not caused by the lifting incident of July 15, 2014. When asked to explain how these preexisting conditions were aggravated, accelerated or exacerbated by the lifting injury, Dr. Butler responded that it seemed as though Petitioner was working in her occupation without incident and that there had not been records provided of concurrent or significant preexisting treatment for back issues. He testified that subsequent to that, Petitioner began treating for back and leg pain and continued to do so on a consistent frequency from the date of injury up until the time that he saw her, and that she had gone through conservative treatment with medication, therapy, spinal injections and ultimately surgical consultation. He testified that Petitioner had variable opinions for treatment but nonetheless had recommendations for surgical treatment from two different specialists, and an EMG with Dr. Trudeau that documented appropriate findings of radiculopathy on the right side that correlated with her subjective complaints. He testified that based on this, he felt that Petitioner had had an aggravation of her underlying degenerative condition. (PX10).

Having reviewed the considered the entirety of the medical evidence in this case, the Arbitrator finds that Petitioner has met her burden of proving that her current condition of ill-being is causally related to the accident of July 15, 2014.

With respect to disputed issue (J) pertaining to necessary medical services, in light of the Arbitrator's aforementioned conclusions, the Arbitrator finds that Petitioner's care and treatment was reasonable, necessary and causally related to her work accident of July 15, 2014. As a result, the Arbitrator finds that Respondent shall pay all reasonable and necessary medical services for treatment rendered as set forth in Petitioner's Exhibit 13, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit for all medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

With respect to disputed issue (K) pertaining to the issue of temporary total disability, the Arbitrator notes that Petitioner claims that she is entitled to temporary total disability benefits for the timeframe of July 16, 2014 through January 24, 2019. (AX1).

Petitioner testified that following her work injury on July 15, 2014, she did not return to work for Respondent. Petitioner, upon seeking treatment with her primary care physician, Dr. Kureishy, on July 19, 2014, began to regularly lose time from work and regularly received off-work slips from Dr. Kureishy. (PX3). The evidence reveals that upon the termination of temporary total disability benefits after the Section 12 IME performed by Dr. deGrange, Petitioner received long-term disability payments from Respondent. Petitioner testified that as a result of financial concerns it was financially more beneficial for her to retire from Respondent, and she terminated her long-term disability benefits effective September 9, 2015. (RX5b). At the time of arbitration, Petitioner testified that she ultimately voluntarily retired from Respondent on October 31, 2015.

As a result of the foregoing, the Arbitrator finds that Respondent shall pay temporary total disability benefits for a period of 67 3/7 weeks, for the timeframe of July 16, 2014 through October 31, 2015, when Petitioner voluntarily removed herself from her employment with Respondent, with Respondent to receive credit for temporary total disability benefits and long-term disability benefits already paid. (AX1).

With respect to disputed issue (L) pertaining to the nature and extent of Petitioner's injury, and consistent with 820 ILCS 305/8.1b, permanent partial disability shall be established using the following criteria: (i) the reported level of impairment pursuant to subsection (a) of Section 8.1b of the Act; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. 820 ILCS 305/8.1b. No single enumerated factor shall be the sole determinant of disability. *Id.*

With respect to Subsection (i) of Section 8.1b(b), the Arbitrator notes that neither party submitted an AMA rating. The Arbitrator places no weight on this factor when making the permanency determination.

With respect to Subsection (ii) of Section 8.1b(b), the Arbitrator notes that Petitioner testified that she was employed by Respondent on the date of accident, that she had been employed by Respondent since August of 1989 and that her job duties involved the cleaning of tools and equipment in a decontamination process. The Arbitrator places greater weight on this factor when making the permanency determination.

With respect to Subsection (iii) of Section 8.1b(b), Petitioner was 58 years old on her date of accident. In light of Petitioner's relatively advanced age, the Arbitrator places lesser weight on this factor when making the permanency determination.

With respect to Subsection (iv) of Section 8.1b(b), the Arbitrator notes that, following her work injury, Petitioner chose to voluntarily retire from her employment with Respondent. As there was no evidence of reduced earning capacity contained in the record, the Arbitrator places lesser weight on this factor when making the permanency determination.

With respect to Subsection (v) of Section 8.1b(b), the Arbitrator notes that Petitioner testified that following surgery by Dr. Butler, she could finally lay in bed instead of on the floor. Petitioner testified that she felt better. Petitioner further testified that she can do all activities of daily living, but can no longer go backpacking. Petitioner complains of pain in her back, which she associates with an unrelated knee condition. At the time of the April 5, 2018 visit with Dr. Butler, it was noted that Petitioner was seen for a one-year follow-up of her lumbar fusion. It was noted that Petitioner's symptoms were aggravated by sitting. It was noted that Petitioner overall was doing quite well, that she was having multiple issues with her right shoulder, that she had recent carpal tunnel surgery, and that she was also contemplating her right knee to be replaced. It was noted that Petitioner was having intermittent left-sided back pain and that there were no radicular symptoms in the lower extremities. Petitioner was recommended to follow-up in one year for an annual check-up. (PX14). The Arbitrator concludes that Petitioner's evidence of disability at the time of arbitration, namely her continued complaints and limitations, were somewhat corroborated by her treating records at the conclusion of her treatment with Dr. Butler. The Arbitrator accordingly places lesser weight on this factor in determining permanency.

The Arbitrator notes that the determination of permanent partial disability benefits is not simply a calculation, but an evaluation of all of the factors as stated in the Act in which consideration is not given to any single factor as the sole determinant. Based on the above factors and the record in its entirety, the Arbitrator concludes that Petitioner sustained permanent partial disability to the extent of **30% loss of use of the person-as-a-whole** under Section 8(d)2 of the Act.

With respect to disputed issue (O) pertaining to the issue of choice of physicians, the Arbitrator finds that Petitioner has not exceeded her choice of physicians under Section 8(a) of the Act.

The evidence reveals that Respondent sent Petitioner to Decatur Memorial Occupational Health as well as Physicians Immediate Care. Petitioner chose to seek treatment with her primary care physician, Dr. Kureishy. Dr. Kureishy then referred Petitioner for treatment with Dr. Rahman, who referred her to pain management. Dr. Kureishy also referred Petitioner to Dr. Amin for a second opinion regarding surgery, and Dr. Amin recommended that Petitioner undergo additional MRI studies, a CT scan, and an EMG with Dr. Trudeau. The Arbitrator finds that this line of treatment constitutes Petitioner's first choice of physicians under Section 8(a).

The evidence further reveals that Petitioner's second choice of physicians was that of Dr. David Fletcher, who referred her to Dr. Butler who ultimately performed her lumbar spine surgery. The Arbitrator finds that this line of treatment constitutes Petitioner's second choice of physicians under Section 8(a).

As a result thereof, the Arbitrator finds that Petitioner has not exceeded her choice of physicians under Section 8(a) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Randa Uwainat,

Petitioner,

vs.

20IWCC0069

No. 15 WC 11223

Illinois Department of Corrections/Stateville Correctional Center,

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

The Commission modifies the Arbitrator's permanency award with respect to the back injury component. The Commission agrees with the Arbitrator's determination of how much relative weight to give each of the factors enumerated in section 8.1b(b) of the Workers' Compensation Act (the Act). However, the Commission finds a lesser degree of disability (factor (v)) than the Arbitrator found. The Commission notes that after a year of conservative treatment, Petitioner underwent a functional capacity evaluation (FCE) on March 17, 2016. The FCE recommended returning to work as a correctional officer with restrictions at the medium physical demand level for 30 to 90 days. On March 22, 2016, Petitioner's pain management physician, Dr. Jain, imposed restrictions pursuant to the FCE—light to medium duty until June 20, 2016, and full duty thereafter. Petitioner last saw Dr. Jain on April 12, 2016, at which time she rated the pain a 3/10. Dr. Jain reaffirmed the restrictions from March 22, 2016. On April 18 and July 6, 2016, Petitioner returned to Dr. Lorenz's orthopedic practice and was seen by his physician's assistant. Both times, Petitioner reported an improvement in her symptoms. The

20IWCC0069

physician's assistant continued the restrictions pursuant to the FCE and prescribed a back brace. In a narrative report dated July 18, 2016, Dr. Lorenz stated: "Over time, [the patient's] symptoms have shown some improvement with continued conservative therapy, though she does continue to complain of chronic lumbar back and radicular pain. [The patient's] condition is permanent and she will need to stay on the work restrictions permanently in order to [avoid] exacerbation." At the arbitration hearing, Petitioner credibly testified about her residual low back symptoms. However, the Commission notes Petitioner's MRI findings after this work injury are fairly similar to the MRI findings after a prior work injury in 2006.

The Commission reduces the back injury component of the permanency award to 10 percent of the person as a whole. All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 16, 2019, is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $829.10 per week for the period of 53 6/7 weeks, from April 3, 2015 through April 13, 2016, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay the medical bills itemized by the Arbitrator, pursuant to §§8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $735.37 per week for a further period of 75 weeks, as provided in §8(d)2 of the Act, for the reason that the back injury caused permanent disability to the extent of 10 percent of the person as a whole and the mental injury caused permanent disability to the extent of 5 percent of the person as a whole.

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

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

Pursuant to §19(f)(1) of the Act, there shall be no right of appeal as the State of Illinois is Respondent in this matter.

DATED: JAN 29 2020
d-01/21/2020
SM/sk
44

Stephen Mathis

L. Elizabeth Coppoletti

Douglas McCarthy

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

UWAINET, RANDA
Employee/Petitioner

Case# **15WC011223**

ILLINOIS DEPT OF CORRECTIONS
Employer/Respondent

20IWCC0069

On 8/16/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.89% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1987 RUBIN LAW GROUP LTD
CATHERINE K DOAN
20 S CLARK ST SUITE 1810
CHICAGO, IL 60603

6212 ASSISTANT ATTY GENERAL
DREW DIERKES
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

1350 CENTRAL MANAGEMENT SERVICES
BUREAU OF RISK MANAGEMENT
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

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

AUG 16 2019

Brendan O'Rourke, Assistant Secretary
Illinois Workers' Compensation Commission

20 IWCC0069

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
CORRECTED ARBITRATION DECISION

Randa Uwainat,
Employee/Petitioner

v.

Illinois Dept. of Corrections,
Employer/Respondent

Case # **15 WC 11223**

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 **Robert M. Harris**, Arbitrator of the Commission, in the city of **Chicago**, on **June 19, 2019**. After reviewing all of the evidence presented, the arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On 3/23/2015, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**64,670.32** ; the average weekly wage was **$1,243.66**.

On the date of accident, Petitioner was **32** 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 $**44,647.39** for TTD, $**-0-** for TPD, $**-0-** for maintenance, and $**-0-** for other benefits, for a total credit of $**44,647.39**.

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

ORDER

- Respondent shall pay Petitioner temporary total disability benefits pursuant to Section 8(b) in the amount of **$829.10**/week for **53-6/7** weeks, for the period of **4/3/2015 through 4/13/2016**, which is the period of temporary total disability for which compensation is due.
- Respondent shall pay the further sum of $**20,590.50** for necessary medical services provided by Emergency Medical Services ($1,051), Preferred Open MRI ($4,200), Pinnacle Pain Management ($7,727) and Advanced Physical Medicine ($7,612.50) as provided in Section 8(a) of the Act. The medical bill is awarded subject to payment pursuant to Section 8(a) and Section 8.2, the Medical Fee Schedule. The payment shall be sent directly to Petitioner's attorney in accordance with Section 9080.20 of the Rules Before the Illinois Workers' Compensation Commission. Respondent shall receive credit for any payments made in connection with the medical bills.
- Respondent shall pay Petitioner the sum of $**735.37**/week for a further period of **62.5** weeks, as provided in Section 8(d)2 of the Act, because Petitioner sustained injuries to the back to the extent of **12.5%** loss thereof of use of the person as a whole.
- Respondent shall pay Petitioner the sum of $**735.37**/week for a further period of **25** weeks, as provided in Section 8(d)2 of the Act, because Petitioner sustained permanent mental injuries to the extent of **5%** loss thereof of use of the person as a whole.
- Respondent shall pay Petitioner compensation that has accrued from **3/23/2015** through **6/19/2019**, and shall pay the remainder of the award, if any, in weekly payments.
- Respondent shall receive credit in the amount of $44,647.39 for TTD benefits it has paid.
- See Memorandum of Decision of Arbitrator attached and made a part of hereof.

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

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

Signature of Arbitrator Robert M. Harris

August 15, 2019
Date

AUG 16 2019

Randa Uwainat v. Illinois Department of Corrections

Case Number: 15 WC 11223

D/A: 3/23/2015

MEMORANDUM OF DECISION OF ARBITRATOR

I. Introduction

Evidence in the above-captioned claim was presented to Arbitrator Harris on June 19, 2019. On that date, the Arbitrator heard the testimony of Petitioner. The Arbitrator also received into evidence various exhibits, which included: 1) medical records from several providers; 2) accident reports; 3) MRI reports; 4) physical therapy records; 5) FCE report; 6) narrative report of Dr. Lorenz; 7) medical bills; 8) Section 12 report of Dr. Singh; 9) Section 12 report of Dr. Espinosa in connection with a prior workers' compensation case; 10) settlement contracts in connection with a prior claim; and 11) payment history. The Arbitrator is considering the disputed issues of medical causation, payment of medical bills and the nature and extent of the injury.

Before making conclusions of law in connection with this case, the Arbitrator makes the following findings of fact:

II. Findings of Fact

Petitioner testified before the Arbitrator on June 19, 2019.

Work History

Petitioner testified that on March 23, 2015 she was employed by Respondent as a correctional officer. She was assigned to Stateville. Petitioner had been employed by Respondent since November 29, 2004. She was a member of the AFSME union.

Petitioner testified regarding her job duties for Respondent as a correctional officer. Petitioner testified she provided security, custody and ensured the safety of the prison. Petitioner performed lifting and carrying during lockdowns. Lockdowns occurred when there was a security risk. Petitioner lifted and carried trays. Petitioner testified that she lifted and carried up to 30 or 40 pounds. Petitioner performed reaching and reaching when she did "bar wraps," which was searching the cell doors. Petitioner performed bending to place restraints on inmates. She also performed climbing. Petitioner climbed three flights of stairs per day. Petitioner used a radio and restrains in her job as a correctional officer. Petitioner performed walking when she was escorted inmates to their cell or performing writs. Petitioner explained that a writ was delivering an inmate to court. Petitioner performed standing. Petitioner also performed pushing and pulling. Petitioner pushed and pulled doors. The

doors were made of thick metal and weighed 15 to 20 pounds. Petitioner testified she occasionally restrained inmates. Petitioner testified that she performed all of the job duties prior to March 23, 2015. Petitioner had no problems performing her job duties prior to March 23, 2015.

A. Prior Medical Treatment

Petitioner testified regarding prior treatment for her back. Petitioner sustained a work-related accident on May 11, 2006 to her back. As a result of the May 11, 2006 injury, Petitioner underwent medical treatment, including physical therapy and an MRI. No injections were recommended. Petitioner was released to return to work and did return to work without restrictions. She began working full duty following her release from medical care. Petitioner testified that her back felt fine when she returned to work.

The Section 12 report of Dr. Espinosa in connection with the accident of May 11, 2006 was admitted into evidence. (RX 4). Petitioner experienced low back pain with radiation on the left side. (RX 4). Petitioner had negative straight leg raises. (RX 4). The MRI of May 26, 2006 revealed a left herniated disc at L5-S1 and T12-L1. (RX 4). Dr. Espinosa recommended physical therapy and that Petitioner return to work without restrictions. (RX 4).

The lump sum settlement contract in connection with the May 11, 2006 work-related accident was also admitted into evidence. (RX 3). As a result of the accident, Petitioner reached a settlement of 10% loss of use of the person as a whole. (RX 3). The settlement contracts reflect that the nature of the injury was a low back sprain/strain. (RX 3).

Petitioner also testified that she was involved in a motor vehicle accident in 2010. As a result of the motor vehicle accident, she participated in physical therapy. Petitioner testified that she unable to work for about a month and returned to work without restrictions.

Petitioner testified that since 2010 she has not sustained any new accidents or injuries involving her back. Further, she has not received any medical treatment for her back since 2010. Petitioner also testified that she did not receive any psychiatric treatment prior to March 23, 2015. Petitioner testified that when she reported to work on March 23, 2015, she felt fine and had no problems.

B. Work-Related Accident of March 23, 2015

Petitioner testified that on March 23, 2015 she was performing her job duties for Respondent. She was working at 555 W. Harrison. Petitioner was taking an inmate on a writ to court. The inmate assaulted Petitioner. As Petitioner was setting down paper, she was hit in the back by an inmate and knocked onto a table. Petitioner testified that she was in shock and the inmate's head hit her in the back. Petitioner was pushed

into a table and fell onto the floor. Petitioner testified that she remembered the inmates face as he was restrained by other officers and straining to get to her. Immediately after the accident, Petitioner experienced shock. She also felt a sharp burning sensation in her back, which continued to get worse.

The accident reports were admitted into evidence. (PX 1). The accident report documents that Petitioner was placing her papers in the holding area when the inmate head butted her in the lower back and assaulted her. (PX 1). Petitioner was pushed into a table after she was head butted. (PX 1). She experienced a sharp burning pain in her lower back and weakness in her right leg. (PX 1). After Petitioner was assaulted, she turned around and saw the inmate positons as though he was going to head butt her again. (PX 1). Officer Frazier also completed an accident report. (PX 1). He documented that an inmate rammed his head into Petitioner's back knocking her into a table and to the floor. (PX 1). The accident reports are consistent with Petitioner's testimony.

C. Medical Treatment

Following the work-related accident of March 23, 2015, Petitioner sought medical treatment. She was taken via ambulance to Northwestern Memorial Hospital. (PX 2). Petitioner was initially examined at Northwestern Memorial Hospital on March 23, 2015. (PX 3). X-rays were performed. (PX 3). The x-rays of the lumbar spine revealed partial lumbarization of S1 and minimal retrolisthesis of L4-L5. (PX 3). The diagnosis was low back pain following a traumatic episode at a correctional facility. (PX 3). Petitioner was referred to spine surgery. (PX 3).

Petitioner was examined at Advanced Urgent Care on March 24, 2015. (PX 4). Petitioner had positive tenderness over the paravertebral lower dorsal and lumbar area and positive straight leg raise on the right. (PX 4). The diagnosis was low back pain after blunt trauma, anxiety, diabetes and hypothyroidism. (PX 4). Petitioner was referred to physical therapy and an MRI study was recommended. (PX 4).

Petitioner underwent the recommended MRI study on March 25, 2015. (PX 5). The MRI was performed at Preferred Open MRI. (PX 5). The MRI study of the thoracic spine revealed a right herniation of T11-12. (PX 5). The MRI of the lumbar spine revealed a herniation at L5-S1 with underlying bulge and retrolisthesis narrowing of the foramina and L4-L5 disc bulge with narrowing of the left foramen. (PX 5). Petitioner also had mild disc desiccation at L4-L5 and mild retrolisthesis of L4 on L5. (PX 5).

On March 26, 2015, Petitioner was examined at Advanced Urgent Care. (PX 4). Petitioner requested to talk to a psychiatrist for worsening anxiety after the incident with the prisoner. (PX 4). The diagnosis was low back pain following blunt trauma, right T11-12 disc herniation, left herniation at L5-S1, anxiety diabetes and hypothyroidism. (PX 4). Petitioner was referred to a spinal surgeon for further treatment. (PX 4).

Petitioner was examined by Dr. Jain on March 30, 2015. (PX 6). Dr. Jain noted pain at the lumbar axial, pain with palpation along the paraspinal muscles and hypertonicity, pain and decreased range of motion with flexion and extension and positive straight leg raise. (PX 6). Dr. Jain noted that Petitioner experienced anxiety in relation to inmates in general and feared that they may target her. (PX 6). Dr. Jain set forth an impression of lumbar facet syndrome, lumbar discogenic pain and lumbosacral radiculopathy. (PX 6). Dr. Jain recommended physical therapy and an injection at the L5-S1 level. (PX 6). Dr. Jain noted Petitioner had concerns about the injection since she was a diabetic. (PX 6). Dr. Jain indicated Petitioner's symptoms were directly related to the injury. (PX 6). Dr. Jain also recommended that Petitioner remain off work. (PX 6). Petitioner participated in physical therapy at Advanced Physical Medicine from March 31, 2015 through July 31, 2015. (PX 7).

Petitioner testified she declined to undergo the injections because she was diabetic. She testified her diabetes was not controlled and she did not want to undergo the medical risk of the injections.

On April 13, 2015, Petitioner had a follow up examination with Dr. Jain. (PX 6). Dr. Jain noted Petitioner had a substantial amount of anxiety, mood swings and depression due to being attacked by an inmate. (PX 6). Petitioner continued to have low back pain, pain with palpation along the paraspinal muscles, pain and decreased range of motion with flexion and extension and positive straight leg raises. (PX 6). Dr. Jain referred Petitioner to Dr. Lorenz and a psychologist. (PX 6).

Petitioner testified she was referred to a psychologist because of the depression that she experienced following the work-related accident of March 23, 2015. Petitioner testified that after the accident she had nightmares about the offender. She also experienced flashbacks and nightmares about his face. Petitioner testified that she did not feel "right" since the assault.

On April 23, 2015, Petitioner was examined by Dr. Lorenz. (PX 8). Dr. Lorenz documented that Petitioner had back pain with forward bending and extension, positive straight leg raises on the right and contralaterally on the left and diminished sensation along the L5 dermatome. (PX 8). X-rays revealed sacralization of L5 with L4-L5 retrolisthesis. (PX 8). Dr. Lorenz set forth a diagnosis of L5 radiculitis of the right lower extremity secondary to a work accident, probable disc herniation at L4-L5 and post-traumatic depression. (PX 8). Dr. Lorenz referred Petitioner to Dr. Andres on the basis of her depression and recommended physical therapy. (PX 8). Petitioner did not want to undergo surgery. (PX 8).

Petitioner continued to have follow up examinations with Dr. Jain. (PX 6). Petitioner continued to have substantial anxiety, depression, lumbar pain and radicular symptoms. (PX 6). Dr. Jain continued to refer Petitioner to a psychologist. (PX 6). On July 20, 2015, Dr. Jain noted Petitioner continued to have lumbar pain radiating down her bilateral lower extremities. (PX 6). Petitioner also had anxiety, depression and avoided public places. (PX 6). Dr. Jain referred Petitioner to Dr. Brown. (PX 6).

On August 6, 2015, Petitioner was examined by Dr. Brown. (PX 9). Dr. Brown indicated that Petitioner's treatment was related to the work injury of March 23, 2015. (PX 9). Dr. Brown noted Petitioner had symptoms related to a traumatic reaction to the assault. (PX 9). Petitioner was experiencing disruptive nightmares on a regular basis, daytime intrusive distressing thoughts, panic attacks and isolation. (PX 9). Dr. Brown recommended that Petitioner follow up to address the post-traumatic reaction to the assault. (PX 9).

Petitioner continued to experience low back pain. (PX 6). She continued to have follow up appointments with Dr. Jain. (PX 6). Dr. Jain documented that Petitioner was not interested in surgery. (PX 6).

On October 20, 2015, Petitioner had a follow up examination with Dr. Brown. (PX 9). Dr. Brown noted that Petitioner had diminished mood and her cognitive status was negatively impacted by rumination and anxiety. (PX 9). Dr. Brown set forth a diagnosis of PTSD. (PX 9). Dr. Brown recommended continued therapy. (PX 9). Petitioner continued to participate in therapy with Dr. Brown. (PX 9). Dr. Brown documented on assessment of ongoing PTSD and mood diminishment. (PX 9). Dr. Brown also set forth that Petitioner's cognitive status was impacted by rumination and anxiety. (PX 9).

On October 26, 2015, Dr. Jain noted Petitioner should consider surgery in the future. (PX 6). Dr. Jain recommended a discogram at L2-L3 through L5-S1. (PX 6). Petitioner testified she did not undergo the discogram due to her diabetes which was uncontrolled and her A1Cs were very high. Petitioner continued to have follow up appointments with Dr. Jain. (PX 6).

Dr. Brown examined Petitioner on February 18, 2016. (PX 9). Dr. Brown noted Petitioner's mood was stable and her cognitive status continued to improve; however, she remained susceptible to rumination and anxiety. (PX 9). Dr. brown noted Petitioner had anxiety disorder and no longer met the criteria for PTSD. (PX 9).

Petitioner was last examined by Dr. Brown on March 3, 2016. (PX 9). Dr. Brown documented Petitioner's mood was stable and she demonstrated an improvement in distress and her cognitive status continued to improve. (PX 9). He set forth a diagnosis of anxiety disorder. (PX 9). Dr. Brown noted Petitioner was ready to return to work from a psychological standpoint. (PX 9).

Petitioner underwent an FCE at Advanced Physical Medicine on March 17, 2016. (PX 10). The FCE noted Petitioner could not repeatedly carry, lift, push or pull more than 30 pounds. (PX 10). The FCE recommended that Petitioner return to work at a light duty level for 30-90 days with no lifting more than 30 pound, limited stair climbing and limited bending. (PX 10). Petitioner reported daily low back pain with aggravation with climbing stairs, bending and lifting. (PX 10).

On March 22, 2016, Dr. Jain noted Petitioner continued to have low back pain, which radiated down her thighs. (PX 6). Dr. Jain recommended that Petitioner return to limited work on March 23, 2016 per the FCE. (PX 6).

Dr. Jain examined Petitioner on April 18, 2016. (PX 6). Petitioner continued to have low back pain that radiated into her bilateral thighs. (PX 6). Dr. Jain recommended that Petitioner return to work on a limited basis per the FCE on April 12, 2016 and to full duty work per the FCE on June 20, 2016. (PX 6).

Petitioner was examined by Dr. Lorenz on April 18, 2016. (PX 8). Petitioner complained of low back pain radiating to her hips and buttocks. (PX 8). Dr. Lorenz documented that Petitioner had minimal low back pain with forward flexion and extension and pulling in her spine with straight leg raises. (PX 8). X-rays revealed degenerative changes at the first mobile level with 2 mm retrolisthesis noted with flexion that corrected with extension. (PX 8). Dr. Lorenz recommended physical therapy. (PX 8). Dr. Lorenz recommended that Petitioner return to work with the restrictions of no lifting more than 30 pounds, limited bending and limited repetitive stairs, bending and climbing. (PX 8). Petitioner participated in the recommended physical therapy at ATI Physical Therapy. (PX 11).

Petitioner was last examined by Dr. Lorenz on July 6, 2016. (PX 8). Petitioner continued to work with restrictions. (PX 8). Dr. Lorenz documented that Petitioner experienced pain with opening and closing large steel doors at the dentation center and a stabbing and burning sensation in her back. (PX 8). On physical examination, Petitioner had pain reproduced in the right SI region and lumbar spine with extension and a pulling sensation in the lumbar spine with bilateral straight leg raises. (PX 8). Dr. Lorenz recommended a decompressive brace. (PX 8). Dr. Lorenz indicated Petitioner could return to work with no lifting greater than 30 pounds, limited bending, limited repetitive stairs, bending and climbing and no pushing and pulling more than 30 pounds. (PX 8). Petitioner testified she obtained the back brace. She no longer wears it because she has gained weight.

D. Medical Opinions of Dr. Lorenz

The narrative report of Dr. Lorenz was admitted into evidence. (PX 12). Dr. Lorenz summarized the medical treatment provided to Petitioner. (PX 12). Dr. Lorenz also documented the subjective complaints of lower back pain and pain radiating down the right lower extremity to the lateral aspect of her calf. (PX 12). On physical examination Petitioner had pulling across her lumbar spine with bilateral straight leg raise and pain with range of motion. (PX 12).

Dr. Lorenz documented the findings of the diagnostic studies. (PX 12). X-rays of the lumbar spine demonstrated sacralization of L5 and retrolisthesis at L4-L5. (PX 12). The MRI of 2015 revealed disc desiccation and a small central, right sided disc herniation at the first mobile level, which was L4-L5. (PX 12).

Dr. Lorenz indicated a diagnosis of L4-L5 right sided disc herniation with L5 radiculitis secondary to a work injury of March 23, 2015. (PX 12). Dr. Lorenz opined that all treatment was reasonable and necessary. (PX 12). Dr. Lorenz noted Petitioner was not able to undergo an ESI or a Medrol pack, but she continued to benefit from physical therapy. (PX 12).

Dr. Lorenz reviewed Dr. Singh's Section 12 report of April 4, 2016. (PX 12). Dr. Lorenz disagreed with Dr. Singh's findings. (PX 12). Dr. Lorenz stated the MRI noted disc desiccation at the first mobile level and a small, right sided central disc herniation. (PX 12). Petitioner also had pre-existing degenerative changes of the lumbar spine. (PX 12). Dr. Lorenz opined the degenerative changes were exacerbated by the work-related accident of March 23, 2015 and the new findings of the disc herniation and L5 radiculitis were caused by the work-related accident of March 23, 2015. (PX 12). Dr. Lorenz noted Petitioner continued to complain of back pain and intermittent radicular pain, which required continued physical therapy and care. (PX 12). Dr. Lorenz indicated Petitioner could return to work within the restrictions of the FCE. (PX 21). The restrictions included returning to work at a medium physical demand level with no lifting over 30 pounds, no carrying over 25 pounds, no pushing/pulling over 30 pounds and limited bending and climbing and no repetitive stairs. (PX 12). Dr. Lorenz noted Petitioner's condition improved with conservative therapy; however, she continued to experience chronic lumbar pain and radicular pain. (PX 12). Dr. Lorenz opined Petitioner's condition was permanent and she would require permanent work restrictions to avoid exacerbating her back condition. (PX 12).

E. Section 12 Report of Dr. Singh

The Section 12 report of Dr. Singh was admitted into evidence. (RX 2). Dr. Singh reviewed the MRI studies of the thoracic and lumbar spine. (RX 2). He did not review or perform x-rays. (RX 2). Dr. Singh did not perform a straight leg raise test. (RX 2). Dr. Singh documented that the MRI of the thoracic spine revealed normal thoracic kyphosis without evidence of central or foraminal stenosis. (RX 2). The MRI of the lumbar spine revealed decreased disc signal intensity and height at L5-S1 with retrolisthesis and minimal stenosis. (RX 2). Dr. Singh indicated a diagnosis of lumbar strain and degenerative disc disease at L5-S1. (RX 2). Dr. Singh stated the soft tissue muscle strain resolved and Petitioner could return to work without restrictions. (RX 2). Dr. Singh stated the disc degeneration at L5-S1 was pre-existing in nature. (RX 2). Dr. Singh stated the neurologic examination was normal and Petitioner exhibited symptom magnification. (RX 2). Dr. Singh stated

the diagnosis was resolved lumbar strain and opined the current symptoms were not related to the work accident. (RX 2). Dr. Singh stated four weeks of physical therapy was reasonable medical treatment. (RX 2).

F. Medical Bills

Several medical bills were admitted into evidence. (PX 13). The medical bills from Emergency Medical Services ($1,051), Preferred Open MRI ($4,200), Pinnacle Pain Management ($7,727) and Advanced Physical Medicine ($7,612.50) were admitted into evidence. (PX 13). The medical bills total $13,284). (PX 13). A payment log of the medical bills paid by Respondent was also admitted into evidence. (RX 1).

G. Post Injury Employment

Petitioner received payment of extended benefits for the period of April 3, 2015 through April 13, 2016. (RX 1). Petitioner received her full salary during the period that she was unable to return to work. Petitioner received her full salary pursuant to Illinois Law since she sustained an injury at work when she was assaulted.

Petitioner returned to work for Respondent. Initially she was assigned to the mail room, which was a light duty assignment. However, Respondent stopped accommodating Petitioner's work restrictions following the Section 12 examination. Petitioner testified that she returned to work for Respondent as a correctional officer. Petitioner explained she was "lucky" and was assigned to a light duty position. Petitioner's new assignment was at the medium security ward and her job duties included escorting inmates to their cells. Petitioner worked in this position until January 2017. Petitioner testified the job at the medium security ward was within her work restrictions.

Petitioner testified that when she returned to work for Respondent she was scared that she would see the inmate who attacked her again. Petitioner also testified she experienced pain in her low back. When she sat for a long period of time, she experienced pain in her low back.

In January 2017, Petitioner began a new job as a parole agent. Petitioner testified the position of parole agent was very light. Petitioner testified that while she was working as a parole agent, she experienced pain in her back. She drove for long periods of time and experienced burning in her low back. Petitioner took breaks to stand up and purchased pillows to support her back while she drove. Petitioner testified she has not sustained any new accidents or injuries since March 23, 2015.

H. Current Subjective Complaints

Petitioner testified about her current subjective complaints. Petitioner testified she experiences pain and burning in her low back. Petitioner performs a home exercise program for her back complaints and she uses a

TENS unit for the pain. Petitioner testified that when the low back pain is really bad, she takes Ibuprofen. Petitioner testified the pain in her back is worse than currently than it was following the accident in 2006.

Petitioner also testified regarding her current mental status. Petitioner testified her psychological condition is better than following the accident; however, she still experiences anxiety. Petitioner testified that if an offender becomes loud or has a mental health issue, she becomes more anxious and scared.

III. Conclusions of Law

In support of the Arbitrator's decision relating to "F," whether Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator makes the following conclusions:

The Arbitrator incorporates the facts stated above into the sections that follow. The Arbitrator further finds that Petitioner's testimony was credible and unrebutted. The Arbitrator also finds that Petitioner's testimony was consistent with the histories, treatment and objective findings documented in the medical records, which were offered into evidence at the time of the hearing.

The Arbitrator finds and concludes Petitioner's current condition of ill-being in connection regarding her back, including the L4-L5 right sided disc herniation with L5 radiculitis and an aggravation of the preexisting degenerative disc disease, and her psychological condition of ill-being, including the PTSD, depression and anxiety, are all causally connected to the work-related accident of March 23, 2015. The Arbitrator relies on Petitioner's unrebutted testimony, the medical record admitted at hearing and the credible, weight and reliable medical opinions of Dr. Lorenz, Dr. Jain and Dr. Brown. The Arbitrator accords the opinions of Dr. Singh, Respondent's Section 12 physician, little weight.

To recover under the Act, an employee must show that there is a causal connection between the claimant's employment and the injury. In *Sisbro, Inc. v. Industrial Commission*, 207 Ill.2d 193, 797 N.E.2d 665 (2003), the Illinois Supreme Court held that "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." *Id.* The accident "need not be the sole causative factor, nor even the primary causative factor, as long as it was *a* causative factor in the resulting condition of ill-being." *Id.* (emphasis in original).

A. Medical Opinions Supporting a Finding of Causation

Petitioner established her current condition of ill-being in relating to her back and psychological state are casually connected to the work-related accident of March 23, 2015 through the supporting treating medical records. With regard to her mental condition, Dr. Brown examined Petitioner. Dr. Brown diagnosed PTSD and anxiety. Dr. Brown opined Petitioner had symptoms concerning a traumatic reaction to the assault. Dr. Brown opined the psychiatric treatment was related to the work-related assault on March 23, 2015. Dr. Brown recommended that Petitioner continue therapy to address the post-traumatic reaction to the assault. **The Arbitrator emphasizes that Dr. Brown's opinions are unrebutted.** The Arbitrator emphasizes Respondent did not submit any medical evidence disputing or challenging Petitioner's psychological condition.

With regard to Petitioner's back condition, Dr. Jain documented a diagnosis of lumbar facet syndrome, lumbar discogenic pain and lumbosacral radiculopathy. **Dr. Jain opined Petitioner's symptoms were directly related to the work injury.**

Petitioner also established medical causation of the back through the opinions of Dr. Lorenz. Dr. Lorenz set forth a diagnosis of L4-L5 right sided disc herniation with L5 radiculitis secondary to a work injury of March 23, 2015. Dr. Lorenz stated that the MRI notes disc desiccation at the first mobile level and a small, right sided central disc herniation. **Dr. Lorenz opined that the degenerative changes were exacerbated by the work-related accident of March 23, 2015 and the new findings of the disc herniation and L5 radiculitis were caused by the work-related accident of March 23, 2015.** Dr. Lorenz's opinions are consistent with the findings documented in the MRI reports from Preferred Open MRI.

B. Chain of Events Analysis

The Arbitrator further finds and concludes Petitioner has established the current back and psychological conditions of ill-being are casually connected to the work-related accident of March 23, 2015 through the "chain of events" analysis. Proof of prior good health and change immediately following and continuing after an injury may establish that the impaired condition was due to injury. *Ill. Power Co. v. Indus. Com'n*, 176 Ill.App.3d 317, 530 N.E.2d 617 (4th Dist. 1988).

In *Corn Belt Energy v. Illinois Workers' Compensation Commission*, 2016 IL App (3d) 150311WC (3d Dist. 2016) the court held that the Arbitrator could accord more weight to the chain of events analysis than the opinions of the Section 12 physician. In *Kawa v. Illinois Workers' Compensation Commission*, 2013 IL App (1st) 12469WC, 991 N.E.2d 430 (1st Dist. 2013), the Appellate Court reaffirmed the chain of events analysis. The court found that the claimant established a "causal nexus between the accident and his condition of ill-being" based on the evidence that the claimant's condition had begun no sooner than the work-related accident and continued with no intervening cause that broke the chain of events. *Id.*

The court in *Schroeder v. Illinois Workers' Compensation Commission*, 2017 IL App (4th) 160192, 79 N.E.3d 833 (4th Dist. 2017) applied the chain of events analysis to pre-existing conditions. Specifically, the court upheld a finding of medical causation where the claimant had a significant pre-existing injury. *Id.* The court found it significant that despite any objective changes in the pre-injury and post-injury MRI, the claimant's condition deteriorated following the work injury. *Id.*

In the instant case, Petitioner did not receive any psychiatric treatment prior to March 23, 2015. Petitioner did sustain prior disk injuries to her back. Petitioner sustained a work-related accident involving her back on May 11, 2006. (RX 3, LSSC, 06 WC 32515, "sprain/strain"). As a result of that accident, Petitioner underwent physical therapy and an MRI study. Injections were not recommended. Petitioner was released to return to work and returned to work for Respondent without restrictions. Petitioner also sustained a motor vehicle accident in 2010 which affected her back. Petitioner testified she received some physical therapy and was unable to work for about a month. Petitioner returned to work for Respondent without restrictions. Petitioner testified that between 2010 and March 23, 2015, she did not receive any medical treatment for her back. Petitioner testified that prior to the work-related accident of March 23, 2015, she felt fine and was having no problems with her back.

Immediately, following the work-related accident of March 23, 2015, Petitioner began experiencing symptoms in her back. The symptoms continue to the present date. Petitioner also began experiencing psychiatric symptoms, including anxiety, depression, nightmares and flashbacks. Petitioner's ongoing complaints were documented in the medical records. Following the work-related accident, Petitioner began a course of medical treatment, which included office visits, physical therapy, cognitive therapy, diagnostic studies and a recommendation for injections. Further, back surgery was discussed. The recommendations for medical treatment began immediately following the work-related accident of March 23, 2015.

The Arbitrator also finds it significant that Petitioner's condition changed following the work-related accident of March 23, 2015 as compared to the prior minor injuries she sustained. Specifically, Dr. Espinosa reviewed an MRI study from May 26, 2006. The MRI revealed a left herniated disc at L5-S1 and T12-L1. The MRI studies from March 25, 2015 revealed a T11-T12 disc herniation and a L4-L5 disc bulge and L5-S1 disc herniation. **The MRI studies documented that the work-related accident caused new pathology, which was not present in 2006.** Further, Dr. Espinosa documented that Petitioner had left sided lower extremity pain. Currently, Petitioner experiences bilateral lower extremity pain, worse on the right side. Thus, her subjective complaints in connection with the work-related accident of March 23, 2015 were different than from the prior accident. Moreover, Dr. Espinosa set forth that Petitioner had negative straight leg raises in 2006. However, the medical records in connection with the work-related accident of March 23, 2015 document positive straight

leg raises. Additionally, Petitioner testified she felt fine following the accident in 2006 and prior to the work-related accident of March 23, 2013. However, her symptoms are worse currently than in 2006. Also, the settlement contracts from 2006 document that Petitioner sustained only back sprain/strain.

Accordingly, based on the medical evidence, Petitioner's testimony and diagnostic studies, the Arbitrator finds and concludes Petitioner's current subjective complaints were different and worse than in 2006 and the objective findings changed following the work-related accident of March 23, 2015. Therefore, the Arbitrator finds that Petitioner's current condition of ill-being was causally connected to the work-related accident of March 23, 2015.

Based on the medical records and Petitioner's unrebutted testimony, Petitioner was not under active medical care and not experiencing any symptom in her back or mentally prior to March 23, 2015. Immediately following the work-related accident of March 23, 2015, Petitioner sought medical treatment for her back and mental condition. Accordingly, Petitioner established that the current condition of ill-being in connection with the back and psychological condition was casually connected to the work-related accident of March 23, 2015 through the chain of events analysis. In support of this finding the Arbitrator also cites *Steak 'n Shake v. Illinois Workers' Compensation Commission*, 2016 IL App (3d) 150500WC (3d Dist. 2016)

C. Medical Opinions of Dr. Singh, Respondent's Section 12 Physician

The Arbitrator considered the opinions of Dr. Singh, Respondent's Section 12 physician. The Arbitrator accords the opinions of Dr. Singh little weight. The Arbitrator finds and concludes Dr. Singh's opinions do not rely on and were not based on a review of the complete medical records, ignore the objective findings and are incomplete. Therefore, his opinions lack necessary supporting foundation. In reaching this conclusion, the Arbitrator relies on the holding in *International Vermiculite Co. v. Industrial Comm'n,*: ***Not only may the Commission decide which medical view is to be accepted, it may attach greater weight to the opinion of the treating physician.*** International Vermiculite Co. v. Industrial Comm'n, 77 Ill.2d 1, 31 Ill.Dec. 789, 394 N.E.2d 1166 (1979); and, ARA Services, Inc. v. Industrial Comm'n, 226 Ill. App. 3d 225, 168 Ill. Dec. 756, 590 N.E. 2d 78 (1992).

Dr. Singh set forth a diagnosis of lumbar strain and degenerative disc disease at L5-S1. Dr. Singh opined the soft tissue muscle strain resolved and the L5-S1 degeneration was pre-existing in nature. Dr. Singh did not take or review any x-rays. The x-rays taken at Northwestern Memorial Hospital and by Dr. Lorenz revealed retrolisthesis. Further, Dr. Singh did not address the T11-T12, L4-L5 and L5-S1 disc herniations revealed by the MRI studies. Dr. Singh also did not document that he performed a straight leg raise. Dr. Singh did not

address Petitioner's ongoing symptoms or whether the condition was aggravated as a result of the work-related accident of March 23, 2015. Further, Dr. Lorenz reviewed the report of Dr. Singh and did not agree with conclusions about diagnosis, causation or work restrictions. Accordingly, the Arbitrator accords the opinions of Dr. Singh little weight.

Conclusion: Based on the medical records, Petitioner's testimony, the more credible, weighty and reliable opinions of Dr. Brown, Dr. Jain and Dr. Lorenz and the chain of events analysis, the Arbitrator finds that Petitioner's current condition of ill-being in connection with her back and mind is casually connected to the work-related accident of March 23, 2015.

In support of the Arbitrator's decision relating to "J," whether the medical services were reasonable and necessary and whether Respondent has paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator makes the following conclusions:

The Arbitrator finds and concludes the medical services provided to Petitioner by Emergency Medical Services, Preferred Open MRI, Pinnacle Pain management and Advanced Pain Medicine constitute reasonable and necessary medical treatment and accordingly Respondent is liable for payment of the medical bills totaling $20,590.50. The Arbitrator relies on the medical records submitted into evidence, the medical opinions of Dr. Lorenz and Petitioner's unrebutted testimony.

Respondent disputed the medical bills based on medical causation. Having found that the current condition of ill-being was causally connected to the work-related accident of March 23, 2015, the Arbitrator awards payment of the medical bills. It is significant that the medical treatment, with the exception of one date of services for Pinnacle Pain Management, occurred prior to Dr. Singh's Section 12 examination.

The Arbitrator finds the medical bills are subject to adjustments consistent with the provisions of the Medical Fee Schedule pursuant to Section 8.2. The Arbitrator orders Respondent to calculate the exact amount of benefits owed to the medical provider pursuant to Section 8.2. Any further disputes relating to the adjustment of the bill may be addressed at further proceedings, consistent with this decision. The Arbitrator further orders Respondent to make payment of the medical bill to Petitioner's attorney pursuant to Section 7080.20 of the Rules Governing the Practice Before the Illinois Worker's Compensation Commission. Respondent shall receive credit for any payments made in connection with the medical bills.

In support of the Arbitrator's decision relating to "L," what is the nature and extent of the injury, the Arbitrator makes the following conclusions:

The Arbitrator finds and concludes that as a result of the work-related accident of March 23, 2015, Petitioner sustained permanent and partial disability to the extent of **12.5%** loss of use of the person as a whole in connection with her back condition (**62.5** weeks of compensation) and **5%** loss of use of the person as a whole for the psychological condition (**25** weeks of compensation). The Arbitrator relies on the medical records admitted into evidence, the medical opinions of Dr. Lorenz, the FCE report, the diagnostic studies and Petitioner's credible and unrebutted testimony.

The Arbitrator considered the opinions of Dr. Singh, Respondent's Section 12 physician, and accords his opinions little weight. The Arbitrator finds that Dr. Singh failed to perform a straight leg raise test, did not consider the MRI studies fully and did not consider the x-rays. The Arbitrator also relies on the holding in *International Vermiculite Company.* 77 Ill.2d 1.

The Arbitrator's finding is consistent with the factors and criteria set forth in Section 8.1(b) of the Act. Pursuant to Section 8.1(b) of the Act, the Arbitrator must consider certain factors and criteria in assessing permanent partial disability, including, the level of impairment under the AMA Guides, the occupation of the injured worker, the age of the injured worker, the future earning capacity of the injured worker and evidence of disability corroborated by the treating medical records. The Act provides that no single enumerated factor shall be the sole determinant of disability. After considering the factors, the Arbitrator finds that Petitioner is permanently partially disabled to the extent of **12.5%** loss of use the person as a whole in connection with the back condition (**62.5** weeks of compensation) and **5%** loss of use of the person as a while for the psychological condition (**25** weeks of compensation), **for total compensation of 17.5% under 8(d)2 or 87.5 weeks of compensation. With respect to the factors, the Arbitrator finds the following:**

A. Level of Impairment under the AMA Guides

The Arbitrator finds that neither Petitioner nor Respondent submitted a report setting forth an AMA impairment rating. The Arbitrator finds that an impairment rating is not necessary based on the appellate courts holding in *Corn Belt Energy v. Illinois Workers' Compensation Commission*, 2016 IL App (3d) 150311WC (3d Dist. 2016). The court held that an AMA Impairment Rating is not required for the Arbitrator to award permanent partial disability benefits. *Id.* Accordingly, the Arbitrator will not consider this factor as it relates to the nature and extent of the injury.

B. Occupation of Petitioner

At the time of the work-related accident, Petitioner was a correctional officer. She lifted and carried up to 30 pounds and performed overhead reaching, pushing and pulling, bending and squatting and climbing.

Petitioner walked and stood as part of her job duties. Petitioner also dealt with inmates on a daily basis. According, the Arbitrator finds that Petitioner's job required physical activity. Significantly, when Petitioner returned to work for Respondent in April 2016, she returned to a lighter position in the medium security ward. Further, she left her employment as a correctional officer in January 2017 and obtained employment as a parole agent, which was lighter work than a correctional officer. Since Petitioner's pre-injury employment was physical, the Arbitrator accords this factor great weight.

C. Age of Petitioner

At the time of the accident, Petitioner was 32. At the time of the hearing, Petitioner was 36 years old. No evidence was presented as to how Petitioner's age affected her disability. However, the Arbitrator notes that Petitioner is a younger woman. She will have a longer work life expectancy. Accordingly, the Arbitrator finds that her age increases Petitioner disability. In support of this finding, the Arbitrator relies on the holding *Flexible Staffing Services v. Illinois Workers' Compensation Commission*, 2016 IL App (1st) 151300WC (1st Dist. 2016) (holding that the Commission can make reasonable inferences from the medical evidence as it relates to how the claimant's age affects his disability).

D. Future Earning Capacity

No evidence of whether Petitioner's future earning capacity impacted was submitted at hearing. However, Dr. Lorenz released Petitioner to return to work with permanent restrictions set forth in the FCE. Petitioner testified that her restrictions were initially accommodated. Following the Section 12 examination with Dr. Singh, Respondent stopped accommodating her restrictions. However, Petitioner testified that she was "lucky" and her new assignment was in the medium security ward. The position was within Petitioner's restrictions. In January 2017, Petitioner left her job as a correctional officer and became a parole agent. The job of parole agent was lighter than the job as a correctional officer. Accordingly, Petitioner's ability to perform her pre-injury employment was affected by the work-related accident. **The Arbitrator accords great weight to the fact that Petitioner was released with permanent restrictions and changed jobs to a lighter position.** In support of this finding, the Arbitrator relies on the holding *Flexible Staffing Services v. Illinois Workers' Compensation Commission*, 2016 IL App (1st) 151300WC (1st Dist. 2016) (holding that the Commission can make reasonable inferences from the medical evidence as it relates to how the claimant's age affects his disability).

E. Evidence of Disability Corroborated by the Treating Medical Records

The medical records of Dr. Jain and Dr. Lorenz established that Petitioner sustained an aggravation of the degenerative disc disease and aggravation at the L5-S1 level and a new herniation at L4-L5 with L5 radiculitis. The diagnosis was confirmed by the MRI studies of March 25, 2015 and the x-rays. Dr. Jain discussed the

possibility of future surgery and injections. Dr. Brown set forth a diagnosis of PTSD and anxiety. His opinions were unrebutted.

The medical records documented Petitioner's subjective complaints. Dr. Lorenz and Dr. Jain documented that Petitioner continued to complain of low back pain radiating bilaterally and into the right lower extremity and a stabbing and burning sensation. Petitioner also experienced pain with flexion and extension in her back. Dr. Brown documented that Petitioner had diminished mood and her cognitive status was negatively impacted by rumination and anxiety. Petitioner initially experienced nightmares, flashbacks, intrusive thoughts, panic attacks and isolation. Further, the medical records of Dr. Jain and Dr. Lorenz documented that Petitioner experienced psychologic symptoms, including anxiety, nightmares and depression, following the work-related accident of March 23, 2015.

Petitioner's testimony was consistent with the medical records. She testified that she had ongoing back pain that was worse with sitting and standing. The back pain affected her ability to drive for long periods of time and she purchased pillows for her car. She also used a TENS unit and stretched at home. Further, Petitioner testified that she still experienced increased anxiety. She is scared and anxious when dealing with mentally unstable offenders or offenders who become angry.

The medical records also documented Petitioner's objective findings. This included the MRI studies which documented a right herniation at T11-T12, a left herniation at L5-S1 with underlying retrolisthesis and L4-L5 disc bulge with narrowing of the foramen. The x-rays revealed sacralization of L5 with L4-L5 retrolisthesis. Petitioner experienced pain in the right SI region and in the lumbar spine with extension and pulling in the lumbar spine with bilateral straight leg raise. Further, the FCE documented Petitioner's physical capabilities which were limited to 30 pounds lifting, carrying, pushing and pulling and limited bending and stair climbing. Petitioner also had impaired cognitive status, diminished mood and PTSD.

The Arbitrator accords this factor great weight. The Arbitrator finds it significant that Petitioner has ongoing subjective complaints and objective findings. Accordingly, based on the medical evidence and considering the above factors, the Arbitrator finds and concludes Petitioner sustained the permanent and partial disability to the person as a whole under Section 8(d)2 to the extent of **12.5%** thereof, or **62.5** weeks of compensation, due to her back injuries, and further sustained the permanent and partial disability to the person as a whole under Section 8(d)2 to the extent of **5%** thereof, or **25** weeks of compensation, due to her psychological injuries, **for total compensation of 87.5 weeks under Section 8(d)2.**

Robert M. Harris

Robert M. Harris, Arbitrator

Dated: August 15, 2019

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 down	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ROBERT BUKALA,

Petitioner,

vs. NO: 16 WC 27025

CITY OF JOLIET,

Respondent.

20IWCC0070

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 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.

This claim involved a work accident sustained by a patrol officer for the City of Joliet who suffered a fracture to the left distal tibia as a result of a fall while chasing a suspect. The Arbitrator incorrectly found that Petitioner suffered the loss of use of 32.5% of the left leg as the result of the accident

The Illinois Supreme Court has previously determined that a distal fibula fracture is classified as part of the foot when determining loss of use. For this reason, the Commission modifies the decision of the Arbitrator and finds Petitioner sustained a permanency loss to the left foot instead of the left leg. Eagle Discount Supermarket v. Industrial Comm., 82 Ill 2d 331, 412 N.E. 492 (1980).

The Commission views the evidence of permanency differently with respect to Section 8.1b (b) factor (v).

Orbiculus

20IWCC0070

(v) evidence of disability corroborated by the medical records

In analyzing the evidence of disability as corroborated by the medical records it is clear that Petitioner has not sought medical treatment for the left ankle since May 3, 2017, two years prior to trial. At the time of the last examination the records reflect that Petitioner was running, exercising, and walking without any pain in his left ankle.

Petitioner testified that he takes over the counter pain medications once a week as a result of the ankle injury and that he is capable of performing his full work duties without difficulty but would sometimes have small amount of swelling after a day extended walking.

Having weighed the evidence and analyzed the Section 8.1b(b) factor (v), the Commission finds Petitioner sustained a 25% loss of use of the left foot under Section 8(e)of the Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $775.18 per week for a period of 41.75 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the loss of use of 25% of the left foot.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner compensation that has accrued from May 31, 2017 through July 10, 2019, and shall pay the remainder of the award, if any, in weekly payments.

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

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

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

DATED: JAN 29 2020
SM/msb
o-01/15/20
44

Stephen Mathis

Douglas McCarthy

L.Elizabeth.Coppoletti

SOUTHCOAST

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BUKALA, ROBERT
Employee/Petitioner

Case# **16WC027025**

CITY OF JOLIET
Employer/Respondent

20IWCC0070

On 7/22/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.01% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in 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 LAW OFFICE
DAVID W MARTAY
134 N LASALLE ST 9TH FL
CHICAGO, IL 60602

3993 ROSARIO CIBELLA & ASSOCIATES
JACOB SCHNEIDER
2561 DIVISION ST SUITE 103
JOLIET, IL 60435

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
NATURE AND EXTENT ONLY

20 IWCC0070

Robert Bukala
Employee/Petitioner

v.

City of Joliet
Employer/Respondent

Case # **16** WC **27025**

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 **Gerald Granada**, Arbitrator of the Commission, in the city of **New Lenox**, on **July 10, 2019**. By stipulation, the parties agree:

On the date of accident, **8/18/16**, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $**84,503.64**, and the average weekly wage was $**1,625.07**.

At the time of injury, Petitioner was **37** years of age, ***married*** with **2** dependent children.

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

Respondent shall be given a credit of $**25,846.49** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**25,846.49**.

After reviewing all of the evidence presented, the Arbitrator hereby makes findings regarding the nature and extent of the injury below.

20IWCC0070

On the date of accident, petitioner was chasing a fleeing suspect and in the course of chasing the suspect slipped on wet grass. Petitioner suffered an injury to his left ankle and leg. He was taken by ambulance to the emergency room at St. Joseph Hospital and came under the care of Dr. Pearson. (Px. 1) On August 30, 2016 petitioner underwent an open reduction and internal fixation for a distal fibular fracture, which required the application of an amniox graft. Petitioner remained off work and received physical therapy through January 30, 2017. He was placed at maximum medical improvement on May 3, 2017. Petitioner testified he continues to suffer from swelling in the leg. Petitioner further testified there has been no discussion with his doctors regarding having the hardware removed in the immediate future.

Applying the factors set forth in Section 8.1b of the Act, the Arbitrator notes the following: (i) no AMA rating was introduced into evidence, so the Arbitrator gives this factor no weight; (ii), Petitioner was a patrolman who returned to the same position following his work-injury, a factor to which the Arbitrator gives considered weight; (iii) Petitioner was 37 years old at the time of injury, a factor to which the Arbitrator gives some weight; (iv) there was no evidence of future earning and the Arbitrator gives no weight to this factor; (v), there was evidence of disability which show that the Petitioner underwent a surgical open reduction and internal fixation for a distal fibular fracture which required the application of an amniox graft. Petitioner testified that he still has the hardware in his leg and that his leg is still giving him problems when he wears his work boots that go above the ankle. Petitioner testified he continues to have swelling in the leg and foot and notices pain when he tries to hike or swim. To treat the pain, Petitioner regularly takes Ibuprofen or Alleve. Based on the factors above, the Arbitrator concludes the injuries sustained by Petitioner caused a 32.5% loss of the left leg as provided in Section 8(e) of the Act.

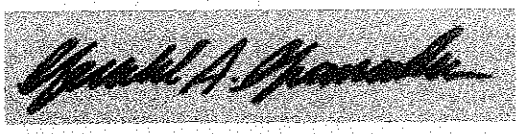
ORDER

Respondent shall pay Petitioner the sum of **$775.18**/week for a further period of **69.875** weeks, as provided in Section **8(e)** of the Act, because the injuries sustained caused **32.5% loss of use of the left leg**.

Respondent shall pay Petitioner compensation that has accrued from **5/31/17** through **7/10/19**, 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 Gerald Granada

7/19/19
Date

JUL 22 2019

Contents

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

Darryl Hudson,

Petitioner,

20IWCC0071

vs.

No. 11 WC 10452

Chicago Public Schools,

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 causal connection, medical expenses, temporary disability, maintenance, permanent disability, penalties and attorney fees, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission notes the opinion of Respondent's section 12 examiner, Dr. Goldberg, that Petitioner reached maximum medical improvement on October 13, 2015. The Commission therefore extends temporary total disability and medical benefits through that date. All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 5, 2019, is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $445.22 per week for a period of 120 5/7 weeks, from June 21, 2013

through October 13, 2015, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay related medical bills in evidence through October 13, 2015, pursuant to §§8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $400.70 per week for a further period of 150 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the permanent disability to the extent of 30 percent of the person as a whole.

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

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental 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: JAN 29 2020
o-12/18/2019
SM/sk
44

Stephen Mathis

L. Elizabeth Coppoletti

DISSENT

I respectfully dissent from the Majority's Decision and would have awarded Petitioner TTD benefits through September 25, 2017, the date Petitioner last treated with Dr. Ernesto Padron. I find the opinions of Dr. Padron more persuasive than the opinion of Dr. Goldberg, Respondent's Section 12 examiner. The record reveals that Petitioner routinely treated with Dr. Padron through September 25, 2017. On November 18, 2016, Petitioner was still symptomatic from his work injury and was kept off work completely by Dr. Padron (Petitioner's exhibit 1 contains Dr. Padron's off work slips through November 18, 2016). Petitioner continued to treat with Dr. Padron on a regular basis between November 18, 2016 and September 25, 2017. Dr. Padron's medical records indicate that Petitioner's pain continued to affect his ability to perform his activities of daily living. There is no indication that Petitioner was released back to work. It was not until September 25, 2017 that Dr. Padron discharged Petitioner from the clinic. Therefore, I would award Petitioner TTD benefits through September 25, 2017.

D. Douglas McCarthy

EP 1 503 031 B1

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HUDSON, DARRYL
Employee/Petitioner

Case# **11WC010452**

20IWCC0071

CPS
Employer/Respondent

On 2/5/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.44% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5317 CASTANEDA LAW OFFICE
JOHN J CASTANEDA
514 W STATE ST SUITE 210
GENEVA, IL 60134

1886 LEAHY EISENBERG & FRAENKEL
SANTIAGO J ECHEVESTE
33 W MONROE ST SUITE 1100
CHICAGO, IL 60603

20 IWCC0071

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

DARRYL HUDSON
Employee/Petitioner

v.

CPS
Employer/Respondent

Case # **11** WC **10452**

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 **MARIA S. BOCANEGRA**, Arbitrator of the Commission, in the city of **CHICAGO, IL**, on **SEPTEMBER 18, 2018 & OCTOBER 10, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of 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 [x] 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. [x] Is Respondent due any credit?
O. [ ] Other _____

FINDINGS

On **10/28/2010**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$34,727.16**; the average weekly wage was **$667.83**.

On the date of accident, Petitioner was **52** years of age, ***single*** with **1** dependent children.

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

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

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$4,808.40** for PPD advance payment and **$0** for medical payments/benefits paid by Respondent, for a total credit of **$4,808.40**. Respondent is entitled to a credit under Section 8(j) of the Act for any and all medical benefits paid.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of **$445.22/week** for **59 weeks**, commencing **6/21/2013** through **8/7/2014**, as provided in Section 8(b) of the Act. Respondent shall pay Petitioner the temporary total disability benefits that have accrued from **6/21/2013** through **8/7/2014**, and shall pay the remainder of the award, if any, in weekly payments. Respondent shall be given a credit of for temporary total disability benefits that have been paid for the period covering **6/21/2013** through **8/7/2014**.

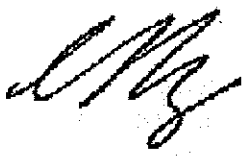
Respondent shall pay reasonable and necessary medical services of H-Wave which total a gross amount of **$4,149.52**, as provided in Sections 8(a) and 8.2 of the Act. Against this specific award, Respondent shall be given a credit for medical benefits that have been paid toward this bill, and Respondent 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 **$400.70/week** for **150 weeks**, because the injuries sustained caused the **30%** loss of the person as a whole, as provided in **Section 8(d)2** of the Act. Against this award, Respondent shall be given a credit of **$4,808.40** for PPD advances previously paid.

Petitioner's request for penalties and fees is ***denied***.

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

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



Signature of Arbitrator

2-5-2019
Date

FEB 5 - 2019

FINDINGS OF FACT

Background

Darryl Hudson ("Petitioner") alleged injuries arising out of and in the course of his employment with Chicago Public Schools ("Respondent") occurring on October 28, 2010. Ax1. On September 19, 2018 and on October 10, 2018, the parties proceeded to arbitration on the disputed issues of causal connection, liability for unpaid medical bills, temporary total disability, maintenance, Respondent's entitlement to credit for benefits paid, nature and extent of the injury and penalties and attorney's fees under Sections 19(k), 19(l) and 16 of the Act. The following is a recitation of the facts adduced at trial.

Previous Section 19(b) Hearing and Decision

This matter was previously tried before Arbitrator Brian Cronin on May 7, 2013 and June 20, 2013. Px7. On December 15, 2013, Arbitrator Cronin found that Petitioner's condition of ill-being was causally related to the undisputed work accident, that Respondent had not yet paid all reasonable and necessary charges for all medical services and that Respondent was entitled to a credit for a prior advance paid. The Arbitrator noted Petitioner was placed at MMI by Dr. Lorenz but from a surgical perspective on May 7, 2012 and hence Petitioner was awarded TTD from 11/3/2010 through 1/9/2011 and from 5/27/2011 through 6/20/2013 – the date of the last hearing.

The Arbitrator found that Petitioner's accident resulted in back pain and back symptoms which later developed into radiculopathy. The Arbitrator further concluded that Petitioner's acute emotional distress was causally related to the work injury. The Arbitrator further noted that it was premature to issue a finding as to the necessity of the spinal cord stimulator because Dr. Lorenz did not specifically recommend or prescribe it.

Regarding disability benefits, the Arbitrator found that as of April 3, 2012, the FCE demonstrated Petitioner could not perform his full duty capacity work activities, placing him at the light to medium work level. TTD was awarded thru the date of the last hearing.

Testimony by Petitioner

Petitioner testified that he previously worked as a custodian for Respondent and that in that capacity, he was required to be able to lift and carry tables, desks, chairs, cabinets, books and equipment. he had to clean bathrooms, do landscaping, remove snow and that most work required repetitive bending. Petitioner confirmed that on the date of his accident, he was lifting 5-6 tables.

Petitioner further testified that he began treating with Drs. Padron and Lorenz and that he last saw Dr. Padron on 9/25/17 and that thereafter, he began seeing his PCP for medications. Petitioner recalled being recommended for a trial spinal cord stimulator in August 2015 but that he never got it because it was not approved. Petitioner stated that his chiropractic and injection therapy did not help.

Petitioner testified he was terminated around 2013 and did not try to reapply for his job after that. He said that around that time, he attempted to return to work in 2013 for approximately 1 month as a lead custodial worker. He is or was a union member with Local 73.

As of the date of this hearing, Petitioner said he is 60 years old. On cross, Petitioner said he currently rated his pain 8 out of 10. Most days his daily pain is 7.5-8 out of 10. He says his pain basically stays the same and that symptoms are located between his shoulder blades and beyond his buttocks. He has had no other accidents, injuries or surgeries. On cross, he said he does what he can do here and there and that he previously admitted to watching a lot of television and that his only treatment is medications. He admitted to taking

medications for low back pain, HTN and that he smokes ½ pack of cigarettes per day. Petitioner admitted to seeing Dr. Ganam for pain medications regularly. He admitted to undergoing approximately 115 psychiatric sessions. Petitioner said he last saw Dr. Padron in September of 2017. Thereafter he started getting medications from his PCP. Petitioner testified that Dr. Padron recommended marijuana and that he attempted to fill out a form. He admitted he currently buys it illegally. He testified he has only tried cocaine a "couple of times," and that he tried anything to dull the pain.

Regarding the FCE, Petitioner said while he recalled taking this test, he did not recall what Dr. Lorenz said he could or could not do. He did not recall being released to work with restrictions. He said he would not classify his job as medium but as heavy. On re-direct, Petitioner stated that his FCE took place before the prior Section 19(b) hearing before Arbitrator Cronin.

Regarding his vocational assessment with Lisa Helma, Petitioner testified on cross that he told her that no doctor released him to go back to work, that he told her he could not obtain medications because insurance did not approve those and that he was awarded SSDI. Petitioner said he told Helma he took 3-4 oxytocin per day and that while he was prescribed a variety of medications by Dr. Padron, it was not all at the same time. He explained he would try different stuff and different times. Petitioner denied telling Helma that he could not sit for more than 5 minutes and that he could not stand for more than 5-10 minutes. He testified no one ever explained to him the results of his FCE. Regarding his driver's license, he admitted that he did not intend to renew it or drive. He stated his doctors told him he should not be driving. Petitioner said he explained he has to turn his whole body rather than just his neck when driving. He admitted to never looking for work and kept no job search logs. At trial, Petitioner confirmed he only has a high school diploma and that he previously worked as a lead custodial worker and steel mill grinder and finisher. He testified he does not own a computer, does not know how to use one, does not have email, does not have typing skills and does not know how to use the internet.

Regarding benefits, Petitioner testified that he was not provided vocational services, that he received one check and was not currently receiving workers' compensation. He testified he never received a letter from his employer or workers compensation as to why benefits were terminated or that they were being terminated. He currently receives SSDI.

Medical Records and Other Documentary Evidence

Medical records from Hinsdale Orthopedics were entered into evidence as a Px2. The record showed a date of service of August 23, 2012, which was already considered in the prior Section 19(b) hearing. Px2, Px7.

Following the hearing before Arbitrator Cronin, Petitioner continued to follow up with Dr. Padron on monthly basis through December 2013. Px1. In July 2013, the doctor noted Petitioner was awaiting a recommended spinal cord stimulator as recommended by the neurosurgeon. However, Petitioner wished to avoid surgery at all costs and would be managed via pain medications. Medications were refilled, and Petitioner was to follow up PRN. Lab testing was positive for Carisoprodol metabolite and marijuana metabolite. Px1:603. Petitioner followed up twice in August 2013, unchanged and a new MRI was ordered. Petitioner followed up each month thereafter through December unchanged and medications were refilled at each visit.

From January 2014 through December 2014, Petitioner saw Dr. Padron nearly monthly. Px1. In January, Petitioner saw Dr. Padron twice having been dispensed Norco at one visit after being unable to fill it due to cost. He was to follow up PRN and was given an H-Wave machine for the low back. Diagnosis was lumbar disc displacement, inflamed SI, spasm and long-term drug therapy. Lab testing was positive for codeine, Morphine, Hydrocodone, Hydromorphone, Amitriptyline and Nortriptyline. Px1:596. From February to May, Petitioner followed up largely unchanged and unresponsive to conservative treatments. Medications were

refilled at each visit. In June 2014, he was diagnosed with sacroiliitis and given Norco. In July 2014, he underwent caudal ESI and bilateral SI injections with limited response. In August 2014, he was given Norco and N3. Lab testing that month was positive for Hydrocodone and marijuana metabolite. Px1:591.

From January 2015 through September 2015, Petitioner followed up with Dr. Padron monthly, unchanged in chief complaint(s), problem(s), history of present illness, physical exam and assessment/plan. At each visit, medications were refilled. In January 2015, lab testing was negative for Carisoprodol, Hydrocodone, Hydromorphone and Meprobamate. Px1:586. In February 2015, lab testing was positive for THC and inconsistent negative for Hydrocodone, Norco, Soma, Tramadol and Dilaudid. Px1:583.

In March 2015, Petitioner saw Dr. Lorenz who noted that Petitioner have a history of significant spinal spondylosis and chronic low back pain. Px2. There were little to no neurological issues noted at that point. Petitioner was previously discharged after his functional capacity evaluation which placed him at 32 pounds. He was under pain management and under consideration for a spinal cord stimulator. Pain management sent Petitioner back to Dr. Lorenz for surgical consultation. On exam, Dr. Lorenz noted that back pain was the same it had been all along with the level of 7 to 8 and fairly constant. Petitioner had difficulty with forward bending, standing and had difficulty with transitional movements. Straight leg raise was negative. X-rays demonstrated significant degenerative disc disease and spurring particularly in the upper lumbar spine. He had a sacralized L5. He had degenerative changes at L3-4 with mild stenosis without any particular findings. The diagnosis remained chronic back pain and degenerative disease of the lumbar spine. The doctor recommended reevaluation by pain management for consideration of spinal cord stimulator. There was nothing surgical to offer. No work restrictions issued. In March 2015, urine testing was inconsistent negative for Norco and inconsistent positive for Ethyl Sulfate and THC (marijuana). Px1:581.

On February 5, 2015, MRI of the lumbar spine showed partially sacralized L5, degenerative changes, mild spinal stenosis at L3-4, multilevel neural foraminal stenosis. There was no significant change compared with the previous scan. Rx16, Px1.

In April 2015, urine testing was inconsistent negative for Norco and inconsistent positive for Ethyl Beta-D, Ethyl Sulfate and THC (marijuana). Px1:579. In May 2015, urine testing was inconsistent positive Benzoylecgonine (cocaine), cocaine, Ethyl Beta-D, Ethyl Sulfate and THC (marijuana). Px1:577.

On July 23, 2015, Petitioner followed up with Dr. Padron. Rx23. Petitioner had fallen two weeks prior exacerbating his symptoms. His pain affected his ability to perform his activities of daily living, range of motion and quality of life. Due to the exacerbation, Petitioner admitted to taking more medication that he was supposed to. A urine screen was ordered but medications were refilled and Dilaudid added. The plan was for EMG/NCV. Assessment was spasm, low back pain, displacement of lumbar intravertebral disc without myelopathy, sacroiliac joint inflamed and long-term drug therapy. EMG/NCV testing failed to show evidence of lumbosacral radiculopathy in either lower extremity. Px1. Urine testing was positive for cocaine and THC. *Id.* at 534. In August 2015, urine testing was inconsistent negative for Norco and inconsistent positive for THC. Px1:532.

On September 1, 2015, Petitioner followed up with Advocate Medical for unrelated HTN. Px3. No mention is made of a work injury, but spinal stenosis is noted. On September 16, 2015, petition was evaluated by Dr. Edward Goldberg at the request of Respondent. Rx6. Petitioner give a history of the accident and at that time noted bilateral low back pain without radicular complaints. Petitioner said that in the past he had had some numbness and tingling down both lower extremities. He had been treated with therapy and injections, but no surgical recommendation had ever been made. He had not worked since approximately January 2011. The doctor was unable to render any opinions given that there were no films records or cover letter. Urine testing in

September was positive for Dilaudid and inconsistent positive for cocaine, Hydrocodone, THC and Ethyl Sulfate. Px1:530-531.

On October 13, 2015, Dr. Goldberg issues an addendum opinion. Rx7. The doctor noted that at the time of his September 2015 evaluation, he found Petitioner to be neurologically intact. He noted Petitioner complained of bilateral low back pain without radiculopathy. The doctor reviewed medical records through July 2015 and concluded that he believed Petitioner suffered an aggravation of the degenerative thoracic and lumbar spines. The doctor did not believe the injections or stimulator were necessary. Dr. Goldberg did not find additional treatment was necessary except to wean Petitioner off medications. The doctor concluded Petitioner could return to work at the light to medium physical demand level per his FCE.

In October 2015, urine testing was inconsistent positive for THC (marijuana); and consistent positive for Norco and Dilaudid. Px1:527-529. In November 2015, urine testing was inconsistent positive for ETG (alcohol derivative), Benzoylecgonine (cocaine) and THC (marijuana); and inconsistent negative for Norco (Hydrocodone, Norhydrocodone, Hydromorphone). Px1:521-523. In December 2015, urine screen testing was consistent positive for Tramadol but inconsistent negative Norco. Rx17, Px1:518-520.

On January 21, 2016, Petitioner followed up with Dr. Padron. Rx17. Medications at that time included amlodipine, Dilaudid, doxazosin, hydrocodone, ibuprofen, topical cream, Norco, omeprazole, oxycodone, soma, tramadol and tramadol extended release. Petitioner was still symptomatic, and his pain affected his ability to perform activities of daily living, range of motion and quality-of-life. The doctor noted positive findings on repeat MRI. Petitioner was to be medically managed at that time. Medications were refilled, and a urine screen was performed. Assessment was spasm, low back pain, lumbar intravertebral disc displacement without myelopathy, SI inflamed and long-term drug therapy. Testing was positive for alcohol, marijuana derivative and cocaine derivative and consistent positive for Norco. Rx17, Px1:515-517.

On February 19, 2016, urine screen testing was negative for expected Norco, including hydrocodone, Hydromorphone and Norhydrocodone. Rx17, Px1:512-514. On February 22, 2016, Petitioner underwent an unrelated care with Advocate. Px3.

In March 2016, urine testing was inconsistent positive for THC (marijuana). Px1:509-511. In April 2016, urine testing was inconsistent positive for THC (marijuana); and inconsistent negative for Norco (Hydrocodone, Norhydrocodone, Hydromorphone). Px1:506-508. On April 5, 2016, Petitioner followed up with Advocate Medical for sleeping problems. Px3. Assessment included conditions unrelated to the work accident.

On June 20, 2016, urine testing was positive for marijuana derivatives but negative for expected Norco, including hydrocodone, Norhydrocodone and Hydromorphone. Rx17, Px1:502-505.

On July 19, 2016, Petitioner followed up with Dr. Padron. Rx17. The doctor prescribed carisoprodol and hydrocodone. Additional medications prescribed at some point prior included amlodipine, bisacodyl, Dilaudid, doxazosin, fluticasone, ibuprofen, anti-inflammatory, neuropathic compound topical cream, Norco, omeprazole, omeprazole delayed release, oxycodone, electrolyte solution, tramadol, tramadol 50 mg, and tramadol extended release. Assessment was unchanged. Urine testing that month was inconsistent positive for Benzoylecgonine (cocaine) and THC (marijuana) and inconsistent negative for Norco (Hydrocodone, Norhydrocodone, Hydromorphone). Px1:499-501.

On August 17, 2016, Petitioner followed up with Dr. Padron Rx17. At that time carisoprodol and oxycodone were prescribed. Additional medications were listed and largely unchanged. Complaints, history, assessment and plan was unchanged. Urine testing that month was inconsistent positive for Benzoylecgonine

(cocaine) and THC (marijuana); and consistent positive for Norco (Hydrocodone, Norhydrocodone, Hydromorphone) and Tramadol. Px1:496-498. On August 29, 2016, Petitioner presented to Advocate Medical for follow-up of HTN, COPD and prostate enlargement. Px3. No references made it to the work accident. Assessment was for conditions or issues not involving this work accident.

On September 2, 2016, Petitioner followed up with Dr. Padron. Rx17. Medication list was unchanged, and Petitioner was prescribed hydrocodone. Complaints, history, assessment and plan was unchanged. Urine testing that month was inconsistent positive for THC (marijuana) and consistent positive for Norco (Hydrocodone, Norhydrocodone, Hydromorphone). Px1:493-495. That same day, Petitioner was evaluated by Advocate Medical for abdominal pain and elevated lipase. He was referred to Trinity Hospital. Px3.

In October 2016, urine testing was inconsistent positive for Benzoylecgonine (cocaine) and THC (marijuana); and consistent positive for Norco (Hydrocodone, Norhydrocodone, Hydromorphone). Px1:483, 485, 490-492. On November 18, 2016, Petitioner followed up with Dr. Padron. Rx17. Medication list was unchanged. Complaint, history, assessment and plan were also unchanged. Petitioner was switched to Oxycodone. A urine screen was performed, and Petitioner was counseled on results. Urine testing was inconsistent positive for Hydromorphone, Benzoylecgonine (cocaine) and THC (marijuana). Px1:486-489.

On January 20, 2017, urine testing was again inconsistent positive for Hydrocodone; consistent positive for Oxycodone and Oxymorphone; and inconsistent negative for Noroxycodone, Carisoprodol (Soma) and Meprobamate. Px1:479-482. On February 17, 2017, Petitioner followed up with Dr. Padron. Rx17. Complaints, history, assessment and plan were unchanged. It was noted that medications were refilled, urine testing was performed in Petitioner was counseled on results. Urine testing was inconsistent positive for Hydrocodone, Benzoylecgonine (cocaine) and THC (marijuana) and consistent positive for Oxycodone, Noroxycodone, Oxymorphone and Carisoprodol (Soma). Px1:471-477. In March 2017, urine testing was inconsistent positive for Benzoylecgonine (cocaine) and THC (marijuana) and inconsistent negative for Oxycodone, Noroxycodone, Oxymorphone, Carisoprodol (Soma) and Meprobamate. Px1:467-470.

In April 2017, urine testing was consistent positive for Oxycodone, Noroxycodone, Oxymorphone, Carisoprodol (Soma) and Meprobamate; inconsistent positive for Hydrocodone and Benzoylecgonine (cocaine). Px1:462-465. On April 26, 2017, Petitioner followed up with Advocate Medical. Px3. Assessment was hypertension, nicotine dependence, obstructive sleep apnea, elevated lipase. Nothing was noted in reference to the work accident.

In May 2017, urine testing was consistent positive for Oxycodone, Noroxycodone and Oxymorphone, inconsistent positive for Hydrocodone, Benzoylecgonine (cocaine) and THC (marijuana) and inconsistent negative for Carisoprodol (Soma) and Meprobamate. Px1:458-461.

On June 27, 2017, Petitioner followed up with Advocate Medical. Px3. The plan was to continue with HTN medication and start Wellbutrin due to history of depression. Urine testing was inconsistent positive for Benzoylecgonine (cocaine) and inconsistent negative for Carisoprodol (Soma), Noroxycodone, Oxycodone and Meprobamate. Px1:454-457. In July 2017, urine testing was inconsistent for hydrocodone and Meprobamate but consistent for Carisoprodol, Noroxycodone, Oxycodone and Oxymorphone. Px1:450-453.

On September 25, 2017, Petitioner saw Dr. Padron. Rx17. Complaints, medications, history, unchanged. Soma and Tamsulosin was added to the prescribed list of medications. Urine testing was performed, and Petitioner was counseled. Testing was inconsistent for Noroxycodone, Oxycodone and oxymorphone, Carisoprodol and Meprobamate but positive for cocaine. Px1:447.

On October 24, 2017, Petitioner followed up with Advocate Medical. Px3. Assessment was spinal stenosis. The plan was for refill of oxycodone, other medications and follow up. The doctor noted chronic back pain and chronic pain medication and dependency. Petitioner was advised to follow up with a new pain specialist and was given a referral.

On December 11, 2017, Petitioner followed up with Advocate Medical. Px3. Medical problems including spinal stenosis and radiculopathy. Assessment was spinal stenosis. The plan was a referral to neurologist given EMG findings. Oxycodone was refilled.

On February 22, 2018, Petitioner followed up with Advocate Medical for management of HTN. Px3. MRI showed progression of L1-2 and L4-5 disc herniation and multilevel arthritis. He continued to have pain and lower back radiating sometimes to his leg described as severe. Oxycodone was renewed.

On April 11, 2018, Petitioner followed up with Advocate Medical for follow-up of unrelated HTN. Px3. Lower back pain and lumbar spinal herniated disc was noted. He was requesting a refill on his pain medication that will be due later that month. Oxycodone was prescribed. He was to follow up with pain management and neurosurgery. The last visit in the record is dated June 14, 2018, when Petitioner followed up with Advocate Medical for management of HTN, unrelated. Px3. Petitioner was prescribed a variety of medications, including Oxycodone.

Wage rates effective July 1, 2015 through June 30, 2018 indicated that earnings for custodial worker ranged from 13.35 per hour in year one of service to $22.38 per hour with 21 or more years of service. Px6. Other salary plans were detailed for lead custodial workers, factor custodial workers, custodial worker assistant, watchmen and central office security officer.

Respondent introduced a job description for custodial worker. Rx24. Physical requirements including heavy work of exerting 50 - 100 pounds of force occasionally, 25 - 50 pounds of force frequently or 10 - 20 pounds of force constantly to move objects. Physical demands were in excess of those for medium work. Activities occurred in and out of buildings and facilities. Essential functions included cleaning various settings inside of buildings and facilities, working with various tools and quit meant to complete task, lifting, moving, operating, holding, raising and lowering and setting up.

Records show Dr. Padron removed Petitioner from work completely from July 12, 2013 through November 18, 2016. Px1.

Evidence Deposition of Lisa Helma

On September 13, 2018, the parties took the evidence deposition of Lisa Helma ("Helma"). Px5. Testifying on behalf of Petitioner, Helma testified that she is a certified rehabilitation counselor. She had a master's degree in rehabilitation counseling for the University of Tennessee. She was nationally certified as of September 2008 and has been a certified counselor since that time. At the time of her deposition, she was employed by Vocamotive. Helma met with Petitioner on March 22, 2018 for the purposes of vocational evaluation. In conjunction with that initial evaluation, she typically reviews medical history, educational history and work history. Situational factors considered include age, education, work experience, physical capabilities, transferable skills in any other factors impacting employability. She explained that a rehabilitation plan provides additional information regarding her recommendations regarding assistance a client would need in getting stable employment.

In this case, Helma reviewed an October 2015 Section 12 exam issued by Dr. Goldberg as well as the April 2012 functional capacity evaluation. In her opinion, these were sufficient to conduct a valid vocational

evaluation. Her findings were summarized in her April 23, 2018 initial evaluation report. Px5, Dep. Ex. 2. During that evaluation, Petitioner disclosed the history of his injury and course of medical treatment. In part, Petitioner related that his current primary care physician would see him on a monthly basis for refills on his pain medications. He needed to find a new pain specialist because Dr. Padron was no longer practicing in his area. He reported he completed an FCE but did not recall the details. He admitted to taking Oxycodone 2-3 times per day and blood pressure meds. He reported some difficulties with daily living. Helma testified that Petitioner was released per his FCE by both Drs. Lorenz and Goldberg. She concluded he was unable to return to his preinjury occupation based upon his current capabilities. She classified his job as heavy.

Regarding education, Helma testified that Petitioner's high school education was limited and did not provide him with any significant transferability of skills. She noted his driver's license was expired and the lack thereof impacted geographic access to the labor market. Helma stated if Petitioner obtained a license he could be employable and placeable if his doctors felt he was capable of driving. She admitted she did not see any comment by his doctor regarding driving. Petitioner denied having computer, keyboarding or software skills. If he were placeable and employable, he would need relevant training for approximately 3 months.

Regarding vocation history, Petitioner related that he worked for the Chicago Board of Education for a total of 16 years. As a custodial engineer, his duties included sweeping, cleaning, making sure the school environment was safe, main team building and grounds, mowing the lawn, trimming the bushes, removing snow, painting, stripping, buffing and waxing floors and setting up the cafeteria in assemblies. Petitioner related that after his work accident he attempted to return to work for a period of time in 2013 but was unable to perform his job duties and that there was no light duty work available in that position. Previously worked for security company, national casting, gazebo foods, a prep cook.

Helma described transferable skills as skills an individual may have based on their level of education in their previous work experiences which would transfer into employment in a stable labor market within their physical capabilities. It was her opinion that Petitioner did not have any type of transferability of skill. She based this opinion on that Petitioner had a work history at the medium to heavy physical demand level. Given his current restrictions at the light to medium physical demand level, the need to alternate positions, his previous work experience would not transfer any into any type of occupation within his physical capabilities.

Regarding his previous employment as a security guard, she did not feel this was a transferable skill because he did not have a permanent employee registration card (PERC) nor did he have a 20 hour security training certification which would be required by most employers for entry-level security positions. Petitioner disclosed that he was responsible for sitting at the front desk and checking people in and out and that it was a temporary position.

Regarding his socioeconomic status, Petitioner lived in Chicago, he was receiving worker's compensation benefits, Social Security disability income, Medicare and that his grandchildren and eighteen-year-old son were financially dependent on him. He denied having a functional automobile, criminal history and denied looking for work. Helma reasoned that if Petitioner was not receiving worker's compensation benefits, while it did not necessarily impact employability or placement potential, it would make participating in vocational a valuation services more challenging.

She opined that Petitioner was employable however she gave a guarded prognosis for a return to work. Specifically, she believed that based upon his physical capabilities, he would have access to some types of employment including gate guard, security guard, concierge and cashier. However, given his advanced age, his level of education and his previous work experiences, his lack of transferable skills and his need to alternate positions throughout the course of the workday, Helma believed placement was expected to be extremely challenging and that he did have an exposure for total disability.

Helma testified that if he was employable, it was still her opinion that he had sustained a reduction in earning capacity given that in his former position he would be earning between $23 and $24 an hour. At the time of her evaluation, his probable wage-earning potential would be between $10 and $13 an hour. She determined these wages based on statistical data and collective experiences at Vocamotive with placement and labor market surveys.

Helma testified that she prepared a vocational evaluation plan dated April 23, 2018 which outlined recommendations regarding locational rehabilitation services. The plan included job targets, projected wages, vocational testing, computer skills basic training, security training, job seeking skills instruction, vocational counseling and behavioral self-management as well as supervised and independent job searches. However, it was her opinion that if Petitioner was to conduct an independent job search he did not have the skills necessary in order to currently obtain employment within his physical capabilities. This was based on him not being familiar with current recommendations for an aggressive job search, not having marketable keyboarding or software skills and lack of necessary computer skills to conduct an aggressive job search. Further, he did not have a current resume or job search correspondence.

On cross-examination, Helma testified that she did not recall having any of Dr. Padron's records and was not aware whether his medical license had been revoked. She had not seen any of Petitioner's primary care physician records. Helma agreed that she had largely not reviewed a majority if not none of Petitioner's medical records. She agreed Petitioner related to her that no doctor had released him to return to work. She agreed she was not aware that Dr. Goldberg placed Petitioner at maximum medical improvement on October 13, 2015 and was not aware that Dr. Lorenz's office placed Petitioner at maximum medical improvement on May 7, 2012 per the functional capacity evaluation.

Helma agreed that the functional capacity evaluation was a valid result. She further agreed that Petitioner related to her that he could sit and stand for 5 to 10 minutes only whereas the functional capacity evaluation determined Petitioner could sit up to 5 to 6 hours per day. Further, she agreed that while Petitioner told her he could only walk 1 to 1 1/2 blocks, the functional capacity evaluation permitted 4 to 5 hours of walking occasionally.

Helma agreed that Petitioner voluntarily allowed his driver's license to expire and did not renew it. She agreed that Petitioner related that he was unable to turn while driving but that his evaluation found him capable of frequent head and neck flexion in rotation. She explained that he did not she did not know exactly what he meant being unable to turn while driving. She agreed that to some extent by voluntarily allowing his license to expire he was voluntarily limiting his employment potential. She further agreed that she never saw any medical opinion indicating he could not drive.

When asked regarding Petitioner's receipt of Social Security benefits, she did not necessarily agree that by applying for and receiving such disability payments, that Petitioner voluntarily took himself out of the workforce and/or that he voluntarily decided not to look for work. On cross, Helma confirmed that it was her opinion that Petitioner was employable but that at 60 years old he was in an advanced age group making it a significant factor. However, she agreed that when Petitioner was released at maximum medical improvement he was 54 years old and would not have been in an advanced age group but rather a person approaching advanced age, but age was still to be a factor.

Arbitrator's Credibility Determination

Petitioner was the only witness to testify at trial. The Arbitrator had an opportunity to observe Petitioner's testimony and his demeanor and found him to be not credible. Petitioner's testimony when compared to his voluminous treatment and vocational records were significantly at odds. Petitioner failed to address or otherwise ignored the overwhelming evidence showing Petitioner's consistent failure to take prescribed medications, failed to address or explain his consistent positive testing for illicit drugs that he described at trial to be occasional at most; failed to address or explain why he failed to look for work and failed to explain why he made statements to Helma regarding his limitations in sitting, standing and other functions. Petitioner was observed, contrary to what he told Helma, sitting for a majority of the trial.

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

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein.

a. Law of the Case - prior 19(b) decision by Arb. Cronin

Under the law of the case doctrine, it generally provides that once an issue has_been 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 the question for all subsequent stages of the suit. See, *Irizarry v. Indus. Comm'n*, 337 Ill. App. 3d 598, 606, 786 N.E.2d 218 (2003). However, the "law-of-the-case doctrine only binds a court when its order was final." *Prof. Trans., Inc. v. Ill. Workers' Comp. Comm'n*, 2012 IL App (3d) 100783WC, ¶ 41, 966 N.E.2d 40, 358 Ill. Dec. 855

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." *Irizarry v. Indus. Comm'n*, 337 Ill. App. 3d 598 (2d Dist. 2003).

Accordingly, this Arbitrator incorporates by reference as though full set forth herein the findings of fact and conclusions of law set forth by Arbitrator Cronin. See, Px1. In that decision, Arbitrator Cronin found Petitioner's lower back, depression and acute emotional distress conditions causally related to his work accident. This determination became a final judgment from which Respondent did not appeal. Thus, the parties cannot relitigate or revisit this issue.

b. Whether subsequent treatment is causally related

Following the hearing before Arbitrator Cronin, Petitioner continued to treat with Dr. Padron, where the doctor prescribed an extensive series of medications, including but not limited to Tramadol, Dilaudid, Norco, Carisoprodol and Hydrocodone. From July 2013 through the last visit with Dr. Padron in September 2017, Petitioner consistently tested negative for the medications he was being prescribed and was consistently positive for illicit substances, including marijuana and cocaine. At trial, Petitioner failed to give any credible or persuasive explanation as to why he was negative for the prescribed medications. Petitioner testified that he only used cocaine a couple of times, but the records clearly fail to corroborate this. Petitioner further testified that Dr. Padron recommended marijuana, but this is also nowhere in his medical records. Medical lab testing protocols indicate "negative results indicate the potential of drug diversion." Rx17. Petitioner failed to adequately address these negative results at trial. Petitioner also failed to explain why he tested inconsistent

positive for drug previously prescribed and for which he otherwise was not expected to be taking. Petitioner's failure to comply with his prescription regimen and failure to explain leads this Arbitrator conclude that drug diversion did in fact take place and/or his lumbar spine condition of ill-being was not so serious as described in his medical records.

Petitioner's credibility is further placed into question by virtue of his perceived ability to perform certain tasks and his ability to have returned to work or otherwise look for work. At trial, Petitioner denied telling Helma he could only sit for 5 minutes or that he could stand for 5-10 minutes. If Helma is incorrect, then her conclusions were partly based on faulty information. If Petitioner is incorrect that he did not relate this to Helma, then he is not credible. In either instance, Petitioner has failed to meet his burden. Further, Petitioner consistently rated his pain as allegedly 7-8 out of 10 throughout his medical records with Dr. Padron. Given the significance of this perceived pain, it is unclear why Petitioner would consistently fail to take his prescribed medications and why Petitioner did not follow up with neurosurgery as directed by his primary in April 2018. Petitioner further stated he did not know what the limitations were of his FCE but given the totality of the evidence the Arbitrator does not find this statement credible. Further, Petitioner's testimony at trial and statements to Helma was that he was unable to drive per his doctor but there is no medical note addressing this perceived limitation.

Regarding those medical records, the Arbitrator must place little to no weight on these records. While Dr. Goldberg agreed generally that Petitioner's accident resulted in a low back injury and eventually a valid FCE that placed him at the light to medium demand level, Dr. Padron's records following the June 2013 hearing are nearly identical in complaints, history, exam, assessment and plan. Despite Dr. Padron indicating that he reviewed urine testing results with Petitioner, there is no credible explanation by the doctor in the record why he continued to prescribe medications that were not being taken and where Petitioner was clearly testing positive for cocaine and marijuana. Further, in November 2016, Dr. Padron switched Petitioner to Oxycodone despite urine results that he allegedly reviewed with Petitioner were showing positive for THC and cocaine. Dr. Padron also removed Petitioner off work without addressing the FCE or otherwise reconciling his decision to remove Petitioner from work when Petitioner had a release to return to work with restrictions under the FCE. Based on the foregoing, the Arbitrator assigns little to no weight to the opinions of Dr. Padron.

In summary, the Arbitrator concludes that Petitioner failed to show that his current condition of ill-being is causally related to his work accident. The medical record demonstrates that Petitioner was placed at maximum medical improvement well before the previous Section 19(b) hearing before Arbitrator Cronin. The treatment that followed after the hearing was largely pain management, which consisted of an over-prescription of medications that were not taken as prescribed in any consistent or credible manner. In the Arbitrator's view, Petitioner's decision to continue with Dr. Padron after the hearing before Arbitrator Cronin were for reasons secondary to and thus unrelated to the work accident.

For the purposes of this hearing, the Arbitrator finds that Petitioner reached maximum medical improvement in August 7, 2014, which is the first notation following his injections where there was little improvement noted. The Arbitrator finds Petitioner plateaued after this date as treatment was more maintenance than progressive and although intended to perhaps be palliative, the Arbitrator finds that this treatment was otherwise unrelated to Petitioner's work accident. Further, the Arbitrator fixes MMI at August 7, 2014 as this is the first notation in the record wherein Petitioner tested positive for illicit drug use. Thereafter, Petitioner continued to treat with Dr. Padron and medical records showed Petitioner began testing largely negative for prescribed medications and positive for illicit drugs.

Regarding Petitioner's depression and acute emotional distress, the Arbitrator concludes Petitioner failed to prove that these remained casually related to his work accident following the hearing before Arbitrator Cronin. Petitioner did not testify as to any ongoing treatment or medications for same after his first hearing.

Petitioner did not submit any medical opinion or evidence that Petitioner continued treatment for same or that his depression was ongoing.

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 (N) ***Is Respondent due any credit?***

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. Petitioner alleged a total of $49,254.58 due and owing as a result of his work accident. Ax2, Px4. Those providers listed included Park Ridge Pain Specialists, TriLab, LLC, Preferred Open MRI, H-Wave, IWP and Advocate Medical Group. Petitioner is awarded medical bills from **July 13, 2013**, which is the first date of service following the 19(b) hearing through **August 7, 2014**, the date of MMI, as submitted in Px4, which include Park Ridge Pain Specialists and H-Wave only. Treatment through this date is related to Petitioner's work accident and corresponding medical records and bills are noted. The Arbitrator notes that Park Ridge Pain Specialists (Dr. Padron) bills reflect a zero balance owed for this time frame awarded and hence no award is made. Px4. The H-Wave gross charges through MMI total **$4,149.52**. Px4. Petitioner is awarded this bill subject to Sections 8(a) and 8.2.

Respondent submitted a request for medical payments credit totaling $112,768.31 but this includes time periods already addressed in Arbitrator's Cronin decision and under law of the case doctrine, this Arbitrator cannot revisit this issue for that time period. See, Rx2, Px7. Moreover, the medical payments credit asserted in Rx4 failed to specify what dates of service payments were intended to cover and rather only shows when checks were printed. Thus, the Arbitrator is unable to specifically quantify the amount of credit against the H-Wave award. Nevertheless, Respondent shall be given a credit of for medical benefits that have been paid specifically toward the H-Wave bill.

The Arbitrator ***denies*** Petitioner's request for any and all medical treatment beyond this date as unreasonable and unnecessary treatment unrelated to his work accident. Treatment after this consisted of excessive prescriptions of medications which Petitioner either never took or took when he was not supposed to under his treatment plan.

ISSUE (K) ***What temporary benefits are in dispute?***
ISSUE (N) ***Is Respondent due any credit?***

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. Having found Petitioner reached MMI as of August 7, 2014, Respondent shall pay Petitioner temporary total disability benefits of **$445.22/week** for **59 weeks**, commencing **6/21/2013** through **8/7/2014**, as provided in Section 8(b) of the Act. Respondent shall pay Petitioner the temporary total disability benefits that have accrued from **6/21/2013** through **8/7/2014**, and shall pay the remainder of the award, if any, in weekly payments. Respondent submitted a request for TTD credit totaling $151,572.60 but this includes time periods already addressed in Arbitrator's Cronin decision and under law of the case doctrine, this Arbitrator cannot revisit this issue for that time period. See, Rx2. Moreover, the TTD credit asserted in Rx2 failed to specify what dates of disability payments were intended to cover and rather only shows when checks were printed. Thus, the Arbitrator is unable to specifically quantify the amount of credit against this award. Nevertheless, Respondent shall be given a credit of for temporary total disability benefits that have been paid for the period covering **6/21/2013** through **8/7/2014**.

Petitioner's request for maintenance is denied. Under section 8(a) of the Act (820 ILCS 305/8(a) (West 2010)), an employer "shall ... pay for treatment, instruction and training necessary for the physical, menta and

vocational rehabilitation of the employee, including all maintenance costs and expenses incidental thereto." Since maintenance is awarded incidental to vocational rehabilitation, an employer is obligated to pay maintenance only "while a claimant is engaged in a prescribed vocational-rehabilitation program." *W.B. Olson, Inc. v. Ill. Workers' Comp. Comm'n*, 2012 IL App (1st) 113129WC, ¶ 39. "A claimant is generally entitled to vocational rehabilitation when he sustains a work-related injury which causes a reduction in his earning power and there is evidence that rehabilitation will increase his earning capacity." *Greaney v. Indus. Comm'n*, 358 Ill. App. 3d 1002, 1019, 832 N.E.2d 331 (1st Dist. 2005). Because the primary goal of rehabilitation is to return the injured employee to work (*Schoon v. Indus. Comm'n*, 259 Ill. App. 3d 587, 594, 630 N.E.2d 1341 (3d Dist. 1994)), if the injured employee has sufficient skills to obtain employment without further training or education, that factor weighs against an award of vocational rehabilitation. *National Tea Co. v. Indus. Comm'n*, 97 Ill. 2d 424, 432 (1983). Moreover, an injured employee is generally not entitled to vocational rehabilitation if the evidence shows that he does not intend to return to work, although able to do so. *Schoon*, 259 Ill. App. 3d at 594.

Following Petitioner's MMI date of 8/7/2014, Petitioner continued to treat with Dr. Padron and in September 2017 switched care to his primary. The duration of this treatment was largely medication management only. Dr. Padron continued to take Petitioner "off work" through November 18, 2016. Px1. Having assigned little weight to the opinions of Dr. Padron, the Arbitrator declines to consider the doctor's opinions as to Petitioner's ability to work after 8/7/2014. Prior to this, in 2012, Petitioner was placed at the light to medium physical demand level per his FCE, which was determined to be valid and which was endorsed by Dr. Goldberg. See, Rx7. This FCE was previously reviewed by Arbitrator Cronin and under the law of the case doctrine, the validity of the FCE cannot be relitigated. Nevertheless, following Petitioner's FCE and after his hearing before Arbitrator Cronin, there is no evidence that Petitioner has met his burden that would entitle him to maintenance benefits.

Petitioner did not give any evidence he requested vocational rehabilitation until 2018 – more than 4 years after MMI. During these four years, Petitioner failed to show effort and motivation to undertake self-directed job search or formal vocational efforts. Further, any prospects for recovery remained suspect given the opinions of Dr. Padron and Petitioner's compliance or lack thereof with the prescribed pain medication management. Rather, Petitioner's conduct indicates a lack of motivation to find work and/or undergo vocational efforts: he admitted he did not bother to look for work, did not know the parameters of his FCE, voluntarily decided to not renew his driver's license and exaggerated his physical limitations to vocational counselor Helma. Simply put, the evidence showed Petitioner did not want to return to work. *Schoon*, 259 Ill. App. 3d at 594. Accordingly, Petitioner's request for maintenance benefits are denied.

ISSUE (L) ***What is the nature and extent of the injury?***
ISSUE (N) ***Is Respondent due any credit?***

The Arbitrator incorporates the foregoing findings of fact and conclusions of law as though fully set forth herein. Having found that Petitioner reached maximum medical improvement on August 7, 2014 for his low back injury, Petitioner's claim for permanency is ripe for adjudication. Petitioner seeks a wage differential award under Section 8(d)(1). To qualify for wage-differential benefits, a claimant must prove: (1) a partial incapacity that prevents claimant from pursuing his usual and customary line of employment and (2) an impairment of earnings. 820 ILCS 305/8(d)(1) (West 2010). The purpose of a wage-differential award is to compensate an injured claimant for his reduced earning capacity. *Jackson Park Hospital v. Ill. Workers' Comp. Comm'n*, 2016 IL App (1st) 142431WC, ¶ 39. The amount of a wage-differential benefit is "equal to 66-2/3% of the difference between the average amount which [the claimant] would be able to earn in the full performance of his duties in the occupation in which he was engaged at 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." *Id.*

Petitioner asserts he is entitled to a wage differential award because his permanent restrictions prevent him from returning to work as outlined in his FCE and because he has suffered an impairment of earnings based upon Helma's opinions. The Arbitrator accepts the results of the FCE under law of the case doctrine. As to impairment of earnings, Helma concluded Petitioner could earn between $10 and $13 an hour. She determined these wages based on statistical data, collective experiences at Vocamotive with placement and labor market surveys. However, neither the statistical data, "collective experiences" and/or labor market surveys were not placed into evidence to substantiate this conclusion. The Arbitrator assigns little weight to this portion of her opinion. Further, the Arbitrator concludes Petitioner abandoned the job market when he failed to look for work, was non-compliant in his recovery efforts and chose not to renew his driver's license thereby failing to prove his earnings capability. Thus, Petitioner failed to prove he is entitled to a wage loss and accordingly, the Arbitrator awards permanency under loss of trade under Section 8(d)(2).

Section 8(d)(2) of the Act provides for a PPD award based on a percentage-of-the-person-as-a-whole. 820 ILCS 305/8(d)(2) (West 2010). A percentage of-the-person-as-a-whole award is appropriate in three circumstances: (1) when a claimant's injuries do not prevent him from pursuing the duties of his employment but he is disabled from pursuing other occupations or is otherwise physically impaired; (2) when a claimant's injuries partially incapacitate him from pursuing the duties of his usual and customary line of employment but do not result in an impairment of earning capacity; or (3) when a claimant, having suffered an impairment of earning capacity, elects to waive his right to recover. 820 ILCS 305/8(d)(2) (West 2010). Because Petitioner's low back injuries resulted in partial incapacitation that prevented him from returning to his usual and customary employment as a janitor but did not result in any impairment of earning capacity, a loss of trade award is appropriate under these circumstances. At the time of the prior arbitration hearing, Arbitrator Cronin found that Petitioner's injuries resulted in a low back injury with radiculopathy. Subsequent medical records showed Petitioner's radiculopathy eventually resolved and Dr. Padron continued to diagnose Petitioner with lumbar disc displacement, inflamed SI, spasm, sacroiliitis and long-term drug therapy. Petitioner was determined not to be a surgical candidate. Based upon the credible record as a whole, the Arbitrator concludes that Respondent shall pay Petitioner permanent partial disability benefits of **$400.70/week** for **150 weeks**, because the injuries sustained caused the **30%** loss of the person as a whole, as provided in **Section 8(d)2** of the Act. As to credit, Respondent previously received a credit totaling $5,821.32, which totals all but the last advance listed in Rx3. See, Px7. Thus, Respondent is entitled to a credit in the amount of **$4,808.40** for PPD advances paid.

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

Petitioner's request for penalties and fees is denied as Petitioner failed to specify the basis of his assertion that penalties and fees were owing, failed to show that he demanded certain benefits under any portion of the Act and otherwise failed to show the Respondent's conduct was for unreasonable, vexatious and/or frivolous delay. Of note, Respondent paid certain "advances" and other payments under Section 8(j). Further, Petitioner has not shown he made any written demands for payments of any kind at any time. Accordingly, his request for penalties and fees is denied.

Signature of Arbitrator

2-5-2019
Date

STATE OF ILLINOIS)
) SS.
COUNTY OF MCLEAN)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JOSHUA WHITEHEAD,

Petitioner,

20IWCC0072

vs. NO: 16 WC 29373

SCHECK MECHANICAL CORP.,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) 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, prospective medical treatment, and temporary total disability, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

The Commission affirms the Arbitrator's decision finding that Petitioner's left shoulder/scapula condition is causally related to injuries sustained in the work accident on August 19, 2016. The Commission further affirms the Arbitrator's finding that the spine condition is unrelated to the accident. However, the Commission reverses the Arbitrator's decision regarding Petitioner's headaches and finds they are causally related to injuries sustained in the work accident on August 19, 2016.

Regarding the left shoulder condition, there is a continuum of complaints to the left shoulder/scapula area that are all related to the initial injury. Following Petitioner's last visit with Dr. Wottowa, Petitioner continued to complain of the popping sensation in his back and ongoing

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pain as early as his next appointment with his primary physician (Px4, December 6, 2016 visit). At no point at any appointment did he report that he was symptom free.

Based on the evidence, the Commission finds that Petitioner met his burden of proof that the left shoulder condition is related. The Commission further finds Dr. Solman to be more persuasive than Dr. Li in regard to Petitioner's left shoulder condition and the need for surgery.

Moreover, the Commission finds that the headaches from which Petitioner suffered were causally connected to the accident of August 19, 2016, and that the associated medical expenses should be awarded. Petitioner credibly testified regarding the extent and severity of his headaches and was diagnosed with post-concussive syndrome by his treating physicians. There was no evidence that Petitioner suffered from headaches prior to his work accident, but there is significant evidence as to the severity and frequency of headaches suffered thereafter throughout the medical records.

Additionally, Petitioner's headaches only appeared to be alleviated with medication. Dr. Glantz's testimony was not persuasive, especially when he testified that "It's my testimony that after P fell 12-15 feet, landed on his head, and began having a delayed onset of headaches those headaches are idiopathic and are completely not related to falling 10-16 feet and landing on his head." (Rx3, p. 41) Based on the history and mechanism of injury – a fall of 12-15 feet with a loss of consciousness and a clear injury to the head, it is reasonable to assume that Petitioner's head hurt even though that complaint is not specifically documented in the initial medical treatment records. There are points in the records where Petitioner did indicate that his head has been hurting ever since the work accident. (*See e.g.* Px3, October 26, 2016, November 3, 2016 visits; Px6, November 4, 2016 MRI; Px4, December 5, 2016 visit "has had headaches ever since")

The Arbitrator is affirmed in the award of the medical expenses and prospective medical treatment as prescribed by Dr. Solman. However the medical bills associated with the treatment for the persistent headaches and post-concussive syndrome are also awarded as Petitioner met his burden that said condition was causally related to his work accident of August 19, 2016. The Commission also awards the medical bill of November 30, 2017, denied by the Arbitrator as the treatment is causally connected to his left shoulder injury.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $1,040.00 per week for a period of 101 weeks, commencing September 22, 2016 through August 30, 2018, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $24,392.39 outlined in the Arbitrator's Order, as well as $2,964.00 related to the injection from November 30, 2017, as well as all medical expenses related to the treatment for Petitioner's post-concussive syndrome and headaches under §8(a) of the Act subject to the fee schedule in §8.2 of the Act.

SPECIMEN

20 IWCC0072

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner is awarded prospective medical care as recommended by Dr. Solman.

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: JAN 29 2020

MEP/dmm
O: 120319
49

Maria E. Portela

Thomas J. Tyrrell

Kathryn A. Doerries

STOP

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

WHITEHEAD, JOSHUA
Employee/Petitioner

Case# **16WC029373**

SCHECK MECHANICAL CORP
Employer/Respondent

20IWCC0072

On 10/16/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.41% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4888 SHORT & DAUGHERTY PC
KEITH SHORT
325 MARKET ST
ALTON, IL 62002

5001 GAIDO & FINTZEN
MALLORY ZIMET
30 N LASALLE ST SUITE 3010
CHICAGO, IL 60602

20IWCC0072

STATE OF ILLINOIS)
)SS.
COUNTY OF MC CLEAN)

☐ 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)

Joshua Whitehead
Employee/Petitioner

v.

Scheck Mechanical Corp.
Employer/Respondent

Case # **16** WC **29373**

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 **Bloomington**, on **8/30/18**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ 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

20IWCC0072

On the date of accident, **8/19/16**, Respondent ***was*** operating under and subject 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 left shoulder/scapula/thoracic condition of ill-being ***is*** causally related to the accident.

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

In the year preceding the injury, Petitioner earned **$81,120.00**; the average weekly wage was **$1,560.00**.

On the date of accident, Petitioner was **35** 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 **$34,320.00** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$34,320.00**.

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $1,040.00/week for 101 weeks, commencing 9/22/16 through 8/30/18, as provided in Section 8(b) of the Act. Respondent shall receive a credit for any TTD or disability benefits it has paid for the time period in question.

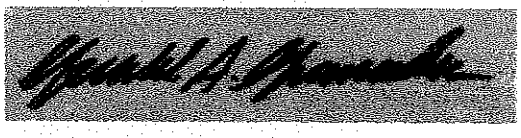
Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $1,600.00 to Dr. Solman, $14,572.39 to Mason District Hospital, $7,629.00 to Springfield Clinic, $171.00 to Clinical Radiology, and $420.00 to Petitioner for medication, as provided in Sections 8(a) and 8.2 of the Act.

Petitioner is further awarded prospective medical care as recommended by Dr. Solman.

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

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

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



Signature of Arbitrator

10/15/18
Date

OCT 16 2018

20IWCC0072

FINDINGS OF FACT

This case involves a Petitioner alleging injuries sustained while working for the Respondent on August 19, 2016. Respondent disputes Petitioner's claims and the issues in dispute are: 1) accident, 2) causation, 3) medical expenses, 4) TTD and 5) prospective medical care.

On August 19, 2016 Petitioner was working as a boilermaker for Respondent at a power plant in central Illinois. Petitioner was doing repairs inside the power plant that day. Petitioner testified that on the day of his accident, the temperature within the plant ranged from 120° to 140°. He was wearing a full protective suit, helmet and carrying tools. He presented evidentiary photographs of the area in which he worked. (PX 15A through F) He testified that he sat on a metal beam (PX 15 E), became lightheaded and passed out. When he awoke, he realized that he fallen backwards between the metal beam and the nearby walkway, and fell approximately 12 to 15 feet to a grated-metal walkway below.

Petitioner's coworkers found him and he was later taken to the Mason District Hospital emergency room by ambulance. At the emergency room he was diagnosed with facial laceration, a broken clavicle, shoulder, neck and low back pain. Following his emergency room visit, Petitioner was released to light duty work the following day. Petitioner testified that he worked light duty on August 20 and 21 as a watchman for other workers in the event they were injured or required assistance, and did no boilermaker work. As the day passed he noted that his clavicle became more painful. Consequently, he returned to the Mason District Hospital emergency room.

On August 22, 2016, Petitioner was diagnosed as having ongoing problems this clavicle fracture. He gave a history of being in a local bar and trying to pick up a glass when he felt a tearing sensation in the left shoulder around the clavicle. The pain extended into his left arm. Repeat x-rays showed he had a nondisplaced left clavicle fracture. He was taken off work for 5 to 6 days and was recommended to follow his regular physician. Petitioner testified that he did not have a family physician or regular physician prior to this accident.

Petitioner testified that his employer advised him to secure medical treatment through Dr. Lam, a corporate physician in Pennsylvania. Petitioner called Dr. Lam repeatedly in an effort to get additional medical care. Dr. Lam did not meet or examine Petitioner. Petitioner testified that Dr. Lam referred Petitioner to physicians at the Springfield Clinic.

On September 27, 2016 Petitioner saw orthopedic surgeons Dr. Western and Dr. Wottowa at the Springfield Clinic. On October, 26, 2016, Dr. Wottowa noted that Petitioner had an obvious fracture of the proximal third of the left clavicle. Petitioner had been in therapy for four weeks and his shoulder was feeling somewhat better. The doctor did note some irregular swelling along the sternal clavicular joint. Petitioner also had complaints of pain behind his left eye and other neurologic problems. Petitioner eventually saw neurologist Dr. Gelber at the Springfield clinic, who placed Petitioner on medication for migraines. On October 26, 2016, Petitioner was released to light duty work with restrictions of no lifting over 20 pounds with the left arm. Petitioner testified that the Respondent was not able to accommodate his light duty restrictions.

On November 3, 2016 Petitioner returned to Springfield Clinic with complaints of headache, left clavicle pain, left scapular fracture and weakness in his left arm. The doctor noted ongoing pain in the left scapula and clavicle areas with focus on the sternal clavicular notch. (PX 4) Petitioner underwent an

20IWCC0072

MRI of his cervical spine on November 3, 2016, which was essentially normal. His November 4, 2016 MRI of the thoracic spine and the lumbar spine did not reveal any surgical pathology.

Petitioner saw Dr. Western on December 16, 2016 with complaints of neck and back pain. Dr. Western noted a constant aching and pressure type pain in Petitioner's mid to lower thoracic region. Dr. Western also noted that, "when [Petitioner] coughs or sneezes he has a popping in the thoracic spine about that area." During physical examination Petitioner exhibited limited mobility in the left side of the back with pain in the area of T-10 for which Dr. Western concluded, "thoracic dysfunction secondary to fall from height." (PX 4)

On April 25, 2017 Petitioner saw Dr. Wottowa who noted that Dr. Western had again recommended physical therapy for Petitioner's back, but that it would not be approved by workers compensation. Dr. Wottowa noted that Petitioner had, "some shoulder girdle discomfort and weakness, which I think should respond to therapy and this has not been approved. I will rewrite this again for him today." He also noted that Petitioner's back was hurting him at that time. Among his chief complaints, Petitioner was, "still having a lot of pain in multiple areas. As a reminder, he has a back injury and a left collarbone fracture. The left collarbone has healed, but he has diffuse pain over the shoulder girdle area. It hurts over the sternal clavicular joint. It hurts over the trapezium. It hurts over the shoulder blade itself." It was observed that Petitioner had 13 active problems. Among them, post-concussion syndrome, persistent headaches, clavicle pain and left shoulder pain (PX 4)

On August 25, 2017 Petitioner began treating with Dr. Solman, an orthopedic surgeon specializing in sports medicine. Petitioner was referred to Dr. Solman by his attorney and is Petitioner's only self-selected physician, as all of Petitioner's other physicians had been at the direction of the employer. Dr. Solman testified via evidence deposition on February 13, 2018. When Petitioner first saw Dr. Solman, he gave a consistent history of injury and complained of pain in his left scapula and thoracic region as well as the sternoclavicular notch. (PX 1, pg. 11) Dr. Solman reviewed Petitioner's diagnostic studies, medical records and the photographs which had been entered as Petitioner's group exhibit 15. On physical exam Dr. Solman noted elevation or extension of Petitioner's left shoulder blade with significant grinding and spasm in the shoulder. Petitioner complained of tenderness. (PX 1, pg. 10; PX 5) Dr. Solman also noted significant popping in Petitioner's left posterior shoulder near the thoracic spine and recommended an MRI and injections.

Dr. Solman referred Petitioner to pain management specialist Dr. Hurford, who gave Petitioner injections in the sternoclavicular notch and superomedial angle the left scapula on November 30, 2017. Petitioner felt the immediate improvement in pain, though the popping never went away. Over time the pain returned. (PX 5) Dr. Solman testified that the injections serve to help identify and confirm the objective nature of the clavicle and scapula pain. Consequently, Dr. Solman recommended an MRI of the shoulder and/or arthroscopic evaluation and treatment. (PX 1, pg. 30) He further testified that Petitioner might require removal of bone from the sternoclavicular notch to "decrease the grinding." (31) Dr. Solman testified that Petitioner was incapable of performing his usual and customary employment as of the first office visit, August 25, 2017. Dr. Solman believed that Petitioner was disabled from full duty from the date of the accident and that the fall was the cause of the need for work restrictions and additional treatment. Dr. Solman testified that Petitioner requires a 20lbs below shoulder lifting restriction, no overhead work and no heavy lifting away from the body. He indicated that these restrictions applied to the neck as well as the shoulder and clavicle. (PX 1, pg. 44)

20 IWCC0072

On May 17, 2018, Dr. Lawrence Li testified via evidence deposition. He conducted an independent medical examination of Petitioner on April 6, 2017 with a subsequent records review dated October 28, 2017. The April 6, 2017 exam focused on the left clavicle fracture. Petitioner complained of continued popping, grinding, soreness, and weakness. Dr. Li had Petitioner do door pushups and he noted no atrophy in his shoulder girdle and no scapula dysfunction. Dr. Li placed Petitioner at maximum medical improvement. His strength and range of motion were good and he did not require any additional treatment, including physical therapy. In Dr. Li's supplemental report from October 28, 2017, he reviewed the actual images of the September 7, 2017 CT scan of the bilateral sternoclavicular joint, CT scan of the scapula, MRI of the left shoulder, and Dr. Solman's notes. Dr. Li stated that there were no abnormalities whatsoever in the sternoclavicular joints. There was no evidence of any bony injuries, muscle atrophy, or swelling of any type in the scapula. The MRI revealed a partial-thickness bursal-sided tear of the supraspinatus tendon. There was no evidence of any muscle atrophy or complete tearing. The biceps tendon was normal. Dr. Li stated that he did not see any evidence of posterior subluxation of the clavicle on the sternum. This was also supported by the radiologist's interpretation. There was no scapula abnormality in either the CT scan, MRI, or physical exam. Petitioner had full range of motion of the shoulder. There was no popping of the sternoclavicular joint.

Dr. Li stated that he did not see a hook on the scapula, as interpreted by Dr. Solman. Even if that did exist, it would be a pre-existing condition. He explained this further during his deposition, stating that a hooked scapula referred merely to the shape of the scapula. This would not be altered by a fall. Dr. Li did not find that Petitioner was a candidate for injections. He would want to see something abnormal on physical exam that is corroborated by the imaging before administering an injection. Dr. Li was asked, if Petitioner can reproduce the snapping at trial, whether that is an objective sign of dysfunction with the scapula. Dr. Li stated that it would be impossible to tell where the snapping was coming from. A lot of people have snapping, but this is very nonspecific. Dr. Li still wouldn't perform an injection even if he could reproduce the snap because there was no abnormality on imaging. He did not see any inflammation on imaging, which was also the radiologist's interpretation. You would be putting a needle blindly into the shoulder because you do not know where the snapping is coming from. Petitioner was treated appropriately already based on the objective findings. Because there was nothing on imaging, he could be treated with anti-inflammatory medications and ice.

On June 6, 2018, the parties deposed Dr. Van Fleet, who examined Petitioner's spine and rendered a report on December 22, 2017. Petitioner complained of pain across his neck, in the thoracic spine, and down into the lumbar spine. Dr. Van Fleet reviewed the November 4, 2016 cervical, thoracic, and lumbar MRIs and opined that they were all normal. Dr. Van Fleet stated that Petitioner has no objective findings. Range of motion in the neck was normal. The only complaint is that of pain with palpation, but there is no evidence of any paraspinal spasm. Dr. Van Fleet opined that Petitioner could have sustained a strain on August 19, 2016, but that would have resolved and currently there is no diagnosis. Petitioner's complaints of pain are nonspecific and not supported by any objective findings, either on imaging or physical examination. Petitioner is at maximum medical improvement and does not need any additional treatment. Dr. Van Fleet opined that Petitioner can return to his regular activities as related to his spine.

On July 12, 2018, the parties deposed Dr. Glantz, who performed an exam on February 27, 2017 for Petitioner's complaints of headaches, neurological complaints, and vision problems. Petitioner

20IWCC0072

complained of daily headaches located typically behind the right eye, but can be on the opposite side. Dr. Glantz reviewed the records, and noted that Petitioner began complaining of headaches approximately 1.5 months after the accident. Petitioner reported that he had headaches from the beginning, they improved, and then got worse about 1.5 months after the accident. Dr. Glantz could not find any mention of headaches in the medical records for the first 1.5 months after the accident. Dr. Glantz stated that Petitioner suffered a concussion at the time of injury. However, by the time he arrived to the emergency room, his neurological symptoms had cleared. Headaches are subjective and there are no objective tests. Dr. Glantz did state that his neurologic exam was normal and the brain scans from November 3, 2016 were normal. He did not find that Petitioner's current headaches were a result of the accident. Dr. Glantz stated that the headaches could not have been caused by the accident because there was a 1.5 month delay in symptoms. If the accident caused headaches, the symptoms would have been immediate. A complete review of the medical records all corroborate headaches beginning 1.5 months post-accident. This includes records from Springfield Hospital and Dr. Gregoire. Dr. Glantz opined that in terms of treatment rendered, the in-patient stay from November 3, 2016-November 5, 2016 was unnecessary. The MRI studies were reasonable based on his symptoms, but these could have been performed as an outpatient. A hospital stay was not necessary. Also for the reasons above, neither the testing nor the hospital stay were causally related to the accident. Dr. Glantz further opined that Petitioner is at maximum medical improvement for his headaches as related to the incident with no need for activity limitations.

Petitioner testified that he continues to have excruciating pain in his left shoulder. He no longer has full range of motion of the left shoulder and has a snapping sensation whenever he uses the shoulder extensively. He is seeking additional diagnostic evaluation and treatment with his chosen physician, Dr. Corey Solman. Petitioner also suffers neck pain, which may be consequential to the scapula injury. Dr. Solman has recommended a referral to an orthopedic surgeon for additional evaluation if treatment of the scapula/shoulder injury does not cause improvement of symptomology. Petitioner also has persistent pain at the sternoclavicular notch. He testified that he has a popping and grinding soreness over the site of the fracture and at the notch itself. He has suffered migraines since the injury. He has been on various narcotics including hydrocodone and Metaxalone. The migraines used to be every few weeks to once a month. However, Petitioner acknowledged that in the last six months the migraines have slowly improved, and he does not believe they functionally limit his ability to return to his regular employment.

CONCLUSIONS OF LAW

1. With regard to the issue of accident, the Arbitrator finds that the Petitioner has met his burden of proof. In support of this finding, the Arbitrator relies on the Petitioner's unrebutted testimony regarding the events of August 19, 2016, in which the Petitioner lost consciousness and apparently fell 12' to 15' down onto a metal grated walkway. Petitioner's testimony regarding this event is corroborated by the history provided to the various medical providers and no evidence was offered by Respondent to rebut Petitioner's claim on this issue. Therefore, the Arbitrator concludes that the Petitioner sustained an accident while working for the Respondent on August 19, 2016.

2. Regarding the issue of causation, the Arbitrator notes that the primary question in dispute is the Petitioner's complaints relating to his left shoulder/scapula/thoracic pain. The Arbitrator finds that with regard to the question of causation as to the Petitioner's left shoulder/scapula/thoracic condition, the Petitioner has met his burden of proof. In support of this finding the Arbitrator relies on the Petitioner's

20IWCC0072

credible testimony regarding his continued physical complaints stemming from his injuries to these body parts as evidenced in the Petitioner's treating medical records and the records and opinions of Dr. Solman. His left posterior shoulder complaints were objectively verified by his ability to reproduce an audible snapping sound when he rotated his left shoulder. Dr. Li acknowledged in his deposition testimony that a snapping in the left scapula, accompanied by pain, would merit an MRI and additional diagnostic evaluation. Petitioner testified that Dr. Li made no effort to reproduce the snapping sound. The snapping was plainly audible to the attorneys and the Arbitrator. It was also noticed by Dr. Solman and by the physicians at the Springfield Clinic. Based on this evidence, the Arbitrator concludes that the Petitioner's left shoulder condition is causally related to his August 19, 2016 work accident.

With regard to the issue of causation relating to the Petitioner's spine condition and his complaints of headaches, the Arbitrator finds that these conditions are not causally related to his work accident and that Petitioner has reached maximum medical improvement for these conditions. In support of this finding, the Arbitrator finds persuasive the opinions and testimony of Dr. Van Fleet and Dr. Glantz, who agree that the Petitioner has reached MMI and does not need further medical treatment for these conditions. Petitioner himself acknowledged his current complaints are focused on his left shoulder/scapula/thoracic injuries, which still bother him and for which he is still seeking treatment. Thus, the Arbitrator concludes that the Petitioner's condition of ill-being related to his spinal or neurological conditions are not causally related to his work accident.

3. With regard to issue of whether medical services provided to Petitioner were reasonable and necessary and whether Respondent has paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds as follows:

The Arbitrator reviewed the following medical bills submitted by Petitioner. Respondent is awarded a credit for all amounts previously paid.

- $1,600.00 to Dr. Solman for dates of service August 25, 2017 through September 20, 2017. The Arbitrator finds that Petitioner's current condition of ill-being to his scapula and sternoclavicular joint are causally related to the injury and therefore the Arbitrator awards Petitioner this medical expense subject to the medical fee schedule.

- $14,572.39 to Mason District Hospital for dates of service August 19, 2016 through November 15, 2016. The Arbitrator finds that this treatment is reasonable, necessary, and causally related to the injury and therefore awards this medical expense to Petitioner, subject to the medical fee schedule. Respondent shall be given a credit for amounts paid.

- $7,629.00 to Springfield Clinic for dates of service September 27, 2016 through August 1, 2017. The Arbitrator finds that this treatment is reasonable, necessary, and causally related to the injury and therefore awards this medical expense to Petitioner, subject to the medical fee schedule. Respondent shall be given a credit for amounts paid.

- $2,964.00 to Spine and Orthopedic Medical Center for date of service November 30, 2017. The injection was not reasonable, necessary, or causally related to the injury, for the reasons stated above. The Arbitrator declines to award this bill.

20IWCC0072

- $24,809.80 to Memorial Medical Center for date of service November 4, 2016. The Arbitrator declines to Award the bill. Petitioner's spine condition is not causally related to his injury. Additionally, an overnight stay was unnecessary to receive diagnostic testing. The Arbitrator finds Dr. Glantz's opinion persuasive in this regard. Concerning the brain MRI, the Arbitrator does not find this charge reasonable, as it appears that this was double-charged, as Clinic Radiology also has a charge for a brain MRI from November 3, 2016. The Arbitrator declines to Award the bill that was double-billed.

- $2,402.50 to Clinical Radiology for dates of service August 19, 2016 through November 3, 2016. The Arbitrator Awards $47.50 for the August 19, 2016 cervical x-ray. The Arbitrator Awards $123.50 for the shoulder and chest x-rays. Concerning the bills from November 3-4, 2016, it appears that this treatment was double-billed from Memorial Hospital's charges. For the reasons above, the remaining charges are not awarded as they are not reasonable, necessary, or causally related to the injury.

- $48.80 to Clinical Pathology for date of service November 3, 2016. The Petitioner did not meet his burden in proving that these charges were reasonable, necessary, and related to the accident and the Arbitrator declines to award this bill.

- $1,213.34 for prescriptions paid by Petitioner for dates of service December 5, 2016 through October 27, 2017. The Arbitrator declines to Award Amitriptyline as Petitioner's headaches are not causally related to the injury. Petitioner did not meet his burden on proof showing that Hydrochlorothiazide is causally related to his cervical fracture. The Arbitrator awards $240.00 for Hydrocodone administered November 12, 2016 through March 14, 2017. Petitioner thereafter reached maximum medical improvement and the remaining charges are not awarded. Lisinopril is a blood pressure medication and the Arbitrator declines to award that. The Arbitrator awards $180.00 for Metaxalone administered November 11, 2016 through March 14, 2017. Petitioner's headaches are not causally related to the injury and the Arbitrator declines to award Topiramate.

4. With regard to the issue of TTD, the Arbitrator finds that the Petitioner has met his burden of proof and awards the Petitioner TTD from September 22, 2016 through August 30, 2018, as provided in Section 8(b) of the Act. Respondent shall receive a credit for any TTD or disability benefits it has paid for the time period in question. In support of this finding, the Arbitrator relies on the Petitioner's credible testimony and the medical evidence with show that Petitioner has had continued complaints and restrictions related to his left shoulder/scapula/thoracic injuries, for which he is still seeking medical treatment. Respondent has not accommodated the restrictions placed on Petitioner by the Springfield Clinic physicians and Solman, and therefore Petitioner is entitled to TTD for the time period in question.

5. Regarding the issue of prospective medical care, the Arbitrator finds that the Petitioner has met his burden of proof. In support of this finding, the Arbitrator relies on the Petitioner's credible testimony regarding his ongoing and current physical complaints, and the medical opinions of Dr. Solman who recommends further testing and treatment of the Petitioner's left shoulder condition. Therefore, the Arbitrator awards the Petitioner the prospective medical care as recommended by Dr. Solman.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

KENNETH BERGLIND,

Petitioner,

20IWCC0073

vs.

NO: 09 WC 44138

CITY OF CHICAGO,

Respondent.

DECISION AND OPINION ON PETITION UNDER §19(h) OF THE ACT

This matter comes before the Commission on Petitioner's 19(h) Petition, filed on April 28, 2015, for a finding of medical causation as well as payment of temporary total disability benefits, payment of medical bills and authorization for payment for prospective medical care. A hearing was held before Commissioner Portela on April 16, 2019, in Chicago, Illinois, and a record was made.

An Arbitration hearing was held on February 6, 2013, and a decision was issued on December 12, 2014. Neither party reviewed the decision which became final. The relevant inquiry before us is whether Petitioner's condition of ill-being regarding his shoulders and right elbow remains causally related to his work injury and whether he is entitled to additional temporary total disability benefits, medical expenses, prospective medical treatment and a future hearing to determine a new amount of permanent partial disability.

At the 2013 hearing, Respondent stipulated as to causal connection pertaining to both the right and left shoulders and the September 14, 2009 work accident. At issue at the time of the Arbitration hearing was whether Petitioner's left and right elbow conditions were causally related to the work accident, medical and nature and extent. Petitioner was paid for his lost time associated with the September 14, 2009 work accident and did not seek temporary total disability benefits at the time of the original hearing. Respondent has since stipulated to temporary total disability for the time period from July 2, 2015 through May 25, 2019 and August 2, 2018 through April 12, 2019. However, Respondent disputes temporary total disability payments from May 26, 2018 through August 1, 2018.

20IWCC0073

Bilateral Shoulders

In the underlying case at Arbitration, the parties agreed that Petitioner sustained accidental injuries that arose out of and in the course of Petitioner's employment with Respondent. Respondent challenged the alleged injuries to the right and left elbows, but the Arbitrator found that the Petitioner's injuries to the left and right shoulders were causally connected to the Petitioner's accident on September 14, 2009. (Arb. Decision, p. 14)

Two days after the accident, Petitioner sought treatment from MercyWorks. Petitioner initially only sought treatment for his shoulders, but by October 7, 2009, when he went to see Dr. Wolin, he presented with complaints to his bilateral shoulders and bilateral elbows. Dr. Wolin treated Petitioner from October 7, 2009 through May 4, 2010. Dr. Wolin sent Petitioner for physical therapy, as well as diagnostic exams (MRIs and MR arthrograms) of his bilateral shoulders and bilateral elbows. Dr. Wolin causally connected the bilateral shoulders to the September 14, 2009, accident at the November 24, 2009 office visit, wherein he stated: "bilateral osteoarthritis with partial cuff tear right and labral changes on the left. While the osteoarthritis preexisted this most recent episode the partial cuff tear and the labral changes appear related to the work injury." (TA Px3)

By April 20, 2010, Dr. Wolin opined that Petitioner's options were shoulder surgery due to the condition of his shoulders, or an FCE. Petitioner wanted to avoid surgery. (TA Px3) As of May 14, 2010, Dr. Wolin noted the restrictions of the FCE were permanent but recommended that Petitioner see Dr. Goldberg for a discussion of shoulder arthroplasty. (TA Px3) Petitioner has not sought treatment from Dr. Wolin since May of 2010. Petitioner returned to work under the limitations as set forth in the FCE in June of 2010.

Petitioner was seen by Dr. Brian Coe for his bilateral shoulder injuries on December 7, 2010. He noted Petitioner sustained an internal derangement of both shoulders, right shoulder partial rotator cuff tearing and left shoulder glenoid labral tearing with aggravation of degenerative arthritis in both shoulders as a result of the September 14, 2009 work accident. Dr. Coe opined that there was a causal connection between the work accident and Petitioner's current condition of ill-being and recommended future medical treatment. Dr. Coe opined that the additional treatment would include the possibility of surgery (bilateral shoulder joint arthroplasties) as discussed by Dr. Wolin. (TA Px16)

Petitioner worked for the next 5 years, until July 21, 2015, without missing any significant amount of time from work. In that time period, Petitioner's condition continued to deteriorate. There has been no change in the bilateral shoulder condition since the prior hearing, and there was a recommendation for bilateral shoulder surgery at the time of the initial hearing. (TA Px3 and TA Px16).

Since the time of the Hearing on Arbitration, Petitioner has been under the medical care of Drs. Wolin, Goldberg and Chudik for his bilateral shoulder condition. (Px1, Px9 and Px10) Petitioner was also treating with Dr. Wolin for the right elbow condition. (Px1) At no point did any of these physicians release Petitioner to return to work or release Petitioner from medical care. Both Drs. Chudik and Goldberg recommended bilateral shoulder replacement. (Px10) The Commission considers the medical opinion of Dr. Chudik to be persuasive in finding that

20IWCC0073

Petitioner's current bilateral shoulder condition is causally connected to the September 14, 2009 work accident.

The Commission notes the fact that a referral for a contemplated bilateral shoulder replacement was made back in 2010 is most persuasive in finding that Petitioner's bilateral shoulder condition is causally related to injuries sustained in the September 14, 2009 work accident. All of the testimony in this case by Petitioner as well as the experts is consistent with the fact that it was reasonable for Petitioner to want to delay such extensive and invasive surgery.

Respondent's argument that Petitioner was able to return to work within the FCE restrictions and that is therefore indicative that his condition was further deteriorated merely by his activities of daily living has some merit. However, it is more persuasive that but for the accident of September 14, 2009, Petitioner's condition may not have been aggravated to the extent of possible surgery being recommended in the first place. The issuing of three reports by Dr. Marra, likely at the direction of Respondent, wherein it appears his causation opinion was altered, also detracts from the credibility of his opinion. All physicians agree that Petitioner's condition warrants bilateral shoulder replacement and Petitioner has met his burden that this need is causally connected to the September 14, 2009, accident.

Right Elbow

At the hearing before the Commission on April 16, 2019, Respondent did not submit any medical evidence disputing the causation of the right elbow condition. Dr. Wolin causally connected the right elbow condition to the September 14, 2009 work accident. Petitioner had proof of prior good health and a change in same immediately following and continuing after the injury. Petitioner testified that since the February 6, 2013 hearing, he had not sustained any new accidents involving his bilateral shoulders or right elbow. His symptoms persist to the present date and he has been under continuous medical treatment.

Regarding the right elbow, Petitioner met his burden of proof as to causation. Respondent's own expert agreed in 2016 that Petitioner's need for surgery was related to the original work accident (Px18), and Petitioner never seemed to fully recover from his elbow injuries despite the multiple conservative and invasive treatments. Petitioner had ongoing and continuous care as it related to the right elbow and it appears Petitioner was taken off of work due to his ongoing and consistent complaints regarding the right elbow. No physician – either treating or Section 12 – found Petitioner to be magnifying his symptoms. Additionally, Respondent's expert agreed that Petitioner's right elbow problem was a permanent condition prohibiting him from returning to his previous employment as an ironworker and at a minimum, an FCE would be required to determine new restrictions. Based on that evidence, Petitioner was clearly not at maximum medical improvement, and there was no evidence introduced to dispute Dr. Wolin's causation opinion that Petitioner's right elbow condition was related to the 2009 work accident.

Petitioner argues that he is entitled to payment of the medical bills from Dr. Wolin, Dr. Chudik and Athletico, temporary total disability benefits from June 2, 2015 through April 16, 2019, authorization of payment for the bilateral shoulder replacement recommended by Dr. Chudik and an evaluation with Dr. Gryzlo. The Commission agrees.

20IWCC0073

As Petitioner's condition has deteriorated and destabilized since the rendering of the 2014 Arbitrator decision, the 19(h) Petition is an appropriate remedy for seeking additional benefits. *Poor v. Industrial Commission*, 298 Ill.App.3d 719 (1998).

Both parties set forth persuasive arguments, but ultimately, the Commission finds that Petitioner did meet his burden of proof regarding causation as to the current condition of ill being in the shoulders as well as his right elbow. Accordingly, Petitioner should be awarded the medical expenses, prospective medical treatment, and temporary total disability and a hearing to determine a new amount of permanent partial disability should be held at a future date.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's Petition under §19(h) is hereby granted as outlined above.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $1,075.60 per week for a period of 202 1/7 weeks, commencing June 2, 2015 through April 16, 2019, that being the period of temporary total incapacity for work under §8(b).

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $14,523.00 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 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 shall pay for prospective surgery as recommended by Dr. Chudik as well as a further elbow examination in the form of a second opinion visit with Dr. Gryzlo 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 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: JAN 29 2020

Maria Elena Portela
Maria E. Portela

Thomas J. Tyrrell
Thomas J. Tyrrell

Kathryn A. Doerries
Kathryn A. Doerries

MEP/dmm
O:121019
49

STATE OF ILLINOIS)
) SS.
COUNTY OF JEFFERSON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Illinois Workers' Compensation Commission,
Insurance Compliance Division,
Petitioner,

vs.

No. 14 INC 00083,
20 WC 00700

David M. Johnson, Individually And D/B/A
David M. Johnson Logging,
Respondent.

20IWCC0074

DECISION AND OPINION RE: INSURANCE NON-COMPLIANCE

Petitioner, the Illinois Workers' Compensation Commission, Insurance Compliance Division, brings this action, by and through the Office of the Illinois Attorney General, against the above-captioned Respondent, alleging violations of Section 4(a) of the Illinois Workers' Compensation Act for failure to procure mandatory workers' compensation insurance. Petitioner alleges that Respondent knowingly and willfully lacked workers' compensation insurance for 238 days. A compliance hearing was held in Mt. Vernon before Commissioner Parker on November 5, 2019. Petitioner was represented by the Office of the Illinois Attorney General. Respondent did not appear in person or through counsel. A record was taken.

The Commission sought the maximum fine allowed under the Act, $500.00 per day for each day Mr. Johnson did business individually and as owner of David M. Johnson Logging and failed to provide coverage for his injured employee, William Chamness (238 days x $500.00 = $119,000.00), plus $145,144.74 which the Injured Workers' Benefit Fund paid out to Mr. Chamness, and $749.70 in unpaid insurance premiums, for a total of $264,894.44.

20IWCC0074

The Commission, after considering the record in its entirety and being advised of the applicable law, finds that Respondent David M. Johnson, individually and doing business as David M. Johnson Logging, knowingly and willingly violated Section 4(a) of the Act during the period in question. As a result, Respondent shall be held liable for non-compliance with the Act and shall pay a penalty in accordance with Section 4(d) of the Act. The Commission hereby assesses the maximum penalty of $500.00 per day for 238 days, plus $145,144.74 in reimbursement of the Injured Workers' Benefit Fund and $749.70 in unpaid premiums, for a total of $264,894.44.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

1. Investigator Cummins testified he began an investigation of David M. Johnson Logging as a result of a workers' compensation claim filed against the Injured Workers' Benefit Fund by William Chamness.

2. Investigator Cummins testified he searched several databases that document an employer's insurance history, including the National Council on Compensation Insurance ("NCCI") website. Petitioner's Exhibit 6 is a certified letter from NCCI verifying that Respondent did not have a workers' compensation policy from July 20, 2005 through October 31, 2010.

3. Investigator Cummins sent a notice of non-compliance to the business, and when he received no response, a hearing date was set and notices of hearing were sent to Respondent. Petitioner offered Petitioner's Exhibit 4, a Notice of Insurance Compliance Hearing with the certified mail receipt, and Petitioner's Exhibit 5, an affidavit of out-of-state service of the Notice on Respondent. The Notice mailed and personally served on Respondent complies with Commission Rule 9100.90(d)(1)(A) and contains the admonition that Respondent's failure to appear at the hearing

> shall constitute a default and shall result in a finding that there has been a knowing and willful failure to insure your liability to pay compensation in accordance with Section 4(a) of the Workers' Compensation Act and an assessment of civil penalties under Section 4(d) of the Act.

4. Investigator Cummins testified that Petitioner is seeking non-compliance penalties of $500.00 per day for 238 days from March 1, 2010 to October 24, 2010, the period the injured worker, William Chamness, was employed by Respondent.

5. Petitioner also seeks reimbursement of the amount paid by the Injured Workers' Benefit Fund to Respondent's injured worker. The Commission's records show that the Fund paid out $145,144.74 to William Chamness pursuant to the Commission's decision in his claim against Respondent, 10 WC 46191, 15 IWCC 0407.

6. In addition to the fine for non-compliance and reimbursement of the Injured Workers' Benefit Fund, Petitioner seeks unpaid insurance premiums. Investigator Cummins testified that he estimated what Respondent would have paid had he purchased workers' compensation insurance as required under the Act. The estimate is based upon a workers' compensation policy for a similar employer, and that daily premium of $3.15 is multiplied by the 238 days of non-compliance for a total of $749.70.

Pursuant to Section 3 of the Act, certain employers and their employees are automatically subject to the provisions of the Act if they engage in specific businesses including "any enterprise in which sharp edged cutting tools, grinders or implements are used" *820 ILCS 305/3(8);* "any business or enterprise in which electric, gasoline or other power driven equipment is used in the operation thereof" *820 ILCS 305/3(15).*

The Commission finds, pursuant to Section 3 of the Act, as it did in the underlying workers' compensation claim, *Chamness v. David Johnson, Individually and d/b/a David Johnson,* 10 WC 46191, 15 IWCC 0407, that the work Respondent engaged in automatically subjected it to the provisions of the Illinois Workers' Compensation Act and required it to carry workers' compensation insurance.

Regarding the issue of penalties, Section 4(d) of the Act states in part:

> "Upon a finding by the Commission, after reasonable notice and hearing, of the knowing and willful failure or refusal of an employer to comply with any of the provisions of paragraph (a) of this section or the failure or refusal to comply with any order of the Illinois Workers' Compensation Commission pursuant to paragraph (c) of this Section disqualifying him or her to operate as a self insurer and requiring him or her to insure his or her liability, the Commission may assess a civil penalty of up to $500.00 per day for each day of such failure or refusal after the effective date of this amendatory Act of 1989. The minimum penalty under this Section shall be the sum of $10,000.00. Each day of such failure or refusal shall constitute a separate offense." *820 ILCS 305/4(d).*

Here the certification from NCCI shows that Respondent was without workers' compensation insurance from March 1, 2010 to October 24, 2010.

The Commission finds that Petitioner has met its burden of proving that Respondent was operating a business in Illinois, was properly served with notice, and was legally required to maintain workers' compensation insurance but failed to do so for 238 days. Respondent's failure to appear at the compliance hearing results in a finding that his failure to obtain workers compensation insurance was knowing and willful. Accordingly, the Commission finds that Respondent is liable for a penalty for failure to comply with Section 4(a) of the Act. The Commission hereby assesses against Respondent a fine of $119,000.00 for the period Respondent was without workers' compensation insurance, $145,144.74 for reimbursement of the amount paid by the Injured Workers' Benefit Fund, and $749.70 for unpaid premiums, for a total of $264,894.44 in civil penalties under Section 4(d) of the Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent, David M. Johnson, individually and d/b/a David M. Johnson Logging, shall pay fines to the Illinois Workers' Compensation Commission in the amount of $264,894.44 as provided in Section 4(d) of the Act.

Pursuant to Commission Rule 9100.90, once the Commission assesses a penalty against an employer in accordance with Section 4(d) of the Act, payment shall be made according to the following procedure: 1) payment of the penalty shall be made by certified check or money order made payable to the Commission; 2) payment shall be mailed or presented within thirty (30) days of the final order of the Commission or the order of the court of review after final adjudication to

20IWCC0074

Workers' Compensation Commission
Insurance Compliance Division
100 West Randolph Street, Suite 8-328
Chicago, IL 60601

3) or as otherwise directed by www.iwcc.il.gov

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: JAN 29 2020

Marc Parker

Deborah L. Simpson

Barbara N. Flores

MP/dak
r-11/5/19
68

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 up	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

HERBERT BARNETT, JR.,

Petitioner,

vs. NO: 15 WC 38269

ALTORFER/CAT,

Respondent.

20IWCC0075

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 and the nature and extent of the injury, 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.

I. FINDINGS OF FACTS

The decision of the Arbitrator delineates the facts of the case in detail. As relevant to the issues on appeal, the Commission notes that Petitioner began working for Respondent on June 30, 2004. He spent the majority of his time painting containers until sometime in 2015. Prior to painting a container, Petitioner had to clean each container by deburring it, using a cleaner to remove the oil and fixing any dents. He then pressure washed it and air dried it. Petitioner wore protective gear during this process.

On February 27, 2014, Petitioner presented to Soderstrom Skin Institute ("Soderstrom") on referral for a generalized rash ongoing since October. The rash initially started on his hands but progressed to his torso and neck. Petitioner had difficulty sleeping due to the itching. He was diagnosed with possible lichenoid drug eruption v. lichen planus. It was also possible that Petitioner had developed contact dermatitis or pityriasis rosea. A 4mm punch biopsy was obtained from a representative lesion. It was noted that if contact dermatitis was found, patch testing would be considered due to Petitioner's job exposure to chemicals.

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Subsequent medical treatment revealed hyperpigmented plaques around Petitioner's neck, wrists, hands, and forearms. Petitioner's symptomatology was ongoing until patch testing was performed in December of 2014. The results yielded extreme positive reactions to epoxy resin, strong positive reaction to P-Phenylenediamine and a weak positive reaction to Carba mix, Methyidibromo Glutaronitrile.

In the interim, Petitioner treated at UnityPoint Health largely for cough and eye issues. However, a March 11, 2015 medical record reflects that Petitioner presented with a rash on both wrists and hands. He was diagnosed with contact dermatitis.

On March 18, 2015, Petitioner presented to Dr. Moody who noted Petitioner's epoxy allergy. Petitioner's medical history was summarized. It was noted that Petitioner's condition improved when off work, and that his rash development was limited to areas of his body that came into contact with paint. Dr. Moody opined that Petitioner could return to work, but he was to have absolutely no skin contact with epoxy resins or solvents, and needed to use adequate respiratory protection.

On April 6, 2015, Dr. Moody noted that Petitioner's symptoms persisted. Material Safety Data Sheets were ordered from Respondent. Upon review, it was noted that three products appeared to have epoxy resins, including Valspar Gray Primer, Component B Catalyst and Epoxy Primer Curing Agent.

In the interim, Petitioner was restricted from exposure to epoxy resins. However, by May 20, 2015 Petitioner informed Dr. Moody that his rash had not improved. Petitioner indicated this was due to his continued work in areas where there was ambient exposure to epoxy resins, even though he was avoiding direct contact. At this time, Petitioner was removed from working in areas with ambient exposure as well.

On June 4, 2015, Petitioner presented to Soderstrom and stated he had been improving, but a recent flare up had occurred due to paint exposure at work. Subsequent visits to Soderstrom revealed steady improvement in Petitioner's condition.

On October 5, 2015, Petitioner returned to Dr. Moody and indicated his condition had improved although he had experienced a recent flare up. Petitioner indicated he was confident that he was avoiding workplace triggers. Dr. Moody made the work restrictions permanent and prescribed Claritin daily.

Petitioner was transferred to an Assembly Worker position in 2015, where he remained until being laid off during a mass layoff on or about January 18, 2017. Petitioner testified that he has unsuccessfully sought employment since then.

II. CONCLUSIONS OF LAW

Pursuant to section 8.1b of the Act, the Arbitrator weighed the criteria in determining Petitioner's level of permanent partial disability. 820 ILCS 305/8.1b(b) (West 2018). Specifically,

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the Arbitrator noted that neither party offered an impairment rating into evidence and placed no weight on the factor pursuant to subsection (b)(i). She noted that Petitioner was employed as a Painter and testified that he could return to work in that capacity. Petitioner was laid off by Respondent in 2017 for unrelated reasons. Since Petitioner can return to work as a Painter, the Arbitrator gave little weight to the second factor pursuant to subsection (b)(ii). The Arbitrator also noted that Petitioner was 52 years old at the time of his accident and, given his age and the fact that his treating physician placed him on permanent restrictions regarding exposure to epoxy resin, the Arbitrator placed great weight on the third factor pursuant to subsection (b)(iii). Having noted no evidence of impairment to his future earning capacity, and Petitioner's testimony that he was capable of returning to work as a Painter, the Arbitrator placed no weight on the fourth factor pursuant to subsection (b)(iv).

The Arbitrator further noted that Petitioner was diagnosed with contact dermatitis and fully recovered after conservative treatment. He did not lose any time from work and has not sought treatment since October 5, 2015. She noted no evidence in the records alluding to Petitioner's lip pigmentation issues, and no photographic evidence of any pigment loss due to his work injury. The Arbitrator placed lesser weight on this fifth factor pursuant to 8.1b(b)(v). After considering the above factors, the Arbitrator found that Petitioner sustained a 3% loss of use of his person as a whole, pursuant to section 8(d)(2) of the Act. The Commission views the evidence slightly different than does the Arbitrator.

The Commission recognizes that Petitioner is technically capable of returning to work as a Painter. However, due to his permanent restrictions requiring strict avoidance of epoxy resins, the Commission finds that the job market for Petitioner will be limited. Thus, the Commission accords subsections (b)(ii) and (iv) with greater weight as the record reveals that Petitioner's technical return to work as a "Painter" is not indicative of a full duty return to the position he held at the time of his accident, which may affect his future earning capacity as evidenced by his inability since being laid off from Respondent to secure employment in his field.

Accordingly, the Commission finds that this warrants a modification of the nature and extent award up to a 10% loss of use of Petitioner's person as a whole.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $684.24 per week for a period of 50 weeks, as provided in section 8(d)(2) of the Act, for the reason that the injuries sustained caused a 10% loss of use of Petitioner's person as a whole.

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

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

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Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $34,300.00. 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: JAN 29 2020
O: 12/5/19
BNF/wde
045

Barbara N. Flores

Deborah L. Simpson

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BARNETT JR, HERBERT
Employee/Petitioner

Case# **15WC038269**

ALTORFER/CAT
Employer/Respondent

20IWCC0075

On 6/12/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.07% 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:

5983 CARAWAY FISHER & BROOMBAUGH
JASON R CARAWAY
9423 W MAIN ST
BELLEVILLE, IL 62223

2904 HENNESSY & ROACH PC
EMILIE A MILLER
2501 CHATHAM RD SUITE 220
SPRINGFIELD, IL 62704

20IWCC0075

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
NATURE AND EXTENT ONLY

Herbert Barnett, Jr.
Employee/Petitioner

v.

Altorfer/Cat
Employer/Respondent

Case # **15** WC **38269**

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 **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Peoria**, on **May 14, 2018.** By stipulation, the parties agree:

On the date of accident, **December 3, 2014**, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned **$57,948.80**, and the average weekly wage was **$1,140.40**.

At the time of injury, Petitioner was **52** years of age, ***single,*** with **0** dependent children.

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

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

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 **$684.24**/week for a period of **15** weeks, as provided in Section **8(d)2** of the Act, because the injuries sustained caused **3% loss of use of the person-as-a-whole**.

As stipulated by the parties at the time of arbitration, Respondent shall pay reasonable and necessary medical services of $399.50 for the 3/11/15 emergency room visit at UnityPoint Health, as provided in Sections 8(a) and 8.2 of the Act.

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

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

Melinda M. Rowe-Sullivan
Signature of Arbitrator

6/8/18
Date

JUN 12 2018

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Herbert Barnett, Jr.
Employee/Petitioner

Case # **15** WC **38269**

v.

Consolidated cases: **N/A**

Altorfer/Cat
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that he worked as a container painter for Respondent for over 11 years. He testified that during his time painting, he came into contact with various chemicals including epoxy resins. He testified that often his safety equipment was either ineffective or the job itself required him to remove parts of his equipment. There is no dispute that Petitioner encountered epoxy resins while working for Respondent.

Petitioner testified that he was allowed to stop painting containers, but further testified that he continued to encounter ambient exposure to epoxy resins. He testified that he was laid off by Respondent in January of 2017 and has not been recalled. He testified that he has not painted in any other capacity since his layoff and that he has not found any employment. He testified that he could paint again, but that he could not paint in an environment where he could be exposed to epoxy resins.

Petitioner testified that he has not sought any additional medical treatment related to his contact dermatitis after his appointment with Dr. Moody on October 5, 2015. He testified that he believed the loss of natural pigment on his upper and lower lips was related to his contact dermatitis, as his respirator would at times malfunction and allow epoxy resin to come into contact with his face and lips. He testified that he has not worked anywhere since his layoff and that he received unemployment benefits for a period of time. He testified that he drops things, that he cannot stand the heat anymore and that his life had changed since his issues started. He testified that he cannot do outdoor work anymore and that his sex life has been affected as well.

On cross examination, Petitioner testified that he has Type 2 Diabetes and that he also has issues with his liver and pancreas. He agreed that he not treated for the contact dermatitis since 2015. He testified that he changed jobs in 2015 and agreed that Respondent tried to keep him away from epoxy resins. He testified that he switched to assembly work and that he remained in that position until he was laid off in 2017 as part of a mass layoff.

The medical records of Soderstrom Skin Institute were entered into evidence at the time of arbitration as Petitioner's Exhibit 1. The records reflect that Petitioner was seen on February 27, 2014, at which time it was noted that he was referred for a generalized rash that had been ongoing since October. It was noted that it had initially started on Petitioner's hands, that he worked as a painter and that he had had progression of his symptoms so that it now involved his torso and neck. It was noted that Petitioner had difficulty sleeping due to the pruritic. It was noted that on the neck there were slightly violaceous, scaling macules and patches; that the wrists had lichenified hyperpigmented patches with scale and that the distal

fingertips had post-inflammatory hyperpigmentation, as did the left flank. The diagnosis was noted to be that of possible lichenoid drug eruption v. lichen planus; the violaceous color is reminiscent of a lichenoid drug eruption; it is also possible this is a contact/irritant dermatitis or pityriasis rosea. Petitioner was recommended to undergo a 4 mm punch biopsy obtained from a representative lesion. It was noted that if it showed a contact dermatitis, patch testing would be a consideration given that Petitioner worked as a painter and had chemical exposures. (PX1).

The records of Soderstrom Skin Institute reflect that Petitioner was seen on March 13, 2014, at which time it was noted that on exam he had a well-healed biopsy site and a number of hyperpigmented, almost violaceous areas noted about the neck and hands. It was noted that the pathology report indicated hypersensitivity. Petitioner was recommended to undergo patch testing and was given a Kenalog injection on that date. At the time of the March 25, 2014 visit, it was noted that Petitioner had hyperpigmented macules about the forearms and hands. The diagnosis was noted to be that of hypersensitivity likely, much better. Petitioner was recommended patch testing at some point if it got any worse again. At the time of the May 9, 2014 visit, it was noted that the examination showed hyperpigmented plaques and scaly macules, itchy and flared, especially to the face and neck but also some to the arms and forearms. It was noted that previous pathology indicated a hypersensitivity reaction. Petitioner was prescribed medications, given a Kenalog injection and recommended to undergo patch testing. At the time of the September 17, 2014 visit, it was noted that there were lichenified papules and plaques on the wrists and dorsum of the hands, that the palmar surfaces were spared and that the neck and upper extremities had some ill-defined patches or erythema. The diagnosis was noted to be that of hypersensitivity reaction of unclear etiology; lichen simplex chronicus, possibly with some autoeczematization; may have a sensitivity to the gloves. Petitioner was given a Kenalog injection and prescribed medications and creams. It was noted that Petitioner would investigate what type of gloves that he was using and that consideration would be given for possible patch testing. (PX1).

The records of Soderstrom Skin Institute reflect that Petitioner was seen on October 23, 2014, at which time it was noted that there was post-inflammatory hyperpigmentation on the dorsum of the hands and that the wrists had scaling and lichenification, as well as the palmar surface near the thumbs. The diagnosis was noted to be that of hypersensitivity reaction, etiology remains unclear; it may be related to the gloves he wears at work. It was noted that Petitioner also had hand wipes that he forgot about that he was using which had been causing him irritation around the hands and neck, that he had since stopped using them for many weeks and that he had not cleared entirely. Petitioner was given a Kenalog injection and prescribed creams. It was noted that Petitioner was recommended to consider patch testing based on how much more he had responded. At the time of the November 26, 2014 visit, it was noted that there was a widespread morbilliform rash on the trunk and axillae and that he also had lichenification and hyperpigmentation with scale on the wrists. The diagnosis was noted to be that of hypersensitivity reaction, possibly a contact dermatitis. Petitioner was given a Kenalog injection, given cream, and started on SD bath oil, and it was noted that he would be scheduled for patch testing. (PX1).

The records of Soderstrom Skin Institute reflect that Petitioner was seen on December 1, 2014 for patch testing. It was noted that Petitioner had had eruption for over a year mainly to the upper body, especially the wrist area and that it could be very severe at times, moderate and increasing at that time. At the time of the December 3, 2014 visit, it was noted that T.R.U.E. Patch Test panels were removed on that date and that all 36 reactions were then evaluated individually. It was noted that Petitioner had the following reactions: an "Extreme Positive" reaction to Epoxy resin; a "Strong Positive" to *P*-Phenylenediamine, and a "Weak Positive" to Carba mix, Methyldibromo Glutaronitril. The diagnosis was noted to be that of Patch Test Day 2, Removal and Reading. At the time of the December 4, 2014 visit, it was noted that Petitioner returned for his final patch test reading for any delayed reactions. It was noted that Petitioner had the following reactions: an "Extreme Positive" reaction to Epoxy resin and a "Strong Positive" to *P*-Phenylenediamine. It was noted that Petitioner was a painter and oftentimes did not have the protective

gear that he needed, such as gloves, and had repeated exposure to epoxy, and that he would discuss this with his manager and avoid the allergens. It was noted that Petitioner deferred Kenalog as he was doing better. (PX1).

The records of Soderstrom Skin Institute reflect that Petitioner was seen on June 4, 2015, at which time it was noted that he had not been seen since December, that he had been doing well but then had been exposed to paint again in his work environment and that he was flared to the arms and wrist area, very pruritic. The diagnosis was noted to be that of allergic contact dermatitis to Epoxy and *P*-Phenylenediamine, flared. Petitioner was instructed to avoid allergens and was given a Kenalog injection. At the time of the June 17, 2015 visit, it was noted that Petitioner was improving but still had some itchy patches to the wrists and around the perioral distribution, doing much better. The diagnosis was noted to be that of allergic contact dermatitis, much improved. Petitioner was given a Kenalog injection and prescribed creams. At the time of the July 9, 2015 visit, it was noted that Petitioner had had significant improvement and was doing well. It was noted that there was a little bit of itching to the wrist area, but that the skin was doing much better. The diagnosis was noted to be that of allergic contact dermatitis, significant improvement. Petitioner was given a Kenalog injection and prescribed creams. At the time of the July 30, 2015 visit, it was noted that Petitioner's pruritic was controlled about the wrist area, that the patches had faded significantly and that he was very happy. The diagnosis was that of allergic contact dermatitis maintained. Petitioner was instructed to use creams, moisturize frequently and use Claritin or Allegra as needed. (PX1).

The medical records of UnityPoint Health were entered into evidence at the time of arbitration as Petitioner's Exhibit 2. The records reflect that Petitioner was seen in the emergency room on November 21, 2014, at which time it was noted that he presented with cough and eye problems. It was noted that as to the eye problem, the episode had started more than two days ago, that the problem had been gradually worsening, that it was in the right eye and that there was no known exposure to pink eye. It was noted that Petitioner had a chronic hyperpigmented rash to both wrists. The assessment was noted to be that of acute bronchitis and a sty. Petitioner was also assessed with contact dermatitis. (PX2).

The records of UnityPoint Health reflect that Petitioner was seen on December 7, 2014, at which time it was noted that he worked in a warehouse-type setting, that he had to wear a hat but took it off and on several times during the day, that he thought he was bit by something, that it had started small and irritated and was now larger and more painful and that he had a swollen lymph node. The assessment was noted to be that of an infected insect bite or sting/cellulitis. At the time of the March 11, 2015 visit, it was noted that Petitioner presented with a rash on the left wrist, right wrist, left hand and right hand. It was noted that there was moderate blistering, itchiness, redness and scaling and that the onset was gradual. It was noted that Petitioner had a hyperpigmented rash to the volar wrists and redness and scaling in the palmar and low back areas. The assessment was noted to be that of contact dermatitis. (PX2).

The medical records of Dr. Moody were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The records reflect that Petitioner was seen on March 18, 2015, at which time it was noted that he was a painter-assembler at Altorfer where he had worked for about 11 years and that he stated that he had developed bilateral forearm rash that had been present much of the time since 2012. It was noted that recently Petitioner's symptoms had increased and that he had also had problems with dryness of the hands and blistering of the hands, that the onset was about the same time and that the onset of symptoms coincided with his diagnosis of diabetes. It was noted that Petitioner had failed to improve and was referred to Dermatology in 2013 where the evaluation led to the conclusion that he had an epoxy allergy and was diagnosed on the basis of patch testing. It was noted that as to work, it sounded like there was an insufficiency of personal protective equipment around the wrists and that even though Petitioner used gloves and a Tyvek suit, there were leak points between the suit and gloves that resulted in paint getting down into his gloves in the areas where he had the rashes. It was noted that Petitioner had some secondary rash on his lower back but thought that it was related to secondary transfer from his hands. It was noted

that Petitioner's rash improved when he was off work and that other than the areas that he attributed to direct contact, he had not had any distant rash development. It was noted that Dr. Moody thought that it was most likely allergic contact dermatitis subsequent to epoxy resin but that he wanted to see the results of other testing. It was noted that Dr. Moody was going to request medical records from the dermatologist and that he was also going to request MSDSs from the employer. It was noted that Petitioner could return to work, but there was to be absolutely no skin contact with epoxy resins or solvents and that he needed to use adequate respiratory protection. (PX3).

The records of Dr. Moody reflect that Petitioner was seen on April 6, 2015, at which time it was noted that he reported that he had not had any shortness of breath or wheezing since his last visit but that he continued to have widespread itching of his skin. It was noted that the rash on the wrist had not improved, that he particularly had itching of his lower back and that he seemed uncertain as to whether his personal protective equipment was effective. It was noted that there were three products in particular that appeared to have epoxy resins that Petitioner had been found to have positive patch testing for, including Valspar Gray Primer, Component B Catalyst and Epoxy Primer Curing Agent. It was noted that Dr. Moody wanted Petitioner removed from exposure to epoxy resins to see if this helped. It was noted that given the longstanding nature of Petitioner's rash, it may take a while before they could confirm whether or not this was going to improve his situation. Petitioner was recommended to see an allergist to do an evaluation to see if he was at risk for IgE immediate hypersensitivity-type reactions as they could be potentially life-threatening medical events should they occur. It was noted that Petitioner probably had some secondary solvent-type dermatitis as well, but that Dr. Moody thought that the allergy component of his rash was the main concern at that point in time. (PX3).

The records of Dr. Moody reflect that Petitioner was seen on May 20, 2015, at which time it was noted that he stated that since the last visit he had not had any improvement in his rash, even though he had been removed from direct contact with Epoxy resins. It was noted that Petitioner was continuing to have an itchy rash involving both wrists, elbows and legs and that he stated that he was still exposed to epoxy resins because he was still working in the same area where there was ambient exposure even though he was no longer painting. It was noted that Petitioner was going to have to be removed from any areas where there was potential ambient exposure as well as direct exposure and that regarding respiratory clearance, Dr. Moody was only going to clear him for positive pressure as he had had difficulty with facial seal in the past. Petitioner was recommended a dermatology consult. At the time of the October 5, 2015 visit, it was noted that Petitioner reported that since his last visit he had not had any additional treatment with dermatology. It was noted that Petitioner's rash had improved but that he had had a recent flare-up that had been quite itchy. It was noted that the areas involved included the volar aspects of both wrists and an area on his back, and that he had been using the steroid cream from the dermatologist but thought that it was no longer of much help. It was noted that Petitioner seemed pretty confident that he was avoiding the known triggers in the workplace and that Dr. Moody was going to make his work restrictions permanent. Petitioner was restarted on Claritin. (PX3).

The records of Dr. Moody reflect that Petitioner was seen on December 1, 2014, at which time it was noted that since his last visit he had been compliant with his restrictions for avoidance of epoxy resins and solvents, that he had also been seeing the dermatologist, that he had had a single Kenalog injection and that he had continued topical steroid application. It was noted that Petitioner had shown substantial improvement. It was noted that Petitioner continued to have hyperpigmented areas on the volar aspects of both wrists, but that these were smaller in size than before. It was noted that Petitioner still had some lichenification, but that the extent and degree of thickness appeared lessened. It was noted that there were no current blisters and that on the left shin Petitioner continued to have a hyperpigmented area. It was noted that there was significant improvement, but that Dr. Moody thought that the restriction regarding epoxy resins was likely to be permanent. (PX3).

The medical records of Dr. Smart were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. The records reflect that Petitioner was seen on April 29, 2015, at which time it was noted that he had been referred for an occupational allergy evaluation after a diagnosis of contact dermatitis due to epoxy resins and specifically to see if he was at risk for IgE mediated allergic reactions. It was noted that beginning in 2012 Petitioner developed a localized rash on the right thigh and that this was followed by clusters of small itching blisters on the hands and then more localized eczematous patches on the arms, legs and lower back, but mostly at the wrists. It was noted that Petitioner had worked as a finish spray painter at Altorfer for most of the past 11 years painting large pieces such as Caterpillar generators and that he typically wore gloves and a Tyvek suit, but that there was some exposure at the wrists in particular. It was noted that the exam was most remarkable for thickened, dark lichenified chronic lesions at the wrists, especially the flexural surface. It was noted that Dr. Smart agreed with a diagnosis of allergic contact dermatitis based on the combination of skin lesions, positive patch testing and known occupational exposures. It was noted that Dr. Smart also agreed with current recommendations for strict contact avoidance and the use of topical corticosteroids. It was noted that regarding the question of IgE mediated allergy, Dr. Smart had no good reason to suspect this from his clinical history and that he was not aware of any good IgE tests for epoxy resin. It was noted that Petitioner was recommended to continue to avoid epoxy resins and also other irritants such as solvents that could cause or exacerbate contact dermatitis. He was instructed to continue dermatology follow-up and return as needed. (PX4).

The Medical Bills Exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibit 5.

CONCLUSIONS OF LAW

The parties stipulated that Petitioner sustained an accident on December 3, 2014 that arose out of and in the course of his employment with Respondent, and that Petitioner's condition of ill-being was causally connected to this injury. (AX1).

With respect to disputed issue (L) pertaining to the nature and extent of Petitioner's injury, and consistent with 820 ILCS 305/8.1b, permanent partial disability shall be established using the following criteria: (i) the reported level of impairment pursuant to subsection (a) of Section 8.1b of the Act; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. 820 ILCS 305/8.1b. No single enumerated factor shall be the sole determinant of disability. *Id.*

With respect to Subsection (i) of Section 8.1b(b), the Arbitrator notes that no AMA rating was offered by either party. The Arbitrator places no weight on this factor when making the permanency determination.

With respect to Subsection (ii) of Section 8.1b(b), the Arbitrator notes that while Petitioner has been noted to have an allergy to epoxy resins which are found in some paints, Petitioner also testified that this would not prevent him from working as a painter. Petitioner testified that he was laid off by Respondent in January of 2017 for reasons unrelated to his work accident. As the evidence reveals that Petitioner can return to work as a painter, the Arbitrator gives little weight to this factor when making the permanency determination.

With respect to Subsection (iii) of Section 8.1b(b), Petitioner was 52 years old on his date of accident. Given the age of Petitioner and the fact that his treating physician has placed him permanent

restrictions regarding exposure to epoxy resins, the Arbitrator places greater weight on this factor when making the permanency determination.

With respect to Subsection (iv) of Section 8.1b(b), the Arbitrator notes that Petitioner provided no evidence of impairment in earning capacity as a result of his work accident and that Petitioner testified that, despite his restrictions, he can return to work as a painter. The Arbitrator places no weight on this factor when making the permanency determination.

With respect to Subsection (v) of Section 8.1b(b), the Arbitrator notes that Petitioner was diagnosed with contact dermatitis and recovered fully after conservative treatment. Petitioner did not lose any time from work as a result of his accident and the medical evidence reveals that he has not sought treatment since October 5, 2015. (PX3). As it relates to Petitioner's lips, there is no evidence in the medical records that Petitioner reported a rash or pigment issues with his lips while seeking treatment. Also, no photographic evidence was submitted by Petitioner to substantiate his claim of pigment loss to his lips as a result of his work injury. The Arbitrator places lesser weight on this factor in determining permanency.

The Arbitrator notes that the determination of permanent partial disability benefits is not simply a calculation, but an evaluation of all of the factors as stated in the Act in which consideration is not given to any single factor as the sole determinant. Based on the above factors and the record in its entirety, the Arbitrator concludes that Petitioner sustained permanent partial disability to the extent of **3% loss of use of the person-as-a-whole** as provided in Section 8(d)2 of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF MCLEAN)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Maureen Sollars,

Petitioner,

vs. NO: 14 WC 07792

McLean County Health Department,

Respondent.

20IWCC0076

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 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 January 9, 2018, 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.

SOIACC0038

20IWCC0076

No county, city, town, township, incorporated village, school district, body politic or municipal corporation is required to file a bond to secure the payment of the award and the costs of the proceedings in the court to authorize the court to issue such summons. 820 ILCS 305/19(f)(2). Based upon the named Respondent herein, no bond is set by the Commission. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JAN 29 2020
o120519
BNF/mw
045

Barbara N. Flores

Deborah L. Simpson

Marc Parker

8700000105

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SOLLARS, MAUREEN
Employee/Petitioner

Case# **14WC007792**

13WC023192

McLEAN COUNTY HEALTH DEPARTMENT
Employer/Respondent

20IWCC0076

On 1/9/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.57% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

0264 HEYL ROYSTER VOELKER & ALLEN
DANA HUGHES
PO BOX 6199
PEORIA, IL 61601-6199

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

Maureen Sollars
Employee/Petitioner
v.
McLean County Health Department
Employer/Respondent

Case # **14 WC 7792**
13 WC 23192

20IWCC0076

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gregory Dollison**, Arbitrator of the Commission, in the city of **Bloomington, Illinois** on **11/28/17**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On 5/1/13, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned ***$50,195.60***; the average weekly wage was ***$965.30.***

On the date of accident, Petitioner was **49** years of age, ***single*** with **0** children under 18.

ORDER

Having found that Petitioner failed to prove she sustained a compensable accident within the meaning of the Act. All requests 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

1/4/18
Date

JAN 9 - 2018

STATEMENT OF FACTS:

Petitioner, Maureen Sollars, filed two Applications for Adjustment of Claim alleging accidental injuries while employed by Respondent, McLean County Health Department, the first for accidental injuries sustained on November 26, 2012 and the second for injuries which manifested on or about May 1, 2013. The November 26, 2012 claim involved an undisputed injury to the right shoulder. The May 1, 2013 claim is a completely disputed left carpal tunnel claim. The claims were tried together on November 28, 2017.

Petitioner testified she was a program coordinator at the McLean County Health Department since 1997. The essential functions of her job included coordinating health and human service providers for young children. She would spend six hours per day on her computer and 15 to 45 minutes on the phone. Twice a month she would host meetings that would require her to carry various items to the meetings and return them to the health department once finished with the meeting. She could utilize a dolly and cart to carry these materials and her co-workers were available to assist her as needed. Sometimes at these meetings she utilizes a white board to communicate to the meeting attendees. When Petitioner began her employment with Respondent, she had no right arm issues. She acknowledged she did have carpal tunnel syndrome in both hands prior to starting her job with the County.

Petitioner sustained a compensable work place accident involving a slip and fall on her right shoulder on November 26, 2012. Petitioner reported tripping on a sidewalk. She fell forward landing on both knees, her right hand and face. She chipped her left upper incisor and she hurt her right shoulder, which she "jammed" as she landed. She sought treatment at Advocate Occupational Medicine and ultimately with Dr. Mark Hanson who performed an injection and ultimately arthroscopic surgery to the right arm on February 28, 2013. The procedure performed consisted of a right shoulder arthroscopy, arthroscopic subacromial decompression, distal clavicle resection, biceps tenotomy, debridement of biceps stump and labrum with mini-open rotator cuff repair and biceps tenodesis. The post-operative diagnosis was right shoulder subacromial impingement, AC arthritis, rotator cuff tear with labral tear. (PX 4, PX 6, PX 9, PX 10)

Petitioner continued treating with Dr. Hanson post-operatively. She was in therapy and using a sling. On April 4, 2013, Dr. Hanson noted Petitioner was doing surprisingly well. Her motion was to 145° and she had no tenderness. Dr. Hanson released her to work at three hours max effective April 8, 2013. Dr. Hanson indicated she could type and write, but restricted her to no lifting for one month. (PX 10)

Petitioner testified that during the time she was home, she was performing activities of daily living with the right arm in a sling. She also cared for a person with MS during that time. She lived with that person, but did not get paid for the care she provided. During this time, she experienced numbness and tingling in her left hand which she associated with those activities of daily living. Petitioner acknowledged having carpal tunnel syndrome in that hand for 20 years, but had been asymptomatic until her right arm was in the sling, post-surgery. She denied using splints in the past on the left hand.

In April 2013, Petitioner was referred by her primary care physician, Dr. Lilla Berck for an EMG for bilateral hand complaints. Petitioner presented for the diagnostic testing on May 1, 2013. At that time she reported experiencing symptoms for twenty-five (25) years. Petitioner reported she worked as a program manager and used computers. She reported doing a lot of writing with her right hand. Petitioner also reported that she recently had right shoulder surgery and had been using her left hand more often. As a result, her left hand symptoms were greater than the right. She reported pain, numbness, tingling and weakness in the first

three digits of both hands. Petitioner also reported using night splints for many years. The EMG demonstrated severe neuropathies of both wrists that was approximately equal in severity. Surgery was recommended. (PX 7)

On May 6, 2013, Petitioner notified Respondent, via email, that she had bilateral carpal tunnel syndrome. Petitioner wrote: "I have carpal tunnel in both my hands. It has always been worse in the Right hand, with very little aggravation in the Left. I've known how to manage it and get my work done prior to this surgery. Since I had to primarily use the Left for 8 weeks it has become quite painful to hold anything in that hand for more than a minute or two…I can only type for about 10 minutes before the pads of my fingers on my Left hand begin getting pins and needles, then shooting pains in my wrists…I would have thought that the Right would have improved since I didn't use it for so long, but no, the pain is back with a vengeance…" (RX 4)

On May 31, 2013, Petitioner saw Dr. Jerome Oakey with complaints of worsening left hand greater than right numbness with pain since February. He noted prior to that, Petitioner had sporadic pain which was only increased with substantial use such as home renovation activities in the remote past. Dr. Oakey recommended a left carpal tunnel release. (PX 10) Petitioner did not immediately undergo carpal tunnel release but continued with right shoulder rehabilitation efforts for the right shoulder.

At Respondent's request, Petitioner underwent a Section 12 examination with Dr. Michael Lewis on August 9, 2013. In his report dated August 13, 2013, Dr. Lewis noted Petitioner provided a history of the slip and fall on November 27, 2012. At the time of the examination, Petitioner complained of the inability to elevate her right arm post surgery. She also complained that because her right arm was in a sling she had to use her left arm more than usual and subsequently noted numbness in the thumb, index and middle fingers of the left hand. She informed the doctor that she had symptoms referable to both hands for more than 20 years. Petitioner also informed the doctor that she had returned to regular work in July 2013. In addition to the above, Dr. Lewis reviewed medical documentation and performed an examination. Dr. Lewis opined Petitioner was status post repair of a massive rotator cuff tear, right shoulder, with persistent limitation of motion. The doctor opined that said condition was work-related. Dr. Lewis also opined that Petitioner suffered from left carpal tunnel syndrome. The doctor did not believe that said condition was work related. The doctor reasoned that Petitioner had a history of symptoms compatible with carpal tunnel for many years. The doctor also provided that increased use of the left hand while in the right arm sling and also given the nature of Petitioner's job description is not a sufficient casual connection between her condition and a work injury. Dr. Lewis further noted that the attempted repair of the massively torn rotator cuff did not appear to improve Petitioner's range of motion. As a result, he felt Petitioner was at maximum medical improvement. He felt Petitioner was unable to perform overhead work or lift over 20 pounds with the right upper extremity. (PX 2, RX 1)

On August 27, 2013, Petitioner underwent a subsequent right shoulder MRI. The scan demonstrated a full thickness tear of the supraspinatus tendon with tendon retraction. (PX 5) On September 9, 2013, Dr. Hanson noted Petitioner was still unable to elevate the right arm. Dr. Hanson assessed persistent tear. The doctor was concerned that the tear could not be "re-repaired" and referred Petitioner to Dr. Shi at the University of Chicago for a second opinion. (PX 10)

Petitioner presented to Dr. Shi on September 26, 2013. After obtaining a history and performing an examination, Dr. Shi assessed a large recurrent rotator cuff tear to the right shoulder. Dr. Shi discussed surgical options including but not limited to a revision rotator cuff arthroscopy, a reverse total shoulder arthroplasty or tendon transfer. (PX 12)

On April 16, 2014, Petitioner reported to Dr. Hanson that she did not have much pain in her right shoulder while taking Celerex. She had been doing therapy at home with improvement in her range of motion. The doctor noted Petitioner was hesitant to proceed with a total shoulder. Her examination demonstrated decreased range of motion. Her abduction was decreased. Her external and internal rotation was also decreased. At the time, the

doctor recommended waiting on the reverse total shoulder arthroscopy. Work conditioning was prescribed. (PX 10)

Petitioner underwent another course of physical therapy starting in May 2014 which was completed on August 20, 2014. The discharge note indicates that overall, Petitioner felt good but was frustrated she could not do more feeling like she had plateaued. Petitioner was able to use momentum to swing her arm up over her head to do things like change a lite bulb, change curtains and do her hair. She was able to control the arm on its way down. It was also noted that Petitioner continued to have limitations with holding objects above shoulder height for a long period of time and putting objects on shelves. Petitioner was advised to perform home exercises. (PX 16)

On December 10, 2015, Petitioner saw Dr. Robert Seidl for a second opinion regarding her carpal tunnel syndrome. Dr. Seidl noted Petitioner had gradual and insidious onset of symptoms. Her pain had been ongoing for two (2) years. Dr. Seidl diagnosed Petitioner with left hand carpal tunnel syndrome at that visit and recommended surgical release. Petitioner underwent a left carpal tunnel release on October 22, 2016. (PX 17)

On November 8, 2016, Petitioner returned to Dr. Seidl. Petitioner reported "no pertinent negatives" regarding the left wrist. She was "highly satisfied with the results. Her numbness and tingling had resolved. At that visit however, Petitioner reported right wrist joint numbness, pain, and tingling. The doctor diagnosed right wrist carpal tunnel syndrome and recommended surgical release. Dr. Seidl carried out the recommended right carpal tunnel release on December 14, 2016. According to the records submitted, Petitioner last saw Dr. Seidl on February 9, 2017. At that time she complained of shooting pain in her first two digits along with pins and needle feeling. She reported that her pain was increased while typing and she had been dropping items due to a numbness feeling. Medication was prescribed and Petitioner was instructed to follow-up in four (4)weeks. (PX 17) Petitioner testified that she is not claiming that her right hand and subsequent surgery is related to her work activities.

Petitioner offered the evidence deposition testimony of Dr. Seidl into evidence. Petitioner's counsel gave Dr. Seidl a hypothetical describing Petitioner's work duties for Respondent to include working with computers, writing reports, and talking on the phone. Petitioner's attorney also asked Dr. Seidl to assume Petitioner has a surgical procedure in February 2013 which resulted in a right arm restriction and asked Dr. Seidl to comment on a causal relationship between Petitioner's work duties and the restricted nature of her carpal tunnel syndrome in 2013. Dr. Seidl opined Petitioner's work duties for Respondent could exacerbate symptoms of carpal tunnel as would increased activities at home. He further went on to say it was not as definitive to say that activities performed with the left hand while the right hand was immobilized could exacerbate carpal tunnel syndrome. (PX 20, pp. 9-10)

At Respondent's request, Dr. Lewis performed a third Section 12 examination of Petitioner on January 6, 2017. In his report dated January 10, 2017, Dr. Lewis offered an opinion that Petitioner's work duties at Respondent did not cause, contribute to, or aggravate her bilateral carpal tunnel syndrome. He felt Petitioner's carpal tunnel syndrome was the result of non-occupational causes and risk factors. Dr. Lewis noted Petitioner acknowledged that she had symptoms compatible with right carpal tunnel syndrome for twenty-five (25) years. With respect to her left carpal tunnel syndrome, Dr. Lewis cited the AMA Guides which states there is insufficient evidence that keyboard activities are a risk factor for carpal tunnel syndrome. The doctor also noted a Mayo clinic study that concluded there was no increased incidence in carpal tunnel syndrome with those who perform keyboard activities at work as compared to those in a control group. Lastly, the doctor noted Petitioner has a high body mass index for which there is strong evidence that supports that a high body mass index increases risk. (RX 1, dep 4)

At trial, Petitioner testified that currently her left wrist felt "fine."

With respect to C.) Did an accident occur that arose out of and in the course of Petitioner's employment by the Respondent and F.) Is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds as follows:

The Arbitrator finds that Petitioner failed to prove she sustained a compensable work place injury that manifested itself on May 1, 2013. Petitioner has failed to offer sufficient evidence to prove her condition is causally connected to any overuse syndrome she developed as a result of her right arm being immobilized, and has offered insufficient proof of any condition caused by repetitive trauma in the work place.

Petitioner admitted at trail she did not associate her increase in left hand and wrist symptoms with her work duties for McLean County Health Department. She was not required to work in an abnormal position at her work station. She reported to medical professionals that her activities of daily living, which did include some computer use, were causing her symptoms. Petitioner worked from 1997 to 2012 with preexisting carpal tunnel syndrome in both hands. She utilized night splints but never sought additional treatment for carpal tunnel syndrome during that time frame. Following her report of alleged manifestation of left carpal tunnel syndrome in May 2013, Petitioner work in her full and regular capacity until October 2016 when she underwent left carpal tunnel release.

The Arbitrator further finds that Petitioner also failed to establish an overuse syndrome in the left upper extremity caused by immobilization of the right upper extremity. Petitioner testified that she utilized her left upper extremity for activities of daily living when her right arm was immobilized following surgery. However, she did not quantify these activities in any way, nor did Petitioner provide examples of abnormal positioning of her hands or writs including hyperflexion or hyperextension or any other positioning or activities known to cause or aggravate carpal tunnel syndrome. Evidence submitted references activities of daily living aggravating Petitioner's hands which Petitioner described these activities as personal care, eating and computer use. There is no testimony or medical treatment records or any medical testimony regarding the frequency in which Petitioner was performing any of these activities.

Petitioner's offered the testimony of Dr. Seidl to support her position. Dr. Seidl was asked to assume that "on February 28, 2013 she had a surgical procedure to her right shoulder which was a rotator cuff tear with a labral tear. Based on a reasonable degree of medical certainty could her job duties and the fact that she was restricted due to her shoulder surgery cause her carpal tunnel syndrome?" Dr. Seidl responded "I think with the surgery it is hard to say." He went on to further explain that he could not say for sure that Petitioner was increasing her activities with the left hand because the right arm was immobilized. He testified that it was a difficult argument to make. Despite the above testimony, Dr. Seidl expressed an affirmative causal relationship opinion.

In contrast to Dr. Seidl's causal relationship opinion, Dr. Lewis, Respondent's Section 12 examiner, proffered an opinion that Petitioner's left carpal tunnel syndrome was neither related to her work duties for Respondent nor was it related to any alleged overuse. Dr. Lewis cited the AMA Guides to Causation as the basis for his opinion that the fact that Petitioner was wearing a sling on the right hand was not contributory to cause or aggravate carpal tunnel syndrome in the opposite hand. Dr. Lewis cited Petitioner's numerous other comorbidities such as hypertension, hyperthyroidism and obesity as other potential sources of carpal tunnel syndrome. He further cited her 20 plus year history of carpal tunnel syndrome for which she utilized splints to control her symptoms. Dr. Lewis further did not find a causal relationship between Petitioner's carpal tunnel syndrome and her work duties for Respondent. The Arbitrator is persuaded by the opinions offered by Dr. Lewis.

As noted above, Petitioner acknowledged a 20 plus year history of carpal tunnel syndrome which predated her employment with Respondent. She performed her full and regular work duties for almost 20 years with that carpal tunnel syndrome. EMG testing showed severe median neuropathies equal at both sides. Even though Petitioner claims the left hand was bothering her following right shoulder surgery, she clearly complained with pain and problems with the right hand as well. In fact, an email from Petitioner to Respondent reflects that Petitioner was surprised that the right hand was painful during that time. Based on Petitioner's 20 year history of carpal tunnel syndrome and severe neuropathies noted on EMG, it is not surprising Petitioner would be experiencing symptoms in her bilateral hands with activities of daily living. Dr. Lewis noted in his evidence deposition, any activity can cause symptoms but he would expect positive provocative testing would be in place regardless of whether the right arm was ever immobilized. Dr. Lewis' testimony regarding causation is essentially consistent with Dr. Seidl's testimony that one in a sling is not necessarily causative of carpal tunnel syndrome in the other extremity.

Based on all the above, the Arbitrator finds that Petitioner failed to prove she sustained an accidental injury that arose out of and in the course of her employment with Respondent that manifested on May 1, 2013. The Arbitrator further finds that Petitioner failed to prove that her left hand carpal tunnel syndrome condition of ill-being is causally related to her employment with Respondent.

All remaining issue are rendered moot.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Maureen Sollars,

Petitioner,

vs. NO: 13 WC 23192

McLean County Health Department,

Respondent.

20IWCC0077

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 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's decision delineates the facts of the case in detail. As relevant to the issues on appeal, the Commission notes that, in reaching his decision, the Arbitrator found that all reasonable and necessary medical expenses had been paid by Respondent. However, upon review, the Commission notes that certain medical bills from McLean County Orthopedics and University of Chicago Medical Center remain outstanding. Accordingly, the Commission modifies the award for medical expenses and awards Petitioner all outstanding medical expenses related to her right shoulder condition.

All else is affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner all outstanding reasonable and necessary medical expenses from McLean County Orthopedics and University of Chicago Medical Center, pursuant to sections 8(a) and 8.2 of the Act.

SOLICCOOSS

20IWCC0077

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

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

No county, city, town, township, incorporated village, school district, body politic or municipal corporation is required to file a bond to secure the payment of the award and the costs of the proceedings in the court to authorize the court to issue such summons. 820 ILCS 305/19(f)(2). Based upon the named Respondent herein, no bond is set by the Commission. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JAN 29 2020
o:12/5/19
BNF/wde
045

Barbara N. Flores

Deborah L. Simpson

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SOLLARS, MAUREEN
Employee/Petitioner

Case# **13WC023192**
14WC007792

McLEAN COUNTY HEALTH DEPARTMENT
Employer/Respondent

20IWCC0077

On 1/9/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.57% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

0264 HEYL ROYSTER VOELKER & ALLEN
DANA HUGHES
PO BOX 6199
PEORIA, IL 61601-6199

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

Maureen Sollars
Employee/Petitioner

v.

McLean County Health Department
Employer/Respondent

Case # **13 WC 23192**
14 WC 07792

20IWCC0077

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gregory Dollison**, Arbitrator of the Commission, in the city of **Bloomington, Illinois** on **11/28/17.** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **11/26/12,** 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 **$50,195.60**; the average weekly wage was $**965.30**.

On the date of accident, Petitioner was **49** years of age, ***single*** with **0** children under 18.

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

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

Respondent shall be given a credit of $**3,769.24** for TTD, $**2,353.26** for TPD, $* for maintenance, and $* for other benefits, for a total credit of $**6,122.50.**

Respondent is entitled to a credit under Section 8(j) of the Act for any bills paid by its group insurer. Respondent shall hold Petitioner safe and harmless for any such bills that Respondent is receiving credit.

ORDER

Respondent shall pay the Petitioner the sum of **$579.18** / week for a period of **100** weeks, because Petitioner sustained permanent partial disability to the extent of **20%** pursuant to §**8(d)(2)** of the Act.

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

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

Signature of Arbitrator

1/4/18
Date

JAN 9 - 2018

Attachment to Arbitrator Decision
(13 WC 23192)

STATEMENT OF FACTS:

Petitioner, Maureen Sollars, filed two Applications for Adjustment of Claim alleging accidental injuries while employed by Respondent, McLean County Health Department, the first for accidental injuries sustained on November 26, 2012 and the second for injuries which manifested on or about May 1, 2013. The November 26, 2012 claim involved an undisputed injury to the right shoulder. The May 1, 2013 claim is a completely disputed left carpal tunnel claim. The claims were tried together on November 28, 2017.

Petitioner testified she was a program coordinator at the McLean County Health Department since 1997. The essential functions of her job included coordinating health and human service providers for young children. She would spend six hours per day on her computer and 15 to 45 minutes on the phone. Twice a month she would host meetings that would require her to carry various items to the meetings and return them to the health department once finished with the meeting. She could utilize a dolly and cart to carry these materials and her co-workers were available to assist her as needed. Sometimes at these meetings she utilizes a white board to communicate to the meeting attendees. When Petitioner began her employment with Respondent, she had no right arm issues. She acknowledged she did have carpal tunnel syndrome in both hands prior to starting her job with the County.

Petitioner sustained a compensable work place accident involving a slip and fall on her right shoulder on November 26, 2012. Petitioner initially sought treatment at Advocate Bromenn Occupational Health on November 27, 2012. Petitioner reported tripping on a sidewalk. She fell forward landing on both knees, her right hand and face. She chipped her left upper incisor and she hurt her right shoulder, which she "jammed" as she landed. X-rays were taken of the right shoulder which was negative for any fractures. Petitioner was diagnosed with right shoulder sprain; right hand abrasion and traumatic broken tooth (left upper incisor). Petitioner was returned to work light duty and referred to Dr. Mark Hanson. (PX 9)

Petitioner was seen by Dr. Hanson on November 28, 2012. Petitioner reported tripping over steps "yesterday" at work landing on her outstretched right hand, injuring her right shoulder. An examination revealed tenderness at the AC joint and tenderness around the acromion. She had a positive impingement. She had poor strength and she could not elevate above 90°. Dr. Hanson diagnosed rotator cuff strain, right shoulder, and administered an injection. Medication was prescribed and she was returned to restricted work. (PX 10)

Petitioner was seen again at Advocate Bromenn Occupational Health on December 6, 2012. Petitioner continued with right shoulder pain complaints. She reportedly could not lift the right arm above her head. Physical therapy was mentioned. Also noted was that if she had no improvement, a MRI would be recommended. (PX 9)

Petitioner returned to Dr. Hanson on January 2, 2013. Dr. Hanson noted she had tenderness at the cuff with positive impingement. The doctor recommended a MRI which when completed on January 9, 2013 demonstrated a complete tear of the distal supraspinatus tendon with retraction. On January 16, 2013, Dr. Hanson noted the MRI showed a full rotator cuff tear and recommended a right shoulder arthroscopy, subacromial decompression, distal clavicle resection, rotator cuff repair, and possible subscap repair. (PX 6, PX 10)

On February 28, 2013, Dr. Hanson performed a surgical procedure consisting of a right shoulder arthroscopy, arthroscopic subacromial decompression, distal clavicle resection, biceps tenotomy, debridement of biceps stump and labrum with mini-open rotator cuff repair and biceps tenodesis. The post-operative diagnosis was right shoulder subacromial impingement, AC arthritis, rotator cuff tear with labral tear. (PX 4)

Petitioner continued treating with Dr. Hanson post-operatively. She was in therapy and using a sling. On April 4, 2013, Dr. Hanson noted Petitioner was doing surprisingly well. Her motion was to 145° and she had no tenderness. Dr. Hanson released her to work at three hours max effective April 8, 2013. Dr. Hanson indicated she could type and write, but restricted her to no lifting for one month. (PX 10)

Petitioner testified that during the time she was home, she was performing activities of daily living with the right arm in a sling. She also cared for a person with MS during that time. She lived with that person, but did not get paid for the care she provided. During this time, she experienced numbness and tingling in her left hand which she associated with those activities of daily living. Petitioner acknowledged having carpal tunnel syndrome in that hand for 20 years, but had been asymptomatic until her right arm was in the sling, post-surgery. She denied using splints in the past on the left hand.

In April 2013, Petitioner was referred by her primary care physician, Dr. Lilla Berck for an EMG for bilateral hand complaints. Petitioner presented for the diagnostic testing on May 1, 2013. At that time she reported experiencing symptoms for twenty-five (25) years. Petitioner reported she worked as a program manager and used computers. She reported doing a lot of writing with her right hand. Petitioner also reported that she recently had right shoulder surgery and had been using her left hand more often. As a result, her left hand symptoms were greater than the right. She reported pain, numbness, tingling and weakness in the first three digits of both hands. Petitioner also reported using night splints for many years. The EMG demonstrated severe neuropathies of both wrists that was approximately equal in severity. Surgery was recommended. (PX 7)

Petitioner followed-up with Dr. Hanson on May 2, 2013. Dr. Hanson noted Petitioner had improvements in pain and motion. The doctor returned her to restricted work five hours a day until May 18, 2013 when she could return to work full duty as tolerated. (PX 10)

On May 6, 2013, Petitioner notified Respondent, via email, that she had bilateral carpal tunnel syndrome. Petitioner wrote: "I have carpal tunnel in both my hands. It has always been worse in the Right hand, with very little aggravation in the Left. I've known how to manage it and get my work done prior to this surgery. Since I had to primarily use the Left for 8 weeks it has become quite painful to hold anything in that hand for more than a minute or two…I can only type for about 10 minutes before the pads of my fingers on my Left hand begin getting pins and needles, then shooting pains in my wrists…I would have thought that the Right would have improved since I didn't use it for so long, but no, the pain is back with a vengeance…" (RX 4)

Petitioner returned to Dr. Hanson on May 30, 2013. An examination of the right shoulder revealed weakness, catching and locking in her shoulder. She had tenderness over the greater tuberosity and tenderness over the supraspinatus. The Hawkin's test was positive. She had 4/5 abduction. (PX 10)

On May 31, 2013, Petitioner saw Dr. Jerome Oakey with complaints of worsening left hand greater than right numbness with pain since February. He noted prior to that, Petitioner had sporadic pain which was only increased with substantial use such as home renovation activities in the remote past. Dr. Oakey recommended a left carpal tunnel release. (PX 10)

Petitioner did not immediately undergo carpal tunnel release but continued with right shoulder rehabilitation efforts for the right shoulder. On July 24, 2013, Dr. Hanson noted Petitioner continued with tenderness of the rotator cuff. Her range of motion was decreased. She had a positive Hawkin's sign. Her abduction was decreased and external rotation was also decreased. Dr. Hanson recommended an MR arthrogram. (PX 10)

At Respondent's request, Petitioner underwent a Section 12 examination with Dr. Michael Lewis on August 9, 2013. In his report dated August 13, 2013, Dr. Lewis noted Petitioner provided a history of the slip and fall on November 27, 2012. At the time of the examination, Petitioner complained of the inability to elevate her right arm post surgery. She also complained that because her right arm was in a sling she had to use her left arm more than usual and subsequently noted numbness in the thumb, index and middle fingers of the left hand. She informed the doctor that she had symptoms referable to both hands for more than 20 years. Petitioner also informed the doctor that she had returned to regular work in July 2013. In addition to the above, Dr. Lewis reviewed medical documentation and performed an examination. Dr. Lewis noted active forward flexion and abduction on the right were limited to 80°. External rotation was limited to 60° on the left and 40° on the right. Strength was decreased to 4/5. Dr. Lewis opined Petitioner was status post repair of a massive rotator cuff tear, right shoulder, with persistent limitation of motion. The doctor opined that said condition was work-related. Dr. Lewis also opined that Petitioner suffered from left carpal tunnel syndrome. The doctor did not believe that said condition was work related. The doctor reasoned that Petitioner had a history of symptoms compatible with carpal tunnel for many years. The doctor also provided that increased use of the left hand while in the right arm sling and also given the nature of Petitioner's job description is not a sufficient casual connection between her condition and a work injury. Dr. Lewis further noted that the attempted repair of the massively torn rotator cuff did not appear to improve Petitioner's range of motion. As a result, he felt Petitioner was at maximum medical improvement. He felt Petitioner was unable to perform overhead work or lift over 20 pounds with the right upper extremity. (PX 2, RX 1)

On August 27, 2013, Petitioner underwent the prescribed right shoulder MRI. The scan demonstrated a full thickness tear of the supraspinatus tendon with tendon retraction. (PX 5) On September 9, 2013, Dr. Hanson noted Petitioner was still unable to elevate the right arm. Dr. Hanson assessed persistent tear. The doctor was concerned that the tear could not be "re-repaired" and referred Petitioner to Dr. Shi at the University of Chicago for a second opinion. (PX 10)

Petitioner presented to Dr. Shi on September 26, 2013. He reported a history that Petitioner fell or tripped while walking into work and fell on her shoulder. She had had injections, physical therapy, a MRI and surgery. An examination of the right shoulder revealed her forward flexion was 30° actively. Passively she could get to 130°. External rotation was 60° and internal rotation was 20°. Dr. Shi assessed a large recurrent rotator cuff tear to the right shoulder. Dr. Shi discussed surgical options including but not limited to a revision rotator cuff arthroscopy, a reverse total shoulder arthroplasty or tendon transfer. (PX 12)

At Respondents' request, Petitioner underwent a second Section 12 examination with Dr. Lewis on November 22, 2013. In his report dated November 26, 2013, Dr. Lewis recorded his belief that Petitioner had objective findings of an inability to forward flex and abduct her right shoulder above shoulder level and increasing pain in her right shoulder. The doctor noted that although Petitioner was able to perform her regular daily task, she did have a significant functional imitation involving her right shoulder. Dr. Lewis opined that a reverse total shoulder arthroscopy would have the greatest likelihood of improving her functional capacity. (PX 3, RX 1)

On April 16, 2014, Petitioner reported to Dr. Hanson that she did not have much pain in her right shoulder while taking Celerex. She had been doing therapy at home with improvement in her range of motion. The doctor noted Petitioner was hesitant to proceed with a total shoulder. Her examination demonstrated decreased range of motion. Her abduction was decreased. Her external and internal rotation was also decreased. At the time, the doctor recommended waiting on the reverse total shoulder arthroscopy. Work conditioning was prescribed. (PX 10)

Petitioner underwent another course of physical therapy starting in May 2014 which was completed on August 20, 2014. The discharge note indicates that overall, Petitioner felt good but was frustrated she could not

do more feeling like she had plateaued. Petitioner was able to use momentum to swing her arm up over her head to do things like change a lite bulb, change curtains and do her hair. She was able to control the arm on its way down. It was also noted that Petitioner continued to have limitations with holding objects above shoulder height for a long period of time and putting objects on shelves. Petitioner was advised to perform home exercises. (PX 16)

On January 28, 2015, Dr. Hanson authored a note commenting on Petitioner's need for further treatment. The doctor commented that Petitioner's massive rotator cuff tear and need for surgery was directly related to her fall. Dr. Hanson stated the persistent massive tear of her cuff is related to her initial injury and surgery. Dr. Hanson felt enough time had passed that a re-repair is not an option and her next surgery would be a reverse total shoulder replacement. He reiterated that Petitioner's current right shoulder condition is related to her initial fall at work. (PX 1)

On December 10, 2015, Petitioner saw Dr. Robert Seidl for a second opinion regarding her carpal tunnel syndrome. Dr. Seidl noted Petitioner had gradual and insidious onset of symptoms. Her pain had been ongoing for two (2) years. Dr. Seidl diagnosed Petitioner with left hand carpal tunnel syndrome at that visit and recommended surgical release. Petitioner underwent a left carpal tunnel release on October 22, 2016. (PX 17)

On November 8, 2016, Petitioner returned to Dr. Seidl. Petitioner reported "no pertinent negatives" regarding the left wrist. She was "highly satisfied with the results. Her numbness and tingling had resolved. At that visit however, Petitioner reported right wrist joint numbness, pain, and tingling. The doctor diagnosed right wrist carpal tunnel syndrome and recommended surgical release. Dr. Seidl carried out the recommended right carpal tunnel release on December 14, 2016. According to the records submitted, Petitioner last saw Dr. Seidl on February 9, 2017. At that time she complained of shooting pain in her first two digits along with pins and needle feeling. She reported that her pain was increased while typing and she had been dropping items due to a numbness feeling. Medication was prescribed and Petitioner was instructed to follow-up in four (4)weeks. (PX 17) Petitioner testified that she is not claiming that her right hand and subsequent surgery is related to her work activities.

Petitioner offered the evidence deposition testimony of Dr. Seidl into evidence. Petitioner's counsel gave Dr. Seidl a hypothetical describing Petitioner's work duties for Respondent to include working with computers, writing reports, and talking on the phone. Petitioner's attorney also asked Dr. Seidl to assume Petitioner has a surgical procedure in February 2013 which resulted in a right arm restriction and asked Dr. Seidl to comment on a causal relationship between Petitioner's work duties and the restricted nature of her carpal tunnel syndrome in 2013. Dr. Seidl opined Petitioner's work duties for Respondent could exacerbate symptoms of carpal tunnel as would increased activities at home. He further went on to say it was not as definitive to say that activities performed with the left hand while the right hand was immobilized could exacerbate carpal tunnel syndrome. (PX 20, pp. 9-10)

At Respondent's request, Dr. Lewis performed a third Section 12 examination of Petitioner on January 6, 2017. In his report dated January 10, 2017, Dr. Lewis offered an opinion that Petitioner's work duties at Respondent did not cause, contribute to, or aggravate her bilateral carpal tunnel syndrome. He felt Petitioner's carpal tunnel syndrome was the result of non-occupational causes and risk factors. Dr. Lewis noted Petitioner acknowledged that she had symptoms compatible with right carpal tunnel syndrome for twenty-five (25) years. With respect to her left carpal tunnel syndrome, Dr. Lewis cited the AMA Guides which states there is insufficient evidence that keyboard activities are a risk factor for carpal tunnel syndrome. The doctor also noted a Mayo clinic study that concluded there was no increased incidence in carpal tunnel syndrome with those who perform keyboard activities at work as compared to those in a control group. Lastly, the doctor noted Petitioner has a high body mass index for which there is strong evidence that supports that a high body mass index increases risk. (RX 1, dep 4)

Petitioner testified that she has not had any recent treatment to her right shoulder. Petitioner stated she has not undergone the recommended right shoulder surgical procedure and had no plans to do so "at this time." She stated that she is currently working full duty although she is prohibited from lifting over 5 pounds above the shoulder. She has received her regular pay raises (merit system) and she continues to care for the individual with MS.

Petitioner testified that although her right shoulder is "fine" on a "day to day" basis, she is unable to lift boxes over her head. She complained of difficulty moving objects from "side to side." She also has difficulty writing on a chalk board. She has difficulty with household chores. She uses her left hand to put dishes away in upper cabinets.

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

Petitioner sustained an undisputed accident on November 26, 2012 when she tripped on the sidewalk and noted immediate pain in her right arm. A subsequent MRI of her right shoulder showed a complete tear of the distal supraspinatus tendon with retraction. Dr. Hanson, her treating physician, recommended a right shoulder arthroscopy. On February 28, 2013, Dr. Hanson performed a surgical procedure consisting of a right shoulder arthroscopy, arthroscopic subacromial decompression, distal clavicle resection, biceps tenotomy, debridement of biceps stump and labrum with mini-open rotator cuff repair and biceps tenodesis. The postoperative diagnosis was right shoulder subacromial impingement, AC arthritis, rotator cuff tear with labral tear. Subsequent to surgery, Petitioner continued with complaints. A subsequent MRI demonstrated a full thickness tear of the supraspinatus tendon with tendon retraction. Petitioner was seen for a second opinion and ultimately, a reverse total shoulder arthroplasty was deemed appropriate. The surgical procedure was also recommended by Respondent's Section 12 examiner, Dr. Lewis. Both Dr. Hanson and Dr. Lewis opined that a causal relationship existed between Petitioner's right shoulder condition and the accident sustained.

Based on the above, the Arbitrator find that Petitioner's present right shoulder condition of ill-being is causally related to the accident sustained on November 26, 2012.

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:

Respondent has paid all appropriate charges for all reasonable and necessary medical services. As such, none is due and owing.

With respect to (L.) What is the nature and extent of the injury, the Arbitrator finds as follows:

In determining the level of permanent partial disability for injuries incurred on or after September 1, 2011, the Commission shall base its determination on the following factors: (i) the reported level of impairment pursuant to the most current edition of the AMA's "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; (v) evidence of disability corroborated by the treating medical records. (820 ILCS 305/8.1b)

No single enumerated factor shall be the sole determinant of disability. 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)

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 man as a whole pursuant to §8(d)(2) of the Act.

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

(a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but are not limited to: loss of range of motion; loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment.

(b) Also, the Commission shall base its determination on the following factors:

(i) The reported level of impairment;
(ii) The occupation of the injured employee;
(iii) The age of the employee at the time of injury;
(iv) The employee's future earning capacity; and
(v) Evidence of disability corroborated by medical records.

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

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that Petitioner was employed as a Program Coordinator for Respondent at the time of the accident. The Arbitrator notes that although Petitioner was able to return to work in her prior capacity, she has limitations with her ability to reach overhead. The Arbitrator therefore gives greater weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 48 years old at the time of the accident. Because of Petitioner's work life expectancy, the Arbitrator therefore gives greater weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes Petitioner presented no evidence that her earning capacity has been impacted by the injury. Rather, Petitioner's testimony was such that if she did not receive a regular pay raise from the County, it was due to merit or other payment considerations. The Arbitrator therefore gives lesser weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes Petitioner had a rotator cuff tear on MRI. This was repaired surgically. The surgery failed. A subsequent MRI showed an additional tear and a reverse total shoulder arthroplasty has been recommended. Petitioner has not had any formal medical treatment for her right shoulder condition since her course of physical therapy in August 2014. The discharge note indicates that overall, Petitioner felt good but was frustrated she could not do more feeling like she had plateaued. Petitioner was able to use momentum to swing her arm up over her head to do things like change a lite bulb, change curtains and do her hair. She was able to control the arm on its way down. It was also noted that Petitioner continued to have limitations with holding objects above shoulder height for a long period of time and putting objects on shelves. Although it has been quite some time since she has had formal treatment, Petitioner continues to experience similar symptoms. Petitioner credibly testified she is unable to lift boxes over her head. She complained of difficulty moving objects from "side to side." She also has difficulty writing on a chalk board; has difficulty with household chores and uses her left hand to put dishes away in upper cabinets. The Arbitrator therefore gives greater weight to this factor.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

James Kroupa,

Petitioner,

vs. NO: 18 WC 03815

Black Horse Carriers, Inc.,

Respondent.

20IWCC0078

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 3, 2019, 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.

20IWCC0078

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: JAN 29 2020
o121919
BNF/mw
045

Barbara N. Flores

Deborah L. Simpson

Deborah L. Simpson

Marc Parker

Marc Parker

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

KROUPA, JAMES
Employee/Petitioner

Case# **18WC003815**

BLACK HORSE CARRIERS
Employer/Respondent

20IWCC0078

On 5/3/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.39% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4036 MILLON & PESKIN LTD
MITCHELL PESKIN
310 S COUNTY FARM RD SUITE J
WHEATON, IL 60187

2461 NYHAN BAMBRICK KINZIE & LOWRY
DANIEL EGAN
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

James Kroupa
Employee/Petitioner

v.

Black Horse Carriers
Employer/Respondent

Case # **18** WC **03815**

Consolidated cases: _____

20IWCC0078

An *Application for Adjustment 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 T. Cronin**, Arbitrator of the Commission, in the city of **Chicago**, on **2/25/19**. 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. ☒ What temporary benefits are in dispute?
☐ TPD ☐ Maintenance ☒ TTD
L. ☐ What is the nature and extent of the injury?
M. ☐ Should penalties or fees be imposed upon Respondent?
N. ☒ Is Respondent due any credit?
O. ☒ Other: **Is Petitioner entitled to prospective medical care?**

20IWCC0078

FINDINGS

On **1/20/18**, Respondent ***was*** operating under and subject 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 $**46,996.56**; the average weekly wage was $**903.78**.

On the date of accident, Petitioner was **49** years of age, ***married*** with **1** dependent child.

Petitioner ***has not*** received all reasonable and necessary medical services.

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

Respondent shall be given a credit of $**9,210.12** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**9,210.12**.

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

ORDER

For the reasonable and necessary medical services rendered to him, Respondent shall pay Petitioner an amount equal to the unpaid bills of **$145.00** from Parkview Orthopaedic Group and **$5,359.00** from St. Alexius Medical Center, pursuant to Section 8(a) and subject to Section 8.2 of the Act.

Respondent shall pay Petitioner temporary total disability benefits of **$602.52**/week from **1/21/2018** through **1/23/2018** and from **1/25/2018** through **5/14/2018**, which represents a total of **16-1/7** weeks, because Petitioner was temporarily totally disabled during these periods, in accordance with Section 8(b) of the Act.

Respondent shall authorize and pay for the proposed redo decompression surgery at L4-5 and fusion surgery at L4-5 and L5-S1 that Dr. Mekhail has recommended, pursuant to Section 8(a) and subject to Section 8.2 of the Act.

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

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

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

Signature of Arbitrator

5/2/2019
Date

MAY 3 - 2019

ADDENDUM

Findings of Fact:

The Petitioner testified that he had been employed by the Respondent since July 5, 2017. (TX, Pg. 10). He worked as a delivery route driver. (TX, Pg. 11). His job would require him to drive a 26-foot straight truck that had a gate lift and to deliver auto parts to various stores in the northwest suburbs and Chicagoland area. (TX, Pg. 12). He would work 5 days a week, Monday evening through early Saturday morning. (TX, Pg. 11). His shift would typically start at 8:30 p.m. and would end once he would finish his route. This would typically be sometime between 2:30 a.m. and 3:30 a.m. (TX, Pg. 10). He would make approximately 7 stops on his route each day. (TX, Pg. 13).

The Petitioner testified that half of his time on the job involved driving and the other half involved unloading. (TX, Pg. 12). In order to perform his job, he must be able to lift auto parts weighing up to 100 pounds and push and pull pallets up to 1500 to 1800 pounds with the use of a pallet jack. (TX, Pg. 13). If parts fell off the skid, he would pick them up by hand and put them back on the skid. (TX, Pg. 14).

The Petitioner testified that at about 12:00 a.m. on January 20, 2018, he was making a delivery in the course of his employment by the Respondent. (TX, Pgs. 14-15). The Petitioner was finishing up his stop in Chicago. (TX, Pg. 15). He had the pallet jack on the lift gate of his truck. (TX, Pg. 15, 16). He began raising the lift gate. (TX, Pg. 15). When the lift gate was almost at the top of its rise, the Petitioner testified, he heard a noise in the alley, looked and saw a huge rat. (TX, Pg. 15). He testified it seemed like the rat was going to lunge at him, so he moved backwards, tripped over the pallet jack, and falling off the lift gate. (TX Pg. 15). The Petitioner fell approximately 4 feet and landed on the asphalt. (TX Pg. 16). He landed onto his buttocks and back. He also testified that he hit his head. (TX, Pg. 16). The Petitioner testified immediately after this occurred, he had pain in his buttocks, leg and head. (TX, Pg. 17). He took about a 30-45-minute break to regain his composure. (TX, Pg. 17). He thereafter reported the accident via text message to his lead driver, Jim. (TX, Pg. 18). The Petitioner finished his last stop at approximately 3:30 a.m. (TX, Pg. 18). He testified at that time he was feeling worse and that his lower back and leg were hurting him. (TX, Pg. 18). He returned his truck to the terminal, filled out an accident report, went home and laid down. (TX, Pg. 17). After 3-4 hours, he testified, his back pain and right leg pain were getting worse and that he began to feel a tingling into his right leg. (TX, Pg. 19, 20).

The Petitioner treated with Dr. Christopher Hwang at Rush Copley Medical Center during the morning of January 20, 2018. (PX1). The medical history indicated that he had undergone prior back surgery. It also stated that around midnight of last night, he had fallen approximately 4-5 feet off the back of a truck and landed on his lower back and buttock area. (PX1). He reported complaints of back pain and a tingling sensation down his right leg. (PX1). He was prescribed and underwent a CT scan of the lumbar spine and pelvis. (PX1). His January 20, 2018 CT scan of the lumbar spine did not reveal any acute fracture, but did show that he had circumferential disc bulging with multilevel moderate to severe canal or foramina stenosis, most marked at L4-5 and L5-S1. (PX1). The Petitioner was prescribed off work restrictions for three days and directed to follow up with his primary care physician. (TX, Pgs. 20-21; PX1).

At the direction of Barbara Reeper, the Respondent's terminal manager, the Petitioner treated at Physicians Immediate Care in Chicago on January 23, 2018. (TX, Pg. 21; PX2). A history of accident was noted. (PX2). It was also noted that the Petitioner had a chief complaint of lower back pain since his accident

and was having pain that radiated to his right lower extremity, as well as a feeling of tingling down his right leg for the past 3 days. (PX2). Examination findings showed he had tenderness of the right and left paraspinal muscles, a positive straight leg raise test on the right, and reduced lumbosacral range of motion. (PX2). The Petitioner was diagnosed with sprains of ligaments of the lumbar spine and contusion of the lower back and pelvis. (PX2). He was prescribed Deltasone and given light-duty restrictions of no lifting greater than 50 pounds and no driving. (TX, Pg. 23; PX2). The Petitioner had remained off work since his accident and returned to light duty work on January 24, 2018. (TX, Pgs. 21,23).

On January 25, 2018 the Petitioner chose to see his prior surgeon, Dr. Andrew G. Chenelle. (PX3). The history provided was that the Petitioner fell off his truck approximately 4 feet onto his back and hit his head. (PX3). Dr. Chenelle noted the Petitioner had numbness in his right toes, pain across his low back and shooting pains in his right anterior leg. (PX3). The Petitioner reported to Dr. Chenelle that all of his symptoms started after he fell. (PX3). His exam findings revealed the Petitioner had sensory deficit distribution on the right at S1. (PX3). Dr. Chenelle stated in his report that the Petitioner may have "tractioned" a nerve root during the fall. (PX3). He referred the Petitioner out for physical therapy and to pain management for an epidural steroid injection. He also prescribed off-work restrictions and Norco. (PX3).

Upon referral from Dr. Chenelle, the Petitioner saw a pain management doctor, Dr. Edward Yang, on January 29, 2018. (PX3; PX5). Dr. Yang's records contain a history of the accident. It was noted that following the accident, the Petitioner had immediate lower back pain and that the next day he started having pain radiating to his right lower extremity. (PX3; PX5). He diagnosed the Petitioner with lower back pain, lumbar spinal stenosis, right lumbar radiculopathy and lumbar degenerative disc disease. (PX3; PX5) Dr. Yang performed a lumbar epidural steroid injection at L5-S1. (PX5). The Petitioner testified he had minimal relief from this injection; it only lasted a couple of weeks. (TX, Pg. 27). On February 13, 2018, the Petitioner underwent a transforaminal epidural steroid injection at L5-S1 on the right with Dr. Yang. (PX5) The Petitioner said he did not have any symptom relief from this injection. (TX, Pg. 27).

The Petitioner also attended 12 sessions of physical therapy at NW Delnor Aurora Physical Therapy from February 5, 2018 through March 1, 2018. (PX3; PX5). During his first session of physical therapy, the therapist, Barbara Penzato, noted the Petitioner was positive on the right lower extremity with straight leg raise and slump testing. (PX3). At the time of discharge, the physical therapist, Lindsey Ritter, noted that the Petitioner was experiencing numbness in his entire right foot and also that he felt weaker on his right side. (PX3; PX5) The Petitioner testified that this was accurate and that these symptoms began sometime during his course of physical therapy. (TX, Pgs. 27-28). Ms. Ritter also noted that the Petitioner had minimal to no progress in therapy. (PX3, PX5). The Petitioner's testimony confirmed the same. (TX, Pg. 28).

The Petitioner returned to see Dr. Chenelle on March 2, 2018. (PX3) Dr. Chenelle noted that the Petitioner was having worsening back and leg pain with certain exercises and stretches, and worsening numbness in the right foot, which he was now feeling in his right calf. (TX, Pgs. 28-29; PX3). Dr. Chenelle continued the Petitioner's off-work restrictions and prescribed an MRI, which the Petitioner underwent on March 14, 2018. (PX3). According to the radiologist, Dr. Gregory Zweig, the MRI revealed at L4-5, mild diffuse disc bulging with small superimposed central to right central disc protrusion with annular fissure that appears to contact the right L5 nerve root in the lateral recess. (PX3). It also revealed at L5-S1 endplate osteophytes and bulging of the disc with extension into the neural foramina; mild to moderate narrowing of the right neural foramen; moderate narrowing of the left neural foramen with contact of the exiting left L5 nerve root; mild narrowing of the left lateral recess; and mild to moderate narrowing of the right lateral recess with contact of the right S1 nerve root. (PX3).

On March 16, 2018, the Petitioner returned to see Dr. Chenelle, who reviewed the MRI findings and subsequently recommended a right L4-5 XLIF and posterior total laminectomies at L4-S1 with pedicle screw fixation and arthrodesis. (PX3). He also continued the Petitioner's off-work restrictions. (PX3).

On April 5, 2018, the Petitioner sought a second opinion with his prior surgeon, Dr. Anis O. Mekhail. (PX6). Dr. Mekhail noted a history of accident. (PX6; TX, Pg. 31). During the examination, the Petitioner reported back pain going down his right leg with numbness, tingling and weakness. It was noted that he was not having these symptoms before his accident. (PX6). The Petitioner testified that this was accurate. (TX, Pg. 31). He also noted that the Petitioner underwent 2 epidural injections and a course of physical therapy with no relief. (PX6). Dr. Mekhail's physical examination revealed that the Petitioner had decreased sensation in the L5 and S1 distribution on the right side, weakness in his right ankle dorsiflexion, and the inability to walk on his heels or tiptoes. (PX6). Dr. Mekhail also reviewed the Petitioner's x-rays and recent MRI. (PX6). Per Dr. Mekhail, the MRI showed degeneration at L4-5 and more significant degeneration at L5-S1 with retrolisthesis. (PX6). He also stated the MRI showed more stenosis at L4-5 on the right with a disc protrusion, which explained some of the Petitioner's symptoms. (PX6).

Dr. Mekhail prescribed an EMG in order to help him determine if the S1 distribution was playing a part in the symptoms the Petitioner was experiencing. (PX6). While Dr. Mekhail did concur with Dr. Chenelle's recommendation for a fusion, he did not believe the XLIF procedure was warranted as it presented a high risk of nerve root irritation. (PX6). Dr. Mekhail opined that if the Petitioner underwent a fusion at L4-5, he should have one at L5-S1 since that level had degenerated. (PX6). He also indicated he would consider decompressing the L5-S1 level depending on the results of the EMG. (PX6). Dr. Mekhail continued the Petitioner's off-work restrictions. (PX6).

The Petitioner attended a Section 12 examination with Dr. Ghanayem on April 16, 2018 at the request of the Respondent. (TX, Pg. 32; RX8 – Exhibit 2). The Petitioner provided a history that he had developed back pain since his accident. (RX8 – Exhibit 2). He also reported that he had complaints of pain down the back of the right thigh with numbness into the right calf and foot. (RX8 – Exhibit 2). Dr. Ghanayem opined that the findings on his MRI appeared to be long-standing in nature, as well as postsurgical in nature. (RX8 – Exhibit 2). Dr. Ghanayem found no focal motor deficits, intact sensation to light touch, and some tenderness in the paraspinal musculature. (RX8 – Exhibit 2). He indicated he could not substantiate the Petitioner's leg symptoms based on the MRI studies and did not believe the Petitioner was a surgical candidate. (RX8 – Exhibit 2). Dr. Ghanayem concluded that the Petitioner "may have sprained his back and aggravated some of his underlying disk degeneration at L5-S1." (RX8 – Exhibit 2). He also concluded that the Petitioner should be able to resume his regular work activities. (RX8 – Exhibit 2). Dr. Ghanayem also stated that if the Petitioner "continues to have issues as outlined above, he will see me for additional treatment and/or surgery." (RX8 – Exhibit 2).

The Petitioner testified that at the time of the examination, he was wearing his shoes, socks and pants. (TX, Pg. 32-33). During the examination, the Petitioner testified, he was never asked by Dr. Ghanayem to remove these items and he never took off his shoes or socks. (TX, Pg. 32-33). The Petitioner also testified that the entire time Dr. Ghanayem spent examining him was less than 5 minutes. (TX, Pg. 33). The Petitioner testified that during the examination, Dr. Ghanayem never touched his feet or tried to raise his toes and ankles against downward pressure. (TX, Pg. 33).

The Petitioner returned to see Dr. Mekhail on May 14, 2018. Dr. Mekhail again noted the Petitioner had decreased sensation in the L5 distribution and 4/5 weakness in his right ankle dorsiflexion. During that visit he was not able to appreciate S1 distribution symptoms. Dr. Mekhail indicated he was still

recommending that the Petitioner have an EMG. He stated that surgery was a valid option for the Petitioner. Dr. Mekhail also indicated that the Petitioner could return to regular work and that his medical condition would not necessarily prevent him from doing his job. (PX6). Although he testified that the Petitioner could drive, as of May 14, 2018, he opined that he should still have restrictions of no climbing ladders or lifting over 20 pounds. (PX7, Pgs. 37-39).

Dr. Mekhail reviewed and commented on the Section 12 report from Dr. Ghanayem. (PX6). He noted that the Petitioner stated to him that he was never asked to remove his socks and shoes and if that was indeed true, he could not understand how Dr. Ghanayem could have been tested for sensation. (PX6).

The Petitioner testified he was not immediately able to have the EMG test because the Respondent would not authorize it and he could not afford to pay for it. (TX, Pg. 34). The Petitioner eventually had the EMG on November 6, 2018 after he put it through his own health insurance. (TX, Pg. 35; PX8). Dr. John Lavaccare performed the EMG and concluded that the study was abnormal. (PX8). He noted that there was electrophysiologic evidence of mild chronic bilateral low lumbar radiculopathy that was most notable at L4-L5. (PX8). The Petitioner subsequently returned to see Dr. Mekhail on December 6, 2018. (PX8). Dr. Mekhail noted that the Petitioner was still having back pain and right leg pain. (PX8). He also noted the Petitioner was having a hard time sleeping and taking Norco. (PX8). Physical examination revealed the Petitioner had weakness and numbness, decreased sensation at the L5 distribution, and weakness in the right foot. (PX8). He also noted dorsiflexion was 4/5. (PX8). Dr. Mekhail reviewed the EMG and concluded that it showed evidence of L4-5 neural compression, which explained the Petitioner's symptoms. (PX8). Dr. Mekhail again recommended surgery in the form of a redo compression at L4-S1. (PX8). He also recommended a fusion because the Petitioner had prior decompressions. (PX8). The Petitioner testified he has not had the surgery that Dr. Mekhail has recommended because the Respondent has not approved it. (TX, Pg. 36). The Petitioner testified that Dr. Mekhail discussed the risks of surgery with him and that he would like to undergo the procedure. (TX, Pg. 37).

The Petitioner testified that he was off work under his doctors' restrictions following his accident up through May 14, 2018. (TX, Pg. 38). During that period, he only worked 1 day (January 24, 2018). (TX, Pgs. 23-24). After Dr. Mekhail released him to return to work on May 14, 2018, he returned to work for the Respondent until he was discharged on June 12, 2018. (TX, Pgs. 9, 34, 38, 39). The Petitioner testified that although he was working full-duty, he was still having lower back pain and shooting pain into his right leg. (TX, Pg. 39). He also testified he was having difficulty picking up heavy items. (TX, Pg. 39). The Petitioner obtained employment as a route driver at Monroe Transportation on June 21, 2018. (TX, Pgs. 39-40). He testified that worked long hours, had difficulty lifting heavy items, and was unable to perform his job duties. (TX, Pgs. 40-41). Consequently, he left this employment after approximately 4-5 weeks. (TX, Pg. 41).

On July 30, 2018, the Petitioner obtained employment at Lucky's Energy Service. (TX, Pg. 41). He testified that he works as a fuel truck driver and continues to maintain his employment with this employer. (TX, Pgs. 41-42). His job involves driving and fueling other tractor trailers. (TX, Pg. 42). He testified that approximately 50% percent of his time is spent driving and 50% of his time is spent fueling tractors. (TX, Pgs. 42-43). When he fuels tractors, he pulls a hose to the fuel tank of a tractor. (TX, Pg. 43). The Petitioner estimated the weight of the hose was less than 20 pounds. (TX, Pg. 43). He testified he has difficulty performing this job. (TX, Pg. 43). Specifically, he testified, he has extreme pain in his leg and lower back pain while performing the job, but he tolerates it. (TX, Pg. 43).

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Prior Treatment

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The Petitioner initially treated for his lower back in 2006 with Dr. Chenelle. (TX, Pg. 44; PX4). On January 11, 2007, Dr. Chenelle performed an L5-S1 partial hemilaminectomy, microdiscectomy and foraminotomy; and L4-L5 partial hemilaminectomy and foraminotomy. (PX4). Following this surgery, the Petitioner testified, he underwent approximately 4-5 weeks of post-operative treatment. (TX, Pg. 44). He testified that at the completion of his treatment, he felt fine. (TX, Pgs. 44-45). He also testified he was released to return to work without any work restrictions. (TX, Pg. 45).

On March 24, 2011 the Petitioner first saw Dr. Mekhail following a motor vehicle accident in which he was involved. (TX, Pg. 45; PX6). He treated for complaints of right leg pain going down his buttocks to the calf. (TX, Pg. 45; PX6). The Petitioner underwent 3 epidural steroid injections and underwent surgery by Dr. Mekhail on September 20, 2011. (TX, Pg. 45; PX6). The surgery consisted of a right L4-5 decompression, laminotomy, foraminotomy, partial facetectomy and microdiscectomy. (PX6). Following surgery, the Petitioner treated with Dr. Mekhail up through November 10, 2011. Dr. Mekhail had noted and the Petitioner testified, that at that time he was doing very well, had no radiculopathy and had no pain or weakness. (TX, Pg. 46; PX6). The Petitioner was cleared to return to work without any restrictions. (TX, Pg. 46; PX6).

The Petitioner returned to see Dr. Mekhail on June 30, 2014 with complaints of back pain and right leg pain with intermittent numbness and tingling. (TX, Pg. 46; PX6). On October 31, 2014, the Petitioner returned to see Dr. Chenelle following an October 15, 2014 work accident. (TX, Pg. 47; PX4). Dr. Chenelle noted that the Petitioner was having right lower back pain into his buttocks, and a stabbing sensation in his right thigh into the right calf. (PX4). The Petitioner underwent surgery with Dr. Chenelle on November 7, 2014. (PX5). Specifically, the Petitioner underwent a right L4-5 redo partial hemilaminectomy, foraminotomy and microdiscectomy. (PX5). Following that surgery, the Petitioner was released to return to work without restrictions by Dr. Chenelle on March 2, 2015. (TX, Pg. 47; PX4).

The Petitioner returned to Dr. Chenelle on March 27, 2015 with complaints of low back pain radiating to his right leg. (PX4). He was prescribed an MRI, which he had on March 30, 2015. The MRI demonstrated at L4-5, a broad-based disc bulge, a mild central disc protrusion indenting the ventral sac and transiting the right, and left L5 nerve root; and a mild broad disc bulge at L5-S1 with no central canal stenosis or neuroforamina stenosis. (PX5). On April 22, 2015, Dr. Chenelle prescribed physical therapy and pain management. (PX4). The Petitioner testified that he attended physical therapy but did not recall if he saw a pain management doctor. (TX, Pg. 48). The Petitioner returned to see Dr. Chenelle on May 12, 2015 at which time he was released to return to work without restrictions. (TX, Pg. 48; PX4). The Petitioner testified he was feeling fine. (TX, Pg. 49).

The Petitioner testified that he did not treat for back or right leg complaints again until over 2½ years later when he saw Dr. Chenelle in January 2018 for treatment regarding this claim. (TX, Pg. 49). The Petitioner also testified that from May 2015 up until his January 20, 2018 work accident, he did not have any injuries to his lower back, did not have any treatment for his back and right leg, and was not having any complaints involving his lower back and right leg. (TX, Pgs. 49-50). The Petitioner testified that prior to his January 20, 2018 work accident he was feeling fine and he was able to perform his job for the Respondent without any difficulty. (TX, Pg. 50). The Petitioner also testified that since his January 20, 2018 accident, he has not had any injuries to his lower back. (TX, Pg. 50).

20IWCC0078

Current Condition

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The Petitioner testified that he currently has extreme lower right leg pain, that his lower back hurts, and that he has tingling, numbness and weakness in his right foot. (TX, Pg. 51). On a scale of 1-10 with 10 being the worst, he rated his back pain at a 4 and his leg pain at a 7. (TX, Pg. 51). Sometimes he has difficulty with his back from walking. (TX, Pg. 52). He testified that he presently takes Hydrocodone at nighttime. (TX, Pg. 51).

Testimony of Dr. Mekhail

Dr. Anis O. Mekhail testified on behalf of the Petitioner. Dr. Mekhail is a licensed, board-certified, orthopedic surgeon who specializes in spine surgery. (PX7, Pgs. 4-5). He performs approximately 350 back and spine related surgeries a year. (PX7, Pg. 6).

Dr. Mekhail testified that when he saw the Petitioner on April 5, 2018, the Petitioner reported that he was pain free until his accident. (PR7, Pg. 16, 17). During his examination, Dr. Mekhail found the Petitioner had weakness in his right ankle and decreased sensation on the right leg on the right side. (PX7, Pg. 21). This finding meant that there was an impairment of the nerve function by some nerve injury. (PX7, Pg. 21). Dr. Mekhail testified that the Petitioner's weakness in the ankle dorsiflexion usually involves the L5 nerve root that can stem from the L4-5 and L5-S1 levels. (PX7, Pg. 21). He also testified that the decreased sensation he found was in the L5 and S1 distribution. (PX7, Pg. 21).

Dr. Mekhail agreed with Dr. Zweig's reading of the MRI concerning the L4-5 level. (PX7, Pg. 23). Dr. Mekhail testified that if someone has an L4-5 disc bulge with contact of the right L5 nerve root and lateral recess, that person may experience numbness, pain, tingling or weakness or a combination of these symptoms (PX7, Pgs. 23-24). Dr. Mekhail also testified that the Petitioner's symptoms of pain down his leg, numbness in the distribution of the L5 nerve root and outside the leg, and weakness with ankle dorsiflexion (which is the muscle supply by the L5 nerve root), were consistent with the MRI findings. (PX7, Pg. 24).

Dr. Mekhail also agreed with Dr. Zweig's interpretation of the MRI finding at the L5-S1 level. (PX7, Pgs. 24-25). Dr. Mekhail testified that the contact with the right S1 nerve root was caused by stenosis which is a condition that could be aggravated by trauma. (PX7, Pg. 25). Symptoms at the S1 nerve root could include pain, numbness and weakness. (PX7, Pg. 26). The Petitioner had pain down the leg and some numbness and Dr. Mekhail wanted an EMG to determine if the S1 nerve was contributing to those symptoms (PX7, Pg. 26).

Dr. Mekhail is recommending a redo compression at L4-5 and a fusion at L4-5 and at L5-S1. (PX7, Pg. 28). Depending on the results of the EMG, he would consider decompression of the L5-S1 level (PX7, Pgs. 28-29). His surgical approach was different than Dr. Chenelle's. (PX7, Pg. 29). The XLIF L4-5 is associated with a much higher risk of nerve injury and involvement, which can cause more side effects. (PX7, Pg. 29). Dr. Mekhail also indicated that Dr. Chenelle's approach would consist of 2 surgeries, 1 from the side and 1 from the back. (PX7, Pg. 29). Dr. Mekhail believed everything could be done from the back and his approach was less invasive. (PX7, Pg. 29).

Dr. Mekhail opined that surgery is a reasonable treatment option for the Petitioner for 3 reasons. (PX7, Pg. 31). First, the Petitioner has symptoms that match his MRI findings. (PX7, Pg. 31). Second, the Petitioner tried conservative treatment and it did not work. (PX7, Pg. 31). Third, the symptoms the Petitioner is having is affecting his quality of life and the Petitioner would like to proceed with something

to help with his symptoms. (PX7, Pg. 31). If the surgery is successful, Dr. Mekhail would anticipate resolution of the Petitioner's leg pain (85% success rate) and back pain (70% success rate). (PX7, Pgs. 31-32). It was his opinion that if the Petitioner did not have the surgery, it is unlikely that his symptoms would resolve. (PX7, Pg. 33).

Dr. Mekhail testified that he believed the accident was the cause of the Petitioner's symptoms. (PX7, Pgs. 42, 78). He opined that the accident either caused or aggravated the Petitioner's pre-existing condition. (PX7, Pg. 42). Dr. Mekhail testified that if a disc herniation did not exist before the accident, then the injury caused it, if it did exist, then the injury aggravated his pre-existing condition. (PX7, Pgs. 77-78). He also testified that the surgery he proposed for the Petitioner was precipitated by the Petitioner's work accident (PX7, Pg. 43).

Dr. Mekhail disagreed with Dr. Ghanayem's physical findings. Dr. Mekhail testified that contrary to Dr. Ghanayem's findings, on the 2 occasions Mekhail examined the Petitioner, he found he had decreased sensation and weakness. (PX7, Pg. 43). Dr. Mekhail was also perplexed as to how Dr. Ghanayem could have examined the Petitioner for sensation without ever having him take off his shoes or his socks. (PX7, Pg. 74). Dr. Mekhail also disagreed with Ghanayem's opinion that the 2018 MRI does not reveal any compression on the right side. (PX7, Pg. 44). Per Dr. Mekhail, the 2018 MRI shows a disc protrusion pinching on the nerve. (PX7, Pg. 44). Dr. Mekhail did agree with Dr. Ghanayem's statement that the Petitioner could have aggravated his underlying disc degeneration. (PX7, Pg. 44).

Testimony of Dr. Ghanayem

Dr. Alexander J. Ghanayem testified on behalf of the Respondent. He is a board-certified orthopedic spine surgeon. (RX7, Pg. 6). Fifty-percent of his job involves clinical care and the other fifty-percent is an administrator role as Chairman of the Department of Orthopaedic Surgery at Loyola University Medical Center. He is also a Professor. (RX7, Pg. 6, Dep. Ex. 1)

Dr. Ghanayem testified that he is paid $1,800.00 for conducting Section 12 exams. (RX7, Pg. 19). Two-thirds of his examinations are performed on behalf of respondents. (RX7, Pg. 20). He performs about 5-6 Section 12 exams a week. (RX7, Pg.19).

Based on his review of the 2018 MRI, Dr. Ghanayem did not see any compression at the L4-5 level. (RX7, Pgs. 11-12). He testified that there was some compression on the left side of the nerve at L5-S1. (RX7, Pg. 12). He defined compression as pinching of the nerves. (RX7; Pg. 12). He also testified that the Petitioner was not a surgical candidate. (RX7, Pgs. 14-15). He did not believe a fusion would be an effective procedure for the Petitioner. (RX7, Pgs. 14-15). His opinion was based on his belief that the disc space height at L4-5 was preserved. (RX7, Pgs. 14-15). It was also his opinion that a revision procedure was not necessary because the Petitioner had leg symptoms on a subjective basis absent any neurologic compression. (RX7, Pg. 15).

Dr. Ghanayem testified that the Petitioner did not require any additional treatment, which would include diagnostic testing. (RX7, Pg. 16). He opined that the Petitioner was able to return to his regular job activities. (RX7, Pgs. 16-17).

Dr. Ghanayem testified that the physical examination of the Petitioner was quick. (RX7, Pgs. 11, 18). He testified he could teach people how to do the exam in 5 minutes. (RX7 Pg. 11). He guessed the examination of the Petitioner was done in 2 minutes. (RX7, Pg. 18). The Petitioner did not exhibit any Waddell signs during his examination. (RX7, Pg.47).

Dr. Ghanayem testified that he tested for sensation by touching each dermatome with his fingers and compared side to side. (RX7, Pg. 24). There are 6 regions where the nerve goes and that you touch each region from the thigh down to the foot and toes to see if the patient feels it and whether it is the same on each side. (RX7, Pgs. 24-25). He also tested for sensation to light touch on the Petitioner's feet. ((RX7, Pg. 25). However, when asked if he had the Petitioner remove his shoes during his examination, he testified: "I don't remember." (RX7, Pg. 25).

Dr. Ghanayem testified that if a person has compression of the L5 nerve root, he may have pain in the buttock, into the back of the thigh down the calf and into the big toe area. (RX7, Pgs. 29-30). He testified that if a person is having nerve root compression at the S1 nerve root, he may have pain in the back of the buttock, the back of the thigh and calf, the outside of the foot and sometimes on the surface of the foot. (RX7, Pg. 30). He also testified that the following findings would be signs of nerve compression: sensory deficit distribution on the right at S1; positive neurotension in the right lower extremity when tested for straight leg raise and slump; decreased sensation to light touch on the medial plantar aspects of the right foot; decreased sensation in the L5 and S1 distribution of the right; and weakness in right ankle dorsiflexion. (RX7, Pgs. 32-34).

Regarding causation, when Dr. Ghanayem was asked if he believed the Petitioner may have aggravated his underlying disc degeneration at L5-S1, he testified "it caused him to have some back pain with it." (RX7, Pgs. 15-16). He also testified that the complaints ("some back pain and some right thigh – some pain in the back of the thigh and numbness in the right calf and foot") could be in part because of the aggravation. (RX7, Pgs. 21-24).

Conclusions of Law:

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 makes the following findings:

When a pre-existing condition is present, a claimant must show that "a work-related accidental injury aggravated or accelerated the preexisting [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' Comp. Comm'n*, 864 N.E.2d 266, 272-273 (5th Dist. 2007). Even when a pre-existing condition exists, recovery may be obtained if a claimant's employment is a causative factor in his or her current condition of ill-being. *Sisbro, Inc. v. Indus. Comm'n*, 797 N.E.2d 665 (2003).

An accidental injury need not be the sole causative factor, nor even the primary causative factor, as long as it is a causative factor in the resulting condition of ill-being. *Sisbro, Inc. v. Indus. Comm'n*, 797 N.E.2d 665, 672 (2003). "Petitioner need only show that some act or phase of the employment was a causative factor of the resulting injury." *Fierke v. Indus. Comm'n*, 723 N.E.2d 846 (3d Dist. 2000). Employers are to take their employees as they find them. *A.C. & S. v. Indus. Comm'n*, 710 N.E.2d 837 (111. App. 1st Dist., 1999) citing *General Electric Co. v. Indus. Comm'n*, 433 N.E.2d 671, 672 (1982). If a pre-existing condition is aggravated, exacerbated, or accelerated by an accidental injury, the employee is entitled to benefits. *Rock Road Constr. v. Indus. Comm'n*, 227 N.E.2d 65, 67-68 (Ill. 1967); see also *Illinois Valley Irrigation, Inc. v. Indus. Comm'n*, 362 N.E.2d 339 (Ill. 1977).

Additionally, a causal connection between work duties and injured condition may be established by chain of events including workers' compensation claimant's ability to perform duties before date of

accident and inability to perform same duties following date of accident. *Darling v. Indus. Comm'n of Illinois*, 176 Ill. App. 3d 186, 530 N.E.2d 1135 (Ill. App. Ct. 1988).

Medical records reflect that on January 11, 2007, the Petitioner underwent surgery for right L4-5 and L5-S1 herniated nucleus pulposus, L5-S1 calcified disk and intractable L5-S1 right sided radiculopathy. Surgery consisted of L5-S1 partial hemilaminectomy, microdiskectomy and foraminotomy, L4-L5 partial hemilaminectomy and foraminotomy and use of microscope and microdissection. Dr. Chenelle performed this surgery. (PX4) It is unclear for how long the Petitioner treated before and after this surgery as the parties advised of the difficulties in obtaining said records. (TX, Pg. 64)

On September 20, 2011, the Petitioner underwent surgery by Dr. Mekhail for recurrent right lumbar radiculopathy and right L4-5 herniated disk. According to Dr. Mekhail's records, this began after a motor vehicle accident when the Petitioner's car was struck by a snowplow. The Petitioner complained of right leg pain to calf with occasional numbness and tingling to the right foot. (PX6) The operative report reflects that the Petitioner did not respond to conservative treatment. Surgery consisted of a redo right L4-5 decompression laminotomy, foraminotomy, partial facetectomy and microdiskectomy. (PX 6, PX7, Pg. 12) Dr. Mekhail testified that he discharged the Petitioner from care and allowed him to return to work without restrictions, effective November 10, 2011. (PX7, Pg. 13)

The Petitioner returned to Dr. Mekhail on June 30, 2014. (PX7, Pg. 14) The Petitioner complained to Dr. Mekhail of back pain down the right leg with intermittent numbness and tingling for the past few months. (PX7, Pg. 14) Dr. Mekhail testified that he discussed surgery at that time with the Petitioner. He stated that he would recommend fusion surgery because it would be a third surgery to the same part of the low back. (PX7, Pg. 63)

It does not appear that the Petitioner sought follow-up care from Dr. Mekhail at that time. It appears that the Petitioner had another work injury, which occurred on October 15, 2014.

The Petitioner saw Dr. Lami on October 24, 2014. (RX5) Dr. Lami diagnosed the Petitioner with radiculopathy and right foot drop secondary to disk protrusion after a work injury on October 15, 2014. (RX 5)

The Petitioner then saw Dr. Chenelle. (PX4) Dr. Chenelle's records of October 31, 2014 reflect that the Petitioner sustained an injury to his low back when he lost his balance and fell from the lift gate of his truck and landed on the ground. (PX4) Dr. Chenelle recommended surgery. Dr. Chenelle performed surgery on November 7, 2014. Surgery did not involve a fusion as previously recommended by Dr. Mekhail. Surgery consisted of a right redo L4-5 partial hemilaminectomy, foraminotomy and microdiskectomy due to recurrent right L4-5 herniated nucleus pulposus with intractable L5 radiculopathy. (PX4)

After surgery, the Petitioner remained under Dr. Chenelle's care (PX4) and attended physical therapy through February 12, 2015. (RX6) Upon discharge from therapy, the therapist noted that the Petitioner had persistent radiculopathy in the right L4 dermatome. The Petitioner had not met his therapy goals but was discharged from therapy at his request. (RX6)

Despite the notations of his therapist, the Petitioner told Dr. Chenelle on February 26, 2015 that his right leg pain had resolved and that he wanted to return to work. Dr. Chenelle granted this request. (PX4)

On March 27, 2015, the Petitioner returned to Dr. Chenelle again with complaints of right leg pain with intermittent tingling to his right foot. (PX4) An MRI was ordered and the Petitioner was taken off work.

On April 22, 2015, the Petitioner's symptoms were described as pretty similar as his last visit on April 2, 2015 (which included back pain, tingling and sensory changes). Petitioner was kept off work at this time. (PX4)

The Petitioner last saw Dr. Chenelle on May 12, 2015. The Petitioner was allowed to return to work without restriction. It is unclear what the Petitioner's condition was as there were no accompanying medical records. (PX4) What is clear, however, is that seven days after his release to full-duty work, the Petitioner settled his workers' compensation case #14 WC 36735, on May 19, 2015. (RX1)

However, in the case at bar, the Arbitrator finds, by a preponderance of evidence, that the Petitioner's present condition of ill-being is causally related to his January 20, 2018 accident.

First, Dr. Mekhail's testimony established a causal relationship. It was Dr. Mekhail's opinion that the accident either caused the Petitioner's condition or aggravated the Petitioner's pre-existing condition. Even Dr. Ghanayem conceded that the accident may have aggravated the Petitioner's back condition. He agreed that the Petitioner's complaints of back pain, pain in the back of the thigh, and numbness in the Petitioner's right calf and foot could have been caused in part by the aggravation.

Second, there is no evidence that after May 12, 2015, the Petitioner sought treatment for his low back. He was able to perform his job for the Respondent without issue and did not reinjure his back until his January 20, 2018 accident. This is consistent with the histories he provided to Dr. Chenelle, Dr. Mekhail, and Dr. Ghanayem; the Respondent did not present any evidence to the contrary.

Third, the diagnostic test results provide objective evidence consistent with the Petitioner's symptoms. Dr. Mekhail and Dr. Ghanayem reviewed only the March 2018 MRI; neither reviewed the March 20, 2015 MRI (imaging). The radiologist, Dr. Zweig, noted that the March 2018 MRI showed that there was contact with the right L5 nerve root in the lateral recess at L4-5. Dr. Mekhail concurred with this finding. It was his opinion that the Petitioner's symptoms of pain down the right leg, numbness in the distribution of the L5 nerve root and outside the leg, and weakness in ankle dorsiflexion were consistent with 2018 MRI.

Dr. Zweig noted the 2018 MRI revealed mild to moderate narrowing of the right lateral recess with contact of the right S1 nerve root at the L5-S1 level.

Yet, Dr. Mekhail testified that, per the radiologist, we don't know if there is any difference between the March 2015 lumbar MRI and the March 2018 lumbar MRI.

The November 6, 2018 EMG study was abnormal and showed evidence of mild chronic bilateral low lumbar radiculopathy which was most notable at L4-L5. In his December 6, 2018 chart notes, Dr. Mekhail commented that the EMG showed evidence of L4-L5 neural compression, which would explain his symptoms.

The Arbitrator notes that there is no evidence that Dr. Ghanayem ever reviewed the EMG results.

Fourth, both Dr. Chenelle and Dr. Mekhail found, upon examinations, that the Petitioner had nerve root compression at the L4-L5 and L5-S1 levels consistent with the Petitioner's lower back and right lower extremity complaints. Dr. Chenelle's exam findings revealed that the Petitioner had a sensory deficit distribution on the right at S1. Dr. Mekhail found during his first examination that the Petitioner had

decreased sensation in the L5 and S1 distribution on the right side, weakness in his right ankle dorsiflexion, and the inability to walk on his heels or tiptoes. His second and third examinations revealed the Petitioner had decreased sensation in the L5 distribution and 4/5 weakness in his right ankle dorsiflexion. Dr. Mekhail's testimony establishes these findings involve the L5 nerve root and can stem from the L4-5 and L5-S1 levels. Even Dr. Ghaneyem's testimony established that compression of the L5 and S1 nerve roots could lead to the same type of symptoms the Petitioner was experiencing after his accident.

The only doctor who did not find the Petitioner was having nerve compression on the right side was Dr. Ghanayem, who relied on his interpretation of the MRI that failed to show it. According to Dr. Ghanayem, compression is pinching or impingement of the nerve. Yet, despite Dr. Zweig's and Dr. Mekhail's finding that the 2018 MRI showed "contact" was made at the L5 nerve root on the right, at the S1 nerve root on the right, and at the L5 nerve root on the left, Dr. Ghanayem testified that there was only nerve compression on the left at L5 (the side on which the Petitioner was not experiencing symptoms).

Further, the evidence suggests that Dr. Ghanayem did not conduct a thorough examination of the Petitioner. By his own admission, his entire examination was done in 2 minutes. Despite his claim that he tested for sensation to light touch on the Petitioner's feet, he could not remember if he had the Petitioner remove his shoes or socks during the examination. Based on the Petitioner's testimony, the evidence indicates he did not. The Arbitrator questions how Dr. Ghanayem could have effectively tested for sensation to light touch on the Petitioner's feet without having him remove his shoes and socks. Even Dr. Mekhail raised the same concerns in his May 14, 2018 progress note and through his testimony. Furthermore, the Arbitrator notes that Dr. Ghanayem's report was only 1½ pages long. During his deposition, Dr. Ghanayem testified that he did not know which records he reviewed, but that he reviewed whatever records Respondent sent him.

On balance, the Arbitrator finds that the Petitioner is credible.

The Petitioner testified that he struck his head when he fell on January 20, 2018. This is not supported by the passages in either of the January 20, 2018 records of Rush Copley Medical Center (PX1) or the January 23, 2018 records of Physicians' Immediate Care. (PX2) He made no comment to either provider of striking his head or having any injury other than to his low back. There is no explanation from the Petitioner as to why this claim suddenly appears in records of Dr. Chenelle.

Additionally, on January 23, 2018, the staff at Physicians' Immediate Care recorded, in pertinent part, the following History of Present Illness:

> "The patient presents with a chief complaint of constant (but worse at times) back pain of the lower back since Fri., Jan 19, 2018 during the afternoon. It has the following quality: sharp. The patient describes the severity as 7/10, with 10 being the worst imaginable. Context: The patient reports it was the result of an injury that occurred on 1/19/2018, which was work related, which had a sudden onset. The patient had no similar problems in the past ..." (PX2)

The medical records from 2014 and 2015 clearly show that the Petitioner continued to have low back pain and right leg radiculopathy after this third surgery. The records show that in 2014, Dr. Mekhail opined Petitioner was a candidate for fusion surgery.

Dr. Ghanayem testified that the Petitioner told him that he had undergone two prior surgeries to his low back, when, in fact, he had undergone three prior surgeries.

When Dr. Mekhail saw the Petitioner on April 4, 2018, he recorded the following PAST MEDICAL HISTORY: "Unremarkable except for the back problem in 2011 where I did surgery. He is not sure if he had surgery in 2014 and for that I would like to get an operative report." (PX6)

The Petitioner has four prior claims for back injuries on file with this Commission:

In 96 WC 8769, the Petitioner alleged injuries to his back, neck and head. He was paid 11+ weeks of TTD benefits and settlement of this matter was part of a third-party case. (RX4)

In 97 WC 41351, Petitioner alleged injuries to his lower back. He settled this case for 5% loss of use of the man as a whole. (RX3)

In 12 WC 22818, Petitioner alleged injuries to multiple body parts. He settled this case for 3% loss of use of the man as a whole. (RX2)

In 14 WC 36735, Petitioner alleged injuries to his lower back. He settled this case for 25% loss of use of the man as a whole. (RX1)

Interestingly, in both the 2014 accident and the accident at bar, the Petitioner fell off a lift gate and struck his buttocks and back on the ground.

Notwithstanding evidence to the contrary, the Arbitrator finds that the Petitioner is, on balance, credible, since after he underwent each of the 3 prior lumbar spine surgeries, he returned to full-duty work. So, the Petitioner was motivated to return to work. Most recently, it was only after the January 20, 2018 accident that he was unable to return to work and sought treatment for his back. Furthermore, when the Petitioner sought initial post-accident treatment that same day at Rush Copley Medical Center, he reported a history of accident that was consistent with his testimony (except for the head) and reported a prior history of back surgery. Finally, no physician found any Waddell signs after examining the Petitioner.

Upon reviewing all the evidence cited herein, including the testimony of the Petitioner, the Arbitrator finds the testimony of Dr. Mekhail more persuasive than the testimony of Dr. Ghanayem and concludes that the Petitioner's present condition of ill-being is causally related to his January 20, 2018 work accident.

In support of the Arbitrator's decision relating to L. <u>Amount of Compensation Due for Temporary Total Disability</u> and N. <u>Is the Respondent Due any Credit</u>; the Arbitrator finds the following:

The Petitioner's testimony established that he had been off work for the periods of January 21, 2018 through January 23, 2018 and January 25, 2018 through May 14, 2018. During these periods of time, he was on work restrictions from Dr. Hwang, Dr. Chenelle and Dr. Mekhail. Although Dr. Ghanayem believed the Petitioner was capable of returning to work as of April 16, 2018, the evidence shows his condition had clearly not resolved. His back and right leg complaints continued and Dr. Mekhail noted that

as of May 14, 2018, he still showed signs of decreased sensation at the L5 distribution and 4/5 weakness in his right ankle dorsiflexion. Even when the Petitioner did return to work, it was questionable if he was capable of performing full duty as he had difficulty picking up heavy items and continued to experience lower back pain and shooting pain into his left leg.

Based on the foregoing, the Arbitrator finds that the Petitioner was temporarily totally disabled from January 21, 2018 through January 23, 2018 and January 25, 2018 through May 14, 2018. Therefore, he hereby orders the Respondent to pay the Petitioner temporary total disability benefits of $602.52/week for 16-1/7 weeks. The parties stipulated that the Petitioner had received $9,210.12 in TTD benefits. Accordingly, the Arbitrator finds that the Respondent is entitled to credit in this amount.

In support of the Arbitrator's decision relating to J. Whether the Medical Services that Were Provided to Petitioner Were Reasonable and Necessary; the Arbitrator makes the following findings:

The Petitioner submitted into evidence as Petitioner's Exhibit 9 the following unpaid medical bills:

Parkview Orthopaedic Group	**$145.00 (12/6/18)**
St. Alexius Medical Center	**$5,359.00 (11/6/18)**

The Petitioner's testimony and the medical evidence established that the above-referenced bills correspond to treatment the Petitioner received for his lower back condition. Dr. Mekhail prescribed the November 6, 2018 EMG to further help delineate the source of the Petitioner's right lower extremity complaints. The Petitioner's return visit to Dr. Mekhail on December 6, 2018 allowed the Petitioner to review the results of the EMG study and to confirm that Dr. Mekhail was still recommending surgery. The Respondent did not present any evidence to dispute the reasonableness of the above-listed charges.

Based on the foregoing, the Arbitrator finds that the Petitioner is entitled to receive from the Respondent compensation for the above listed bills, pursuant to Section 8(a) and subject to Section 8.2 of the Act.

In support of the Arbitrator's decision relating to O. Whether the Petitioner is Entitled to Prospective Medical Care, the Arbitrator makes the following findings:

The Arbitrator notes that the Petitioner underwent 12 weeks of physical therapy and 2 epidural injections over the course of approximately 3 months. The evidence indicates that the Petitioner's condition failed to improve following this treatment. The Petitioner continues have "extreme" lower right leg pain (7/10) and complains that his lower back hurts (4/10). He also complained of tingling, numbness and weakness in his right foot. The Petitioner also has difficulty walking and presently takes Hydrocodone at nighttime. While the Petitioner is able to work, he is performing a less physically demanding job and continues to experience "[e]xtreme pain in [his] leg and [his] lower back" while performing such job.

On November 6, 2018, John Lavaccare, M.D., administered the EMG/NCV of the lower and concluded as follows:

"This is an abnormal study. There is electrophysiologic evidence of mild chronic bilateral low lumbar radiculopathy which is most notable at L4/L5. Please correlate with imaging and laboratory tests."

The Arbitrator notes that Dr. Ghanayem does not believe that surgery is indicated. He testified to the following:

"Q: Doctor, do you have an opinion within a reasonable degree of medical and surgical certainty whether the petitioner was a candidate for any type of fusion procedure?

A: I believe he was not.

Q: What's the basis for that conclusion?

A: Well, like I said, he had some mechanical low back pain, but he had a disc that had preservation of disc space height at L4-L5. So, fusing that to control back pain is not effective. It just doesn't seem to work that well. He's got symptomatic leg symptoms. He's got leg symptoms on a subjective basis absent any neurologic compression. So, doing a revision procedure to address that doesn't predict good success. So, two operations, he told me about already. He still had some residual symptoms. Every time you go back, there is the law of diminishing returns on top of the fact that the disc space at L4-5 is not collapsed. It equals nonsurgery."

With regard to an EMG, Dr. Ghanayem testified that the results of such study are not going to differentiate a 2014 low back surgery from a 2018 nerve injury at that level, if there are changes. Yet, the study did show mild chronic bilateral low lumbar radiculopathy which is most notable at L4/L5.

The two surgeons with whom the Petitioner treated, Dr. Chenelle and Dr. Mekhail, have recommended he undergo back surgery. While their surgical approaches are different, both surgeons recommended a redo decompression at L4-5 and a fusion at L4-5 and L5-S1. The basis for Dr. Mekhail's surgical recommendation was that the Petitioner had symptoms consistent with his diagnostic objective findings, that the Petitioner failed conservative treatment and that that his symptoms were affecting his quality of life. Per Dr. Mekhail, the proposed surgery has a 70% chance for relieving the Petitioner's lower back symptoms and an 85% chance of resolving his right lower extremity complaints. If the Petitioner does not have the procedure, Dr. Mekhail indicated, his condition is unlikely to resolve. The evidence shows that the Petitioner understands the risks of Dr. Mekhail's proposed surgery and would like to move forward with this treatment option.

With regard to the issue of prospective medical care, the Arbitrator finds the opinions of Dr. Mekhail to be only slightly more persuasive that those of Dr. Ghanayem.

Based upon the foregoing, the Arbitrator finds that the proposed surgical procedure that Dr. Mekhail has recommended is a reasonable and necessary medical treatment option that is causally related to the Petitioner's January 20, 2018 accident. Pursuant to Section 8(a) of the Act, the Arbitrator orders the Respondent to authorize and to pay for such procedure.

Brian T. Cronin

Arbitrator

5-2-2018

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

Kevin Jones,
Petitioner,

vs.

No. 07 WC 4399, previously consolidated with 12 WC 7237

Southwest Airlines Company,
Respondent.

20IWCC0079

DECISION AND OPINION ON REMAND

This matter comes before the Commission on remand from the Circuit Court of Cook County after Respondent's appeal to the Appellate Court was dismissed. Initially the Commission, in its Order dated February 14, 2018, denied Petitioner's request for 116-2/7 weeks of temporary total disability benefits between March 26, 2012 and June 20, 2014 which Petitioner sought pursuant to §8(a), §8(b) and §19(h) of the Act. Petitioner appealed that decision to the Circuit Court, which found that Petitioner did file a timely "request" for such benefits under §19(h) when he filed a Notice of Motion on May 25, 2012, which was never ruled upon by the Commission. The Circuit Court remanded this matter back to the Commission with instructions, "to review Jones's request for Section 19(h) temporary total disability benefits." The Commission has now done so, and sets forth its findings of fact and conclusions of law hereinbelow.

20IWCC0079

Petitioner Kevin Jones, a maintenance mechanic, filed two claims alleging work-related injuries to his left knee. His first claim (07 WC 4399) alleged an accident on August 30, 2005; his second (12 WC 7237) alleged an accident on January 2, 2012. Following his first accident, Petitioner underwent an arthroscopic repair of his left medial meniscus on January 9, 2006 and returned to full duty work on March 27, 2006. Between Petitioner's first and second accidents, his physician, Dr. DeFrino, opined that Petitioner would probably need a total knee replacement. Following the January 2011 arbitration hearing for Petitioner's first accident, the Arbitrator awarded Petitioner 27½% loss of use of the left leg.

On May 25, 2012, Petitioner filed a "Motion Pursuant to Section 8(a) of the Workers' Compensation Act," in which he sought authorization for the knee replacement surgery recommended by Dr. DeFrino. Said motion did not pray for or seek TTD benefits. Along with that motion, Petitioner filed an, "Amended Notice of Motion and Order," in which he requested a July 23, 2012 hearing before Commissioner Donohoo. The reason for the hearing listed on Petitioner's Amended Notice of Motion was: "to present the attached Motion for: Other – 8(a), 19(h)." No motion seeking TTD under §19(h) was attached to this Notice. Nor has any §19(h) Motion been offered into the record, or found in the Commission's physical file, notwithstanding the Commission's online case information screen which showed that on May 25, 2012, "Petition-19H 8A" had been filed.

Petitioner's second accident claim came up for arbitration hearing in late 2012. The Arbitrator hearing that claim denied all benefits, concluding that Petitioner's left knee condition and need for a knee replacement were causally related to his first accident. In a July 25, 2014 decision (14 IWCC 611), the Commission affirmed the Arbitrator's denial of all benefits for Petitioner's second accident, adopting the Arbitrator's conclusion that Petitioner's condition and need for a total knee replacement was not causally related to his 2012 work accident, but rather, was causally related to his 2005 accident. Neither party filed an appeal of that decision, which became a final order.

In a separate July 25, 2014 decision (14 IWCC 612), the Commission granted Petitioner's §8(a) Petition relative to his first accident, and ordered Respondent pay the reasonable and necessary medical expenses related to Petitioner's July 24, 2012 knee replacement surgery. Because no §19(h) motion had been filed, the Commission did not address any §19(h) issues or award Petitioner any temporary total disability benefits in either of their July 25, 2014 decisions.

On November 30, 2015, Petitioner filed another Amended Notice of Motion in which he requested a hearing before a Commissioner on December 17, 2015. That Notice did not indicate a specific reason for that hearing, or a request for TTD benefits under §19(h) or any other section of the Act, and no motion or request for TTD accompanied that notice. That hearing was continued to October 17, 2016, at which time Petitioner appeared and testified he did not work between the January 2, 2012 date of his second injury until June 20, 2014. He further testified he did not receive a salary or TTD benefits between late March 2012 and June 20, 2014. That Review hearing was continued to August 15, 2017, for the introduction of exhibits. On February 14, 2018, the Commission issued its decision denying Petitioner's request for 116-2/7 weeks of temporary total disability benefits under §8(a), §8(b) and §19(h) of the Act.

In remanding this matter back to the Commission for a determination of Petitioner's request for TTD benefits between March 26, 2012 and June 20, 2014, the Circuit Court acknowledged that, when Petitioner filed his May 25, 2012 Notice of Motion, he did *none* of the following:

> "(1) file a separate motion for Section 19(h) benefits alongside the May 25, 2012 notice of motion; (2) formally requested a ruling on Section 19(h) somewhere on the record during the 14 IWCC 611 and 612 proceedings; (3) file documents alongside his 'Request for Hearing' explaining the relief sought; or (4) state on the record before Commissioner Luskin that the testimony elicited was related to the TTD claim."

The Circuit Court then stated, "Nonetheless the Court finds Jones's notice of motion is sufficient to constitute a 'request' under the statute, and the 'request' was never appropriately reviewed." The Circuit Court found that Petitioner's filing of only a "Notice of Motion" for Section 8(a)/19(h) benefits on May 25, 2012 was a sufficient request for TTD under §19(h) of the Act.

In accordance with the Circuit Court's instructions, the Commission has now reviewed the evidence of record, and finds Petitioner did prove that he was temporarily totally incapacitated from work for the period March 26, 2012 through June 20, 2014.

At the October 16, 2016 Review hearing before Commissioner Luskin, Petitioner testified that he was not working and did not receive a salary or TTD benefits between those dates. His testimony was corroborated by Dr. Luke's records which showed that Petitioner was not released to unrestricted work until June 20, 2014. Prior to that date, Petitioner had been receiving treatment including physical therapy, medication and a home exercise program. On May 2, 2014, Dr. Luke authorized Petitioner to go back to a transitional work for 8 weeks, after which Petitioner would be able to work full duty. Petitioner testified, however, that he did not return to work until June 21, 2018.

At the Review hearings before Commissioner Luskin, Respondent offered no evidence to oppose Petitioner's claim for TTD benefits during the period in question. The Commission grants Petitioner's request for 116-2/7 weeks of TTD between March 26, 2012 and June 20, 2014.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Respondent pay to Petitioner the sum of $992.80 per week for a period of 116-27 weeks commencing March 26, 2012 through June 20, 2014, that being the period of temporary total incapacity from work under §19(h) of the Act.

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

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

20IWCC0079

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: JAN 29 2020

Marc Parker

Deborah L. Simpson

Stephen Mathis

r-11/20/19
mp/mcp
68

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 Permanent Disability	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

SHETARA HARRIS,

Petitioner,

vs. NO: 18 WC 9344

SHAPIRO DEVELOPMENTAL CENTER - IDHS,

Respondent.

20IWCC0065

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issue of permanent disability, and being advised of the facts and law, 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 concluded the work accident resulted in permanent disability to Petitioner's right shoulder and right wrist, and disfigurement to her right hand. The Commission views the evidence as to Petitioner's wrist differently.

On the date of accident, Petitioner presented to the Riverside Medical Center emergency room. The records reflect Petitioner described the incident ("was with a combative patient who pulled her arm hard when her hand was supinated") and reported an immediate onset of pain to the right upper extremity radiating into the right arm pit; Petitioner further noted a scratch on her right hand. The musculoskeletal examination findings were limited to right shoulder decreased range of motion as well as tenderness and pain; the emergency room physician also documented a 1 cm abrasion dorsum of the right hand. Petitioner was discharged with a diagnosis of a likely shoulder strain and instructions to follow-up with her primary care physician. PXE.

a0d0c4l0s

The next day, Petitioner was evaluated by Dena Reddick, N.P. In addition to similar shoulder findings as observed in the emergency room, N.P. Reddick's examination revealed mild swelling of the right wrist. N.P. Reddick diagnosed sprains of the right shoulder and right wrist. PXD.

When Petitioner returned to the clinic on March 1, 2018, she complained of pain from her shoulder down her arm. N.P. Reddick documented Petitioner's right shoulder examination findings were unchanged, with ongoing pain as well as deficits in range of motion and strength. The Commission observes Petitioner voiced no complaints specific to her right wrist, and N.P. Reddick's examination revealed the wrist swelling had resolved. PXD.

On March 19, 2018, Petitioner was reevaluated by N.P. Reddick. Although Petitioner continued to report significant shoulder symptoms, she did not complain of wrist problems. N.P. Reddick did not document any objective examination findings for the wrist, and she updated her diagnosis to "sprain of right wrist, improved." This is last time Petitioner's wrist is included in N.P. Reddick's diagnoses. PXD.

Petitioner underwent a course of physical therapy from March 28 through April 9, 2018. Our review of the therapy records reveals the treatment modalities were directed solely to Petitioner's right shoulder. PXE.

The medical records demonstrate Petitioner sustained a mild sprain of her right wrist which fully resolved within a month of the work accident. The Commission finds Petitioner failed to prove she sustained permanent disability to her right hand. As such, the award of 3% loss of use of the right hand is vacated.

All else is affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 21, 2019, as modified above, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $505.97 per week for a period of 12.5 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the 2.5% loss of use of the person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $505.97 per week for a period of 2 weeks, for the reason that the injuries sustained resulted in disfigurement as provided in §8(c) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of 3% loss of use of the right hand is vacated.

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

20IWCC0065

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

Pursuant to Section 19(f)(1), this decision is not subject to judicial review.

DATED: JAN 29 2020

LEC/mck

O: 1/15/2020

43

L. Elizabeth Coppoletti

L. Elizabeth Coppoletti

Stephen J. Mathis

Stephen Mathis

D. Douglas McCarthy

D. Douglas McCarthy

6801H109

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HARRIS, SHETARA
Employee/Petitioner

Case# **18WC009344**

20IWCC0065
20IWCC0065

SHAPIRO DEVELOPMENT CENTER-IDHS
Employer/Respondent

On 8/21/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.84% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

3269 SPIROS LAW PC
ANDREW J PURCELL
2807 N VERMILION ST SUITE 3
DANVILLE, IL 61832

6096 ASSISTANT ATTORNEY GENERAL
JOHN CATALANO
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

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

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

AUG 21 2019

Brendan O'Rourke, Assistant Secretary
Illinois Workers' Compensation Commission

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Shetara Harris
Employee/Petitioner

v.

Shapiro Developmental Center - IDHS
Employer/Respondent

Case # **18** WC **9344**

Consolidated cases: _____

20IWCC0065

An *Application for Adjustment 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 **Kankakee, Illinois**, on **June 19, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ 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 20, 2018**, Respondent ***was*** operating under and subject 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 $**43,850.56**; the average weekly wage was $**843.28**

On the date of accident, Petitioner was **31** years of age, ***single*** 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 Petitioner permanent partial disability benefits of $505.97 per week for a total of 20.65 weeks, because the injuries Petitioner sustained caused permanent partial disability to the extent of 2-1/2% (12.5 weeks), as provided in Section 8(d)2 of the Act; 3% loss of use of the right hand (6.15) as provided in Section 8(e) of the Act; and 2 weeks disfigurement, as provided in Section 8(c) 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

8/20/19
Date

AUG 21 2019

Attachment to Arbitrator Decision
(18 WC 9344)

FINDINGS OF FACT:

Petitioner testified that she worked for Respondent as a Mental Health Technician. Her job duties included feeding, dressing, transporting, and lifting residents of Shapiro Development Center as well as reinforcing behaviors of daily living.

Petitioner testified that on February 20, 2018, she was helping to restrain a highly aggressive Shapiro resident. Petitioner testified that she was familiar with the individual resident and he was unique because he normally had five Shapiro staff members assigned to him as he was "very, very aggressive" and tends to attack and cause harm. Petitioner testified that as she was working with other staff members to get the resident into a restraint bed, the resident grabbed her right arm and "dug in [her] hand" and "snatched" her right arm and wrist. She demonstrated how the resident had ahold of her right hand and pulled her right hand and right arm as he fell to the ground. Petitioner testified that as the resident fell to ground holding on to her right hand, she also fell to the ground and landed on her right side. Petitioner testified that after she fell to the ground, she felt "a burning, tearing sensation and a lot of pain" in her right shoulder. Petitioner also testified she felt pain in her right arm and wrist and had scratches on her right hand that were bleeding.

Petitioner testified she drove herself to Riverside Hospital after the occurrence. She recalled x-rays being taken of her right shoulder and the wound on her right hand, near her knuckles and wrist, being cleaned. Records submitted show Petitioner was examined in the ER at Riverside Medical Center by Nurse Practitioner Colleen Costello, who noted Petitioner was experiencing sharp and constant pain to her right shoulder, which was worse with twisting and movement. (PX. E, p.027) On exam, N.P. Costello noted Petitioner exhibited decreased range of motion, tenderness and pain to her right shoulder. She also noted Petitioner had a 1cm abrasion to her right hand, which was not actively bleeding at that time. (PX. E, p.029) Multiple x-rays were taken of Petitioner's right shoulder. No acute abnormality was seen. (PX. E, pp.038-39) Petitioner was diagnosed with 1.) scratch mark; 2.) right arm injury; and 3.) right shoulder strain. (PX. E. p.26) She given a sling for her right arm, a prescription for Norflex (a muscle relaxer), and was instructed to take anti-inflammatories for pain and to follow up with her primary care doctor. (PX. E, p.030)

Petitioner testified she followed with Nurse Practitioner Dena Reddick with Riverside Healthcare. Nurse Practitioner Reddick's record of examining Petitioner on February 21, 2018 indicate that Petitioner complained of pain in her right arm and shoulder. (Petitioner's Exhibit "PX" D, p.D004). N.P. Reddick noted that the agitated individual "grabbed and twisted [Petitioner's] right wrist also cutting his nails into her skin and wrentching her right shoulder..." (PX. D, p.D004) Petitioner told N.P. Reddick that she was still in pain and the pain "comes and goes all day"; she stated the pain felt better while wearing the sling she was provided. (PX. D, p.004). N.P. Reddick noted reduced strength in Petitioner's right shoulder and pain on palpation of the anterior should and bicep down to the elbow; she also noted abrasions and swelling to Petitioner's right hand. (PX. D, p.006) N.P. Reddick assessed 1.) acute pain of the right shoulder; 2.) sprain of the right shoulder; and 3.) sprain of the right wrist. (PX. D, p.006) She recommended Petitioner use ice on her shoulder and continue to use the right arm sling; she prescribed a muscle relaxer and painkiller, and recommended Petitioner work with restrictions and return in one week. (PX. D, p.006-7)

On March 1, 2018, Petitioner returned to N.P. Reddick and complained of continued pain in her right arm, which she noted as 9 of 10. (PX. D, p.010) She was having difficulty sleeping because she was having too much pain and "tosses and turns all night." (PX. D, p.010) N.P. Reddick referred Petitioner for occupational therapy at that time and recommended she return in two weeks if her symptoms worsened or failed to improve. (PX. D, pp. 012-13) As of her next visit on March 19, 2018, N.P. Reddick noted Petitioner had yet to start therapy "due to insurance issues." (PX. D, p.013) N.P. Reddick noted Petitioner still had reduced strength and

pain on palpation to her right shoulder. (PX. D, p.016) She diagnosed Petitioner with 1.) acute pain of right shoulder; 2.) sprain of right shoulder; 3.) sprain of the right rotator cuff capsule; and 4.) sprain of the right wrist, which was improved. N.P. Reddick ordered Petitioner to remain off work until she was re-evaluated after physical therapy. (PX. D, p.016)

Petitioner had her initial physical therapy evaluation at Riverside Medical Center Rehabilitation Servicers on March 28, 2018. (PX. E, p.082). Petitioner attended five physical therapy sessions from March 28, 2018 through April 10, 2018. At the final visit on April 10th, the therapist documented Petitioner's conveyance that she had no pain and hadn't had any since her last session. Petitioner also reported swinging her arm while walking a little more. The therapist noted Petitioner "...appeared to be consciously allowing her right upper extremity to swing during gait, but returned to guarded posture after leaving therapy." Petitioner also demonstated improved range of motion during exercises. (PX. E, pp.098, 120, 133, 146, & 161-163)

Petitioner's last visit with N.P. Reddick was April 9, 2018 at which time she still complained of mild right shoulder pain. (PX. D, p.021). N.P. Reddick noted that Petitioner had mild pain on resisted range of motion to her right shoulder; she released Petitioner to return to work without restrictions and suggested Petitioner return if her symptoms worse or fail to improve. (PX. D, p.022) Petitioner testified that N.P. Reddick suggested that she "take it easy" when she returned to work. Petitioner testified that when she returned to work she had a "lighter load" and had more help with transporting and lifting individuals. She ultimately returned to full duty work.

Petitioner testified she still experiences sudden sharp pains in her right shoulder, including a burning sensation in her right shoulder and tingling in her dominant right hand. She provided that some weeks were better than others and that it can be constant sometimes. Specifically, she stated that she experiences pain in her right shoulder and right hand approximately two to three days of her four-day working period. Petitioner testified she still uses a heating pad and Icy Hot on her right shoulder and takes Aleve for pain. Lastly, Petitioner testified that she has not sought treatment for her right shoulder, wrist or hand since April 10, 2018. She had never had any prior issues with her right shoulder or right hand prior to the February 20, 2018 injury.

During trial the Arbitrator viewed Petitioner's right hand. The Arbitrator observed faint scars on the right side near the knuckle and the wrist on the right hand.

In support of the Arbitrator's decision relating to C. Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds as follows:

The Arbitrator finds that Petitioner presented sufficient, credible evidence that she sustained an accidental injury the arose out of and in the course of her employment. Petitioner's testimony that she was helping her colleagues detain a patient when that patient pulled her arm and scratched her wrist was corroborated by the medical records in evidence.

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

In addition to Petitioner's credible testimony regarding her injury, Petitioner offered her medical records related to treatment of the subject injury into evidence and without objection from Respondent. Both Petitioner's testimony and the medical records of Petitioner's treatment subsequent to the February 20, 2018 work injury indicate that her condition of ill being is causally connected to the February 20, 2018 injury.

In support of the Arbitrator's decision relating to (L.), What is the nature and extent of the injury, the Arbitrator finds as follows:

In determining the level of permanent partial disability for injuries incurred on or after September 1, 2011, the Commission shall base its determination on the following factors: (i) the reported level of impairment pursuant to the most current edition of the AMA's "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; (v) evidence of disability corroborated by the treating medical records. (820 ILCS 305/8.1b)

No single enumerated factor shall be the sole determinant of disability. 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)

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

(a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but are not limited to: loss of range of motion; loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment.

(b) Also, the Commission shall base its determination on the following factors:

(i) The reported level of impairment;
(ii) The occupation of the injured employee;
(iii) The age of the employee at the time of injury;
(iv) The employee's future earning capacity; and
(v) Evidence of disability corroborated by medical records.

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

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes the record reveals that Petitioner was employed as a Mental Health Technician at the time of the accident. She has since returned to work in her full duty capacity. The Arbitrator therefore gives little weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 31 years old at the time of the accident. Because of Petitioner's age she will live and work with any residuals for a longer period than that of an older individual. As such, the Arbitrator therefore gives greater weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that no evidence was introduced as to Petitioner's future earning capacity. The Arbitrator therefore gives no weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes the records reveal Petitioner suffered right shoulder and right hand injuries, including a right shoulder sprain, right rotator cuff capsule sprain, and right wrist sprain. Petitioner's last visit

with a medical professional was on April 9, 2018 when she saw N.P. Reddick. At that visit, N.P. Reddick noted Petitioner had mild pain on resisted range of motion to her right shoulder. She released Petitioner to return to work without restrictions and suggested Petitioner return if her symptoms worse or fail to improve. Petitioner attended five physical therapy sessions from March 28, 2018 through April 10, 2018. At the final visit on April 10th, the therapist documented Petitioner's conveyance that she had no pain and hadn't had any since her last session. The therapist noted Petitioner "...appeared to be consciously allowing her right upper extremity to swing during gait, but returned to guarded posture after leaving therapy." Petitioner demonstated improved range of motion during exercises and also reported swinging her arm while walking a little more. Petitioner has not sought treatment for her right shoulder, wrist or hand since April 10, 2018. According to Petitioner she still experiences sudden sharp pains in her right shoulder, including a burning sensation in her right shoulder and tingling in her dominant right hand. She provided that some weeks were better than others and that it can be constant sometimes. Specifically, she stated that she experiences pain in her right shoulder and right hand approximately two to three days of her four-day working period. She still uses a heating pad and Icy Hot on her right shoulder and takes Aleve for pain.

Notwithstanding her complaints, it appears that as a result of the treatment received, Petitioner obtained a good result. On April 9, 2018, N.P. Reddick noted Petitioner had mild pain on resisted range of motion to her right shoulder. She released Petitioner to return to work without restrictions. On April 10, 2018, Petitioner conveyed she had no pain and hadn't had any since her last session. Petitioner demonstated improved range of motion during exercises and also reported swinging her arm while walking a little more. The Arbitrator, therefore, gives greater weight to this factor.

Based on all of the foregoing, and in consideration of the factors enumerated in Section 8.1b, the Arbitrator awards permanent partial disability to the extent of 2-1/2% loss of use of the person as a whole pursuant to Section 8(d)2 (right shoulder sprain); 3% loss of use of the right hand under Section 8(e) Act (right wrist sprain) and 2 weeks disfigurement under Section 8(c) (faint scars on the right side near the knuckle and the wrist on the right hand) of the Act.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Benjamin Gelaude,

Petitioner,

vs. NO: 17 WC 10241

Calmer Corn Heads, Inc.,

20IWCC0080

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 causal connection, medical expenses, temporary total disability ("TTD"), 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.

Findings of Fact

In the interest of efficiency, the Commission primarily relies on the Arbitrator's detailed recitation of facts. Petitioner worked for Respondent as an assembler. His work duties included building machinery, assembling new corn heads, painting parts, and performing landscaping work. On August 1, 2016, Petitioner sustained an injury to his low back while performing landscaping work. Petitioner immediately felt pain in his lumbar spine and pain radiating down his right leg. Petitioner's complaints were initially treated conservatively with a lumbar ESI, physical therapy, and work conditioning. A November 2016 EMG/NCS of the right leg was within normal limits with no indication of S1 nerve root radiculopathy. On March 17, 2017, Petitioner was discharged from work conditioning after the therapist determined Petitioner met all the identified goals.

One month later, at the recommendation of his attorney, Petitioner began treatment with a new orthopedic surgeon, Dr. Kube. Dr. Kube is the only doctor who recommended surgical intervention. Petitioner's initial orthopedic doctors all determined Petitioner was not a surgical candidate.

On May 1, 2017, Petitioner underwent a right L5-S1 hemilaminectomy with partial facetectomy and microdiscectomy. Following the surgery, Petitioner's complaints gradually worsened. A November 2017 EMG/NCS indicated mild to moderate right S1 radiculopathy. Dr. Kube placed Petitioner at MMI on January 10, 2018, and prescribed permanent restrictions.

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Respondent's Section 12 examiner, Dr. Van Fleet, opined that the surgery was not reasonable or necessary due to the absence of any objective findings corroborating Petitioner's subjective complaints.

Conclusions of Law

Petitioner bears the burden of proving each element of his case by a preponderance of the evidence. *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill. 2d 193, 203 (2003). After carefully considering the totality of the evidence, the Commission modifies the Arbitrator's conclusion that Petitioner's current condition of ill-being is causally related to the August 1, 2016, work incident. The Commission finds Petitioner's condition of ill-being ceased being causally related to the work incident on March 17, 2017. The Commission affirms and adopts the remainder of the Decision of the Arbitrator.

After reviewing the evidence, the Arbitrator determined Petitioner's current condition of ill-being is causally related to the August 1, 2016, work accident. The Arbitrator also concluded that Petitioner's medical treatment only through March 17, 2017, was reasonable and necessary. These conclusions are in conflict given the totality of the evidence. The Commission fully agrees with the Arbitrator's conclusion that none of Petitioner's medical treatment following his release from work conditioning on March 17, 2017, was reasonable or necessary. After all, Petitioner received treatment from several doctors before he sought care from Dr. Kube and none of those doctors, notably Drs. Peachey, Zhou, and McCall, believed Petitioner was a surgical candidate. Furthermore, Respondent's Section 12 examiner, Dr. Van Fleet, testified credibly that Petitioner was not a surgical candidate.

On March 17, 2017, Petitioner had fulfilled all the goals established in work conditioning. Petitioner reported pain rating less than 2/10 at its worst. Pursuant to the credible testimony of Dr. Van Fleet, Petitioner was at MMI and was able to return to work full duty on March 17, 2017. Instead of returning to work, Petitioner began treatment with Dr. Kube. Dr. Kube immediately recommended surgery and on May 1, 2017, Petitioner underwent a right L5-S1 hemilaminectomy with partial facetectomy and microdiscectomy. Following surgery, Petitioner initially reported some improvement; however, he soon complained of a gradual recurrence of low back pain and right leg radiculopathy. He also occasionally complained of left leg radiculopathy. Dr. Kube testified that he was surprised by Petitioner's increased complaints of radicular complaints after the surgery. He testified that Petitioner's pain scores were higher than they had ever previously been during his August 1, 2017, office visit. By September 2017, Petitioner complained of bouts of severe lumbar pain that were seemingly not triggered by any specific activity. A post-surgery EMG/NCS indicated mild to moderate right S1 radiculopathy; whereas, a pre-surgery EMG/NCS was normal with no indication of S1 nerve root radiculopathy. In January 2018, Dr. Kube placed Petitioner at MMI, wrote that Petitioner required long-term medication management, and prescribed permanent restrictions consistent with the results of a December 2017 FCE.

The Commission finds Petitioner's current condition of ill-being **is not** causally related to the work accident. The Commission further finds the lumbar surgery Dr. Kube performed significantly worsened Petitioner's condition. As a result, Petitioner's current condition of ill-being is causally related to that surgery. For the foregoing reasons, the Commission modifies the

201 ACCOUNTS

20IWCC0080

Decision of the Arbitrator and finds that any causal connection between Petitioner's condition of ill-being and the August 1, 2016, work accident terminated on March 17, 2017.

The Commission otherwise affirms and adopts the Decision of the Arbitrator.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 20, 2018, is modified as stated herein.

IT IS FURTHER ORDERED that Petitioner's current condition of ill-being **is not** causally related to the work accident. Petitioner's condition of ill-being only through March 17, 2017, is causally related to the work accident.

IT IS FURTHER ORDERED that Respondent shall pay to Petitioner temporary total disability benefits that have accrued from **August 2, 2016** through **March 17, 2017**, as provided in Section 8(b) of the Act. Respondent shall be given a credit for temporary total disability benefits that have been paid, including an overpayment of TTD benefits for the period of **March 20, 2017** through **April 9, 2017**, a period of 2-6/7 weeks, in the amount of **$1,214.71**.

IT IS FURTHER ORDERED that Respondent shall pay reasonable, necessary, and related medical charges incurred by Petitioner through March 17, 2017, as provided in Sections 8(a) and 8.2 of the Act. All medical treatment after March 17, 2017, is not reasonable, necessary, and related to the work accident.

IT IS FURTHER ORDERED that Respondent shall pay Petitioner permanent partial disability benefits of **$382.63**/week for **50** weeks, because the injuries sustained caused the 10% loss of use of the whole person, as provided in Section 8(d)2 of the Act.

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $19,500.00. 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: JAN 30 2020
o: 12/3/19
TJT/jds
51

Thomas J. Tyrrell

Maria E. Portela

Kathryn A. Doerries

SD LCC 080

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GELAUDE, BEJAMIN
Employee/Petitioner

Case# **17WC010241**

CALMER CORN HEADS INC
Employer/Respondent

20IWCC0080

On 8/20/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.18% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

0210 GANAN & SHAPIRO PC
BRET E TAYLOR
411 HAMILTON BLVD SUITE 1006
PEORIA, IL 61602

STATE OF ILLINOIS)
)SS.
COUNTY OF **Rock Island**)

20IWCC0080

- ☐ 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

Benjamin Gelaude
Employee/Petitioner

v.

Calmer Corn Heads Inc.
Employer/Respondent

Case # **17** WC **10241**

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 **Rock Island**, on **July 18, 2018**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ 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 or about **8/1/16**, Respondent ***was*** operating under and subject 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 **$33,162.18**; the average weekly wage was **$637.73**.

On the date of accident, Petitioner was **26** years of age, ***married*** with **2** dependent children.

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

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

Respondent shall be given a credit of **$8,853.29** for TTD, **$0** for TPD, **$0** for maintenance, and **$11,807.71** for other benefits, for a total credit of **$20,661.00**.

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

ORDER

Respondent shall pay all reasonable and necessary medical services incurred prior to March 17, 2017, pursuant to the medical fee schedule, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall receive a credit for any related medical expenses it has already paid. Any medical expenses incurred beyond March 17, 2017 are denied as being unreasonable and unnecessary.

Respondent shall pay Petitioner the temporary total disability / maintenance benefits that have accrued from August 1, 2016 through March 17, 2017, and shall be given a credit for temporary total disability / maintenance benefits that have been paid, including an overpayment of TTD benefits for the period of March 20, 2017 through April 9, 2017, a period of 2 and 6/7 weeks, equating to $1,214.71.

Respondent shall pay Petitioner permanent partial disability benefits of $382.63/week for 50 weeks, because the injuries sustained caused the 10% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

Signature of Arbitrator

8/17/18
Date

AUG 20 2018

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FINDINGS OF FACT

This case involves a Petitioner alleging injuries sustained while working for the Respondent on August 1, 2016. Respondent disputes Petitioner's claims and the issues in dispute are: 1) causation; 2) medical expenses; 3) TTD/maintenance; and 4) nature and extent. Respondent's dispute is focused on its liability on these issues after March 17, 2017.

Petitioner testified he began working for Respondent in February 2013 as an assembler. His job responsibilities as an assembler included building machinery, assembling new corn heads, painting parts, and performing landscaping work. On August 1, 2016, Petitioner was performing landscaping work in which he was using a shovel to spread out dirt around the side of a hill and tree in order to prepare for sod. After being bent over while shoveling dirt for a long period of time, Petitioner stood up and felt warmth and pain radiate down his right leg.

On August 3, 2016, Petitioner visited Alwood Chiropractic with complaints of low back pain and stiffness. He was diagnosed with a lumbar strain. (PX 4) Petitioner testified that he had been treating at Alwood Chiropractic once a month for low back complaints prior to the date of injury since 2013. He was referred to Alwood Chiropractic originally by other family members as his mother also treated at this facility. He testified he may have treated at Alwood Chiropractic within the month prior to the date of injury.

On August 16, 2016, Petitioner visited his primary care physician, Dr. Keith Peachey. (RX 4) At that time he provided a consistent injury history and reported low back pain with right leg radiculopathy. Dr. Peachey took Petitioner off work for two weeks and ordered an MRI of the lumbar spine. The MRI of the lumbar spine was performed on September 1, 2016 and showed: minimal bulges at L2-3 and L3-4; a mild bulge with annular fissure at L4-5; and a broad based disc protrusion, right paracentral at L5-S1, which contacted the S1 nerve root without impingement. (PX 2). On September 2, 2016, Dr. Peachey recommended a pain clinic consultation for possible epidural steroid injections as well as a neurosurgical orthopedic consult. (RX 4). Petitioner testified that Dr. Peachey referred him to the Illinois Neurological Institute.

On September 21, 2016, Petitioner saw neurosurgeon Dr. Todd McCall at the Illinois Neurological Institute. Following a clinical examination and review of Petitioner's treatment records, Dr. McCall noted Petitioner had a normal MRI and recommended physical therapy. Dr. McCall recommended Petitioner follow up treatment with Dr. Zhou if physical therapy failed. (RX 1) Dr. McCall noted Petitioner was not a surgical candidate. (RX 1). On September 8, 2016 Petitioner underwent an epidural steroid injection by Dr. Kane. (PX 3) On September 28, 2016, Petitioner began a six-week course of physical therapy at Cottage Rehab. (PX 5)

On November 9, 2016, Petitioner saw Dr. Zhou, a pain management specialist at Illinois Neurological Institute. (RX 2) Dr. Zhou noted the epidural injection by Dr. Kane caused worsening of back pain. Petitioner reported approximately 11 sessions of physical therapy with some improvement of tingling and numbness. He reported being released back to light duty work the previous Thursday by Dr. Peachey. Dr. Zhou reviewed the MRI film and recommended physical therapy and home based exercise to improve his pain. (RX 2) Zhou did not believe there was any need for surgical intervention or injection. (RX 2)

On November 11, 2016, Petitioner returned to Dr. Peachey and reported that the first epidural injection caused more pain going down his left leg - which was not initially involved. (RX 4) Dr. Peachey noted Petitioner had undergone physical therapy, which had not resulted in numbness down his right leg. Dr. Peachey

20 IWCC0080

maintained Petitioner's light duty restrictions and ordered an EMG of the lower extremity. (RX 4) The EMG was performed on November 21, 2016, and was within normal limits for the right lower extremity. (RX 3) There was no indication of S1 nerve root radiculopathy. (RX 3)

On December 7, 2016, Petitioner saw Dr. Zhou and reported his complaints were 50 to 60 percent better after physical therapy. (RX 5) Dr. Zhou again noted the injection had made his pain worse. (RX 5) Petitioner reported he felt he was going in the right direction with his pain management and had returned to light duty work with a 20 pound lifting restriction. (RX 5) Dr. Zhou's records indicate that Petitioner returned to his office for reconsideration of surgical intervention, and further noted Petitioner had significantly improved since the injury with conservative treatment including physical therapy and activity modification at work. (RX 5) Dr. Zhou felt nonsurgical treatment was Petitioner's best option and recommended Petitioner stay with the current treatment plan. (RX 5) Dr. Zhou noted if there was still a concern for surgical intervention, he would recommend Petitioner be seen by a different orthopedic spine surgeon for a second opinion. On that visit, Dr. Zhou released Petitioner from his care. (RX 5)

On January 5, 2017, Petitioner saw Dr. Peachey, who noted Petitioner's physical therapy had ended two to three weeks prior and he was released to a home exercise program. (RX 4) Dr. Peachey also noted that Petitioner did not need surgery and recommended that Petitioner return to his neurosurgeon. (RX 4)

On January 25, 2017, Petitioner saw Dr. Timothy VanFleet for a Section 12 examination. (RX 8) Dr. VanFleet noted Petitioner could heel walk and toe walk without difficulty; forward flex and touch his fingers below his knees; and complained of pain radiating down the right buttock and leg. He had good range of motion at the hips and knees, with symmetric reflexes of the knees and ankles. There was no evidence of tension signs and he had symmetric strength to manual motor testing. Dr. VanFleet diagnosed Petitioner with resolving lumbar radiculopathy. As to the right-sided buttock and leg pain, Dr. VanFleet noted no objective findings that would support these complaints in the form of tension signs or any motor deficits or reflex changes. Dr. VanFleet recommended a continued 20-pound lifting restrictions and a four-week course of work hardening/work conditioning.

Per Dr. VanFleet's recommendation, Dr. Peachey referred Petitioner to Cottage Rehabilitation and Sports Medicine, where he underwent a four-week course of work conditioning from February 20, 2017 through March 17, 2017. (PX 5, RX 7) Upon discharge from work hardening on March 17, 2017, the therapist noted Petitioner's prognosis was good with continued performance of the home exercise program. (RX 7) Petitioner met his goal of being able to lift and carry 50 pounds 60 feet 4 times with pain less than 2 on a scale of 10. Petitioner met his goal of being able to perform simulated shoveling with proper mechanics for at least 10 minutes with pain less than 2 on a scale of 10. Petitioner met 90 percent of his goal of being able to lift 150 pounds from the floor 5 times with pain less than 2 on a scale of 10. Further, Petitioner met 95 percent of his goal of being able to work in a crouched-forward, reaching posture for 5 minutes with pain less than 2 on a scale of 10. He was discharged from work hardening as having met all of his goals. (RX 7)

Petitioner testified that Respondent offered to bring him back to work without restriction on March 20, 2017. Petitioner advised Respondent he was not going to return to work until he had examined the work hardening results with his doctor to make sure he was released. At that point, he was not accepting the offer of work until he had spoken with Dr. Peachey.

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On March 22, 2017, Petitioner saw Dr. Peachey and reported that he had just finished work conditioning and needed to know where to go from there. (RX 4) He reported his employer wanted an estimated return to work date and that he was currently off work because they did not have light duty work for him to do. Petitioner told Dr. Peachey he was not any better than he was when he started the program and he did not think he could go back to work without injuring himself. Clinically, Dr. Peachey noted Petitioner had negative sitting and lying straight leg raises. Dr. Peachey took Petitioner off work for four weeks.

On April 6, 2017, Petitioner saw Dr. Richard Kube, an orthopedic surgeon in Peoria, Illinois. (PX 10) Petitioner testified that his attorney recommended Dr. Kube and Petitioner had Dr. Peachey refer him to Dr. Kube. At his first visit, Petitioner provided a consistent history of injury, noting his complaints of pain were predominantly in his right leg, which was more of a concern than his back. Dr. Kube noted Petitioner had an epidural injection, which actually made him worse and flared his back up. He also noted that rehab seemed to help when he was doing it but then it would relapse. Dr. Kube further noted Petitioner could actually accomplish some pretty heavy tasks, but this also seemed to flare him up. He noted the MRI showed a small disc protrusion and annular tear at L5 S1 on the right side with some stenosis in the lateral recess that was mild to moderate in nature. On that first visit, Dr. Kube recommended a microdiscectomy at L5-S1, and returned Petitioner to work in a light duty capacity of 10 pounds lifting frequently and 35 pounds lifting limited.

On April 7, 2017, Petitioner saw Dr. Timothy VanFleet for a follow up Section 12 examination. (RX 9) Dr. VanFleet noted Petitioner had undergone work conditioning for four weeks as he had previously suggested. Petitioner reported pain on a level of 5 on a scale of 10 on a regular basis. He further reported Dr. Kube had recommended a lumbar discectomy operation, but he was to return to work in a light duty capacity beginning in three days. Dr. VanFleet noted that the Petitioner did not believe he was capable of returning to his regular job. He also noted Petitioner had previously had an EMG which was normal, and an epidural steroid injection which did not provide improvement. On clinical examination, Petitioner could ambulate across the floor, could flex and extend without difficulty, had good range of motion in the hips and knees, and his reflexes were symmetric at the knees and ankles. Dr. VanFleet noted that Petitioner had absolutely no evidence of any tension signs on examination. The MRI films from September 1, 2016 indicated disc degeneration at the L5-S1 level and a very slight right sided protrusion which did not contact the S1 nerve root and did not seem to provide any significant focal neurological compression. Dr. VanFleet found no evidence of radiculopathy as Petitioner had no evidence of tension signs, no reflex changes, no strength changes, and good lumbar range of motion. Dr. VanFleet opined that the Petitioner was able to return to work without restriction based on him meeting his goals in work hardening with the exception of subjective pain complaints. He did not believe Petitioner required any further medical treatment or testing for his low back condition, and that Petitioner had reached maximum medical improvement.

Following the April 7, 2017 Section 12 examination, Petitioner called Dr. Kube's office requesting to speak to Dr. Kube regarding his light duty work restrictions. (PX 10) He was advised he could not have his restrictions changed absent an office visit. On April 18, 2017 Petitioner saw Dr. Kube, who then took Petitioner completely off of work pending the May 1, 2017 surgery.

On May 1, 2017, Petitioner underwent a right L5 S1 hemilaminectomy with partial facetectomy and microdiscectomy with Dr. Kube. (PX 10) Post-operatively, he continued to have right leg pain complaints. Dr. Kube prescribed physical therapy, which was performed at Azer Clinic from June 23, 2017 through July 31, 2017. (PX 9) As of June 15, 2017, Dr. Kube noted Petitioner's left leg was improved but his right leg still had a radicular pattern consistent with the S1 nerve root. Dr. Kube placed him on sedentary work restrictions at that

time. (PX 10) By July 11, 2017, Dr. Kube noted Petitioner still had right leg pain, his strength was good, and increased his work capability to lifting 35 to 50 pounds. (PX 10) On August 1, 2017, Dr. Kube noted Petitioner's complaints remained consistent with an S1 radiculopathy, ordered an MRI, and maintained moderate lifting restrictions of 35 to 50 pounds. (PX 10) On August 30, 2017, Petitioner saw Physician's Assistant Lori Welke at Dr. Kube's office. Petitioner noted he was not working and was at home taking care of his children while his wife worked. He was worried about finding a job within the 35 to 50 pound restrictions, and Physician's Assistant Welke reduced his work restrictions down to light duty activities. (PX 10) An MRI was performed on November 10, 2017 and showed a small broad based posterior disc bulge with superimposed right paracentral to foraminal small disc protrusion with annular fissure or prior surgical changes at L5-S1. (PX 10) There was minimal left and right neuroforaminal narrowing near contact of the exiting right L5 nerve root. (PX 10) On November 20, 2017, Petitioner underwent an EMG/NCV at the referral of Dr. Kube, which indicated mild to moderate right S1 radiculopathy. (PX 8) Following review of the updated MRI and EMG/NCV, Dr. Kube noted Petitioner's nerve issue was probably more a radiculitis as much as anything at S1 on the right. He recommended a functional capacity evaluation and maintained his light duty restrictions pending the FCE. (PX 10) The December 12, 2017 FCE showed Petitioner could lift up to 50 pounds occasionally, 25 pounds frequently, and 10 pounds constantly. (PX 12) Petitioner could lift in the heavy physical demand level, however due to weakness in the right leg and quality of gait at the end of the day, it was recommended Petitioner stay at the medium physical demand level. On January 9, 2018, Dr. Kube placed him on permanent restrictions consistent with the FCE. Dr. Kube felt Petitioner was as maximum medical improvement and would require long-term medication management. (PX 10)

Dr. Timothy VanFleet testified via deposition on September 27, 2017. Dr. VanFleet is an orthopedic surgeon at The Orthopedic Center of Illinois who conducted two different Section 12 examinations of Petitioner. (RX 10, pp. 6 8). At Petitioner's original examination of January 25, 2017, Dr. VanFleet noted Petitioner had no tension signs on clinical examination. (RX 10, pp. 12 13). Petitioner had symmetric reflexes so he had no reflex changes which would correlate with a diagnosis of radiculopathy, and there was no evidence of any strength changes. (RX 10, p. 13). Dr. VanFleet felt there were no positive physical examination findings. (RX 10, p. 13). He further noted Petitioner had a negative EMG, a lack of response to epidural injections, and diagnosed him with a resolving radiculopathy. (RX 10, p. 14). He noted Petitioner could have had a radiculopathy at one point in time, but by the date of his January 2017 evaluation, the radiculopathy was certainly in the late stages of resolution. (RX 10, p. 14). He recommended a 20-pound work restriction and work hardening program. (RX 10, p. 15). He further noted Petitioner was not a surgical candidate. (RX 10, p. 16). He followed up with Petitioner on April 7, 2017, at which time Petitioner advised he had seen Dr. Kube the day before who was recommending surgery. (RX 10, p. 16). Dr. VanFleet conducted a physical examination which he noted was normal, with no tension signs, symmetric reflexes and strength, and no difficulty with ambulation. (RX 10, p. 17). He reviewed the prior MRI images which he felt showed a very slight right sided protrusion which did not contact the S1 nerve root and did not provide any significant focal neurologic compression. (RX 10, p. 18). There was no evidence of stenosis at L5-S1. (RX 10, p. 18). There was no evidence of an annular tear at L5-S1. (RX 10, p. 18). There were no findings in the MRI study that would explain Petitioner's right radicular complaints. (RX 10, p. 18). Dr. VanFleet did not believe the surgery recommended by Dr. Kube was reasonable or necessary to treat any objective findings or subjective complaints. (RX 10, p. 19). The basis for this opinion was a lack of physical examination findings, a negative EMG study, a negative response to epidural injections, and he did not think it was necessary or helpful. (RX 10, p. 19). He testified that the negative result from the epidural steroid injection at L5-S1 was indicative that L5-S1 was not the pain generator. (RX 10, p. 20). Dr. VanFleet further testified the opinion of neurosurgeon Dr. Todd McCall supported his opinion that Petitioner was not a surgical candidate. (RX 10, p. 25). Dr. VanFleet also noted the opinion of pain

management physician Dr. Zhou supported his opinion Petitioner was not a surgical candidate. (RX 10, pp. 26-28). Dr. VanFleet indicated the March 17, 2017 work hardening discharge summary and the therapist's indication that Petitioner had met all of his long term goals further supported his opinion Petitioner was not a surgical candidate. (RX 10, pp. 30 31). Dr. VanFleet confirmed surgery as recommended by Dr. Kube would not be a good idea, as it would be based solely on symptoms alone, which would be unreasonable. (RX 10, pp. 37 38) Dr. VanFleet testified, "If somebody is unreasonable enough to do an operation based upon his symptoms, then I would assume that they're basing it on the injury that he sustained, and so therefore the surgery would be related." (RX 10, p. 38) Dr. VanFleet further stated, "If somebody, some surgeon, not me, not somebody else that he saw, but if some surgeon were to see him and operate on him based upon his current symptoms, then one would assume that that surgery is related to the injury." (RX 10, p. 39)

Petitioner's treating orthopedic surgeon, Dr. Richard Kube, testified via deposition on August 3, 2017. Dr. Kube testified he diagnosed Petitioner with an L5-S1 disc protrusion with stenosis on the right side causing right S1 radiculopathy and low back pain. (PX 14, p. 11) He recommended a lumbar decompression which occurred on May 1, 2017. (PX 14, p. 13) He testified the alleged shoveling incident of August 1, 2017, at least aggravated his lumbar condition causing the need for the surgery he performed on May 1, 2017. (PX 14, p. 21) Dr. Kube felt Petitioner's post-surgical complaints were caused by an inflammatory issue within the nerve, as opposed to a nerve compression/lesion. (PX 14, p. 22) On cross examination, Dr. Kube confirmed Petitioner's own reporting of pain at his last visit, 2 days prior to the deposition, showed his pain complaints had gotten worse since the surgery, and were almost at where he was before the surgery. (PX 14, p. 25) Dr. Kube further confirmed that at his original April 6, 2017 medical visit, he only reviewed the MRI films and some physical therapy records from Cottage Rehab and Sports Medicine. (PX 14, p. 29) He felt the MRI findings did not show a significant neurological condition in the spine, and that there was contact with the S1 nerve root but no direct impingement. (PX 14, p. 26) He testified that at the initial medical visit with Petitioner, he recommended a microdiscectomy to decompress the L5-S1 disc space. (PX 14, pp. 29 30) He confirmed he had not reviewed any of the following medical information: the prior treatment records or opinion of neurosurgeon Dr. Todd McCall; the medical records or opinion of pain management specialist Dr. Zhou; the November 1, 2016 EMG/NCV report and results; or the examination notes or report of Dr. VanFleet from his original Section 12 examination. (PX 14, p. 33) However, Dr. Kube did review the March 17, 2017 work hardening discharge summary and confirmed that three weeks prior to Petitioner's first visit with him, Petitioner had been discharged from work hardening as having met all of his long-term goals. (PX 14, p. 36) When asked to compare the work hardening discharge summary results with Petitioner's work capabilities two days prior to the deposition, Dr. Kube would not state whether Petitioner could do more or less at the time of the deposition versus three weeks prior to Dr. Kube beginning treatment. (PX 14, pp. 36 38)

Petitioner testified he received two letters from Respondent regarding his work status, the first dated April 24, 2017 and the second dated May 8, 2017. (RX 14; RX 15). The April 24, 2017 letter sent to Petitioner indicated Respondent had received Dr. Kube's off work note dated April 18, 2017. (RX 14) The letter asked Petitioner to contact Respondent as there was no indication as to how long Petitioner would be off work in order to determine whether the request for leave could be provided. The letter asked Petitioner to contact Respondent by April 28, 2017. (RX 14) The second letter dated May 8, 2017 indicated Petitioner failed to contact Respondent as requested in the April 24, 2017 letter. (RX 15) Due to his failure to contact Respondent to discuss his employment issues, he was being deemed as having abandoned his position and Respondent was accepting his

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voluntary resignation as of May 5, 2017. (RX 15) The letter specifically indicated if there were extenuating circumstances he wished Respondent to consider regarding his employment status, they must be placed in writing. (RX 15) Petitioner testified he received a letter the morning of surgery, May 1, 2017. Petitioner acknowledged he did not write or mail a letter to Respondent to discuss his voluntary resignation.

Petitioner testified he has been looking for employment since January 9, 2018 and utilized a temporary employment agency by the name of StaffQuick to obtain employment with Euclid Beverage in January 2018 – which lasted only two weeks. At Euclid, Petitioner was working in a beverage warehouse where he stacked up cases of beer on pallets. Petitioner testified the work was not bad, but they could not hire him full time from StaffQuick because the job had a weight lifting requirement of 165 pounds. Petitioner applied for jobs mostly online as he is usually home and does not have a vehicle because his wife works. He currently takes care of his kids and looks for work that fits between his wife's schedule and his. After working with Euclid, the temporary employment agency contacted him again shortly thereafter about another job, but he did not take this job as it did not work with his childcare schedule. Other than these two initial job opportunities, Petitioner acknowledged he had not contacted the temp agency he had hired to find employment in the ensuing seven to eight months up to the date of arbitration, and had no explanation as to why he did not follow up with the agency. Petitioner testified his wife currently supports him and his family while he stays home to take care of his kids. He acknowledged taking care of his kids was a factor in his difficulty in finding a full time job, as his children are a priority in all of his decisions.

Daniel Wallerstedt testified on behalf of Respondent. He has been with Respondent for 15 years, works as an engineer and serves on Respondent's management team. Mr. Wallerstedt testified that it is Respondent's policy to accommodate light duty restrictions for employees injured on the job as best they can. He testified that Respondent would have been able to accommodate Petitioner's light duty restrictions following his surgery if he had still been employed with them. Mr. Wallerstedt confirmed Respondent never received a letter from Petitioner regarding his employment or a written response to either the April 24 or May 8, 2017 letters that were sent to Petitioner. Mr. Wallerstedt further testified there was only one phone call noted in Petitioner's file regarding a response to the May 8, 2017 letter. Upon inquiry from the Arbitrator, Mr. Wallerstedt testified that if Petitioner were to apply to work at Respondent today, there would be a job for him that would fit within his restrictions.

CONCLUSIONS OF LAW

1. With regard to the issue of causation, the Arbitrator finds that the Petitioner has met his burden of proof. The Arbitrator notes that this issue is raised by Respondent based on the question of the reasonableness and necessity of Petitioner's surgery by Dr. Kube. Notwithstanding Petitioner's surgery, all the experts in this case agree that the Petitioner sustained an injury to his back stemming from his undisputed August 1, 2016 work accident. On the question of causation, the Arbitrator finds persuasive the findings and opinions of Petitioner's initial treaters Dr. Peachey, Dr. Zhou, Dr. McCall, and the Section 12 examiner, Dr. VanFleet. The Arbitrator relies on the initial medical evidence which show that Petitioner sustained: minimal bulges at L2-3 and L3-4; a mild bulge with annular fissure at L4-5; and a broad based disc protrusion, right paracentral at L5-S1, which contacted the S1 nerve root without impingement. The records from these providers also indicate Petitioner successfully completed the work conditioning program prescribed by Dr. Peachey and recommended by Dr. VanFleet. There was also mention of Petitioner suffering from radiculopathy, which Dr. VanFleet opined had resolved – an opinion the Arbitrator finds persuasive in light of the preponderance of the medical evidence.

Although there is an issue regarding the surgery Petitioner underwent with Dr. Kube, that surgery does not appear to have broken the chain of causation in light of Dr. Kube's own admission that the Petitioner's condition did not improve as Petitioner continued to have complaints of pain following the procedure. Based on the weight of the medical evidence, the Arbitrator concludes that the Petitioner's condition of ill-being as documented by his initial treating physicians (Dr. Peachey, Dr. Zhou, Dr. McCall) and by Dr. VanFleet is causally related to his August 1, 2016 accident.

2. Regarding the issue of medical treatment, the Arbitrator finds that the Petitioner's medical treatment through March 17, 2017 – the date of his release from work hardening – has been reasonable and necessary in addressing his work-related back condition. This finding is supported by the preponderance of the medical evidence, which show that Petitioner was making good progress in his treatment to the point where he reached all the goals of work conditioning. Respondent shall pay for any related, reasonable and necessary medical expenses incurred through March 17, 2017 and shall receive a credit for any expenses it has already paid.

The Arbitrator further finds that Petitioner's treatment after March 17, 2017 – particularly the treatment with Dr. Kube - was not reasonable and necessary. This finding is supported by the medical evidence, which shows that following his completion of work conditioning on March 17, 2017, Petitioner continued his complaints of pain. The Arbitrator notes that despite the efforts of his treating physicians and the IME to get the Petitioner back to work and to continue with a home exercise program, the Petitioner felt he could not go back to work and sought care from Dr. Kube on April 6, 2017 at the recommendation of his attorney. Dr. Kube diagnosed Petitioner with an L5-S1 disc protrusion with stenosis on the right side causing right S1 radiculopathy and low back pain, for which he felt a surgical lumbar decompression was necessary. Dr. Kube made the surgical recommendation on Petitioner's very first visit without having reviewed any of the Petitioner's prior medical records - including the opinions that Petitioner was not a surgical candidate according to all the Petitioner's prior medical providers as well as the Section 12 examiner. It is therefore not surprising that Dr. Kube confirmed through his deposition testimony that the Petitioner continued to complain of pain following the surgery and that his pain levels were higher than before the surgery. Dr. Kube's testimony confirmed what the previous treating physicians and the IME Dr. VanFleet had all opined earlier: Petitioner was not a surgical candidate. It further reinforces Dr. VanFleet's testimony that surgery was not reasonable and necessary for this Petitioner. Based on this information, the Arbitrator denies any medical treatment beyond March 17, 2017 as being unreasonable and unnecessary.

3. Based on the Arbitrator's conclusions regarding the issues of causation and medical expenses, the Arbitrator further finds that the Petitioner is entitled to TTD/maintenance from the date of accident through March 17, 2017. This finding is also supported by the testimony of both the Petitioner and Mr. Wallerstedt. Petitioner confirmed that the Respondent offered him employment a number of times. Petitioner rejected the offer to return to regular work on March 20, 2017 because he felt he could not go back to work despite the positive findings from work conditioning and his improvement noted by his treating physicians and the IME up to that point. The Arbitrator also relies on the credible testimony of Mr. Wallerstedt, who indicated that it is Respondent's policy to accommodate light duty restrictions of injured workers, which they could have done for Petitioner if he chose to return to work. Based on the stipulations between the parties, it appears the Respondent has more than satisfied its obligation to pay Petitioner any TTD or maintenance that may have been due and owing to the Petitioner through March 17, 2017. Thus no further TTD or maintenance benefits are awarded and Respondent shall receive a credit for any overpayment of TTD or maintenance benefits paid.

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4. With regard to the issue of nature and extent, the Arbitrator notes that 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 makes the following findings listed below.

(i) Impairment. No permanent partial disability impairment report and/or opinion was submitted into evidence and therefore the Arbitrator gives no weight to this factor.

(ii) Occupation. Petitioner was employed as an assembler at the time of the accident, and was there was evidence that he was medically able to return to work in his prior capacity as a result of said injury. The disputed medical evidence indicates Petitioner could return to work with restrictions, but Respondent provided evidence that it could have accommodated those restrictions. Despite either scenario, Petitioner testified that he declined Respondent's offers of employment and currently has difficulty finding employment due to childcare scheduling. The Arbitrator gives great weight to this factor.

(iii) Age. Petitioner was 26 years old at the time of the incident. The Arbitrator gives some weight to this factor.

(iv) Future Earning Capacity. There was no persuasive evidence that Petitioner's future earning capacity has been impacted by this accident since Petitioner rejected attempts by the Respondent to return him to work and Petitioner rejected the offers to return to work in any capacity. Although Petitioner testified that he has attempted to return to work after this incident, he admits that his childcare scheduling has been a major factor in his purported job search. The Arbitrator therefore gives considerable weight to this factor.

(v) Evidence of Disability. There was evidence of disability corroborated by the medical records, which show that Petitioner suffered: minimal bulges at L2-3 and L3-4; a mild bulge with annular fissure at L4-5; and a broad based disc protrusion, right paracentral at L5-S1, which contacted the S1 nerve root without impingement - which required Petitioner to undergo an injection, followed by physical therapy and work conditioning. The bulk of the medical evidence shows that Petitioner had a good recovery from his injuries and contradicts Petitioner's testimony. Petitioner testified that his current complaints include pain down his leg and in his low back that limits his activities of running, climbing stairs and shoveling for which he takes prescribed pain medication. Based on the evidence introduced at trial, the Arbitrator gives significant weight to this factor.

Based on the factors above, the Arbitrator concludes the injuries sustained by Petitioner caused a 10% loss of the person as a whole, as provided in Section 8(d)(2) of the Act.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Hannah Larson,

Petitioner,

vs.

NO: 15 WC 22225

Quad City Skydiving Center,

20IWCC0081

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 employment and accident, and being advised of the facts and law, reverses the Decision of the Arbitrator as stated below.

Findings of Fact

On the date of accident, Petitioner was a pilot flying a Cessna 182 for the Respondent's skydiving operations. She testified that Brian Larson, a friend, knew Petitioner wanted to increase her flight time and told her that Respondent was looking for an additional pilot. Petitioner met with Dennis Jensen, the owner of the business. She testified that the flying hours she logged while working for Respondent went towards the requirements for her airline transit pilot certificate. That certificate was necessary to obtain her current job as a commercial pilot. Petitioner and Mr. Jensen agreed she would fly for Respondent for approximately 5-8 hours on Sundays.

On June 29, 2014, Petitioner crashed the plane during a landing attempt. Petitioner sustained blunt force trauma to her face causing lacerations and a broken nose. Her injuries ultimately required two reconstructive nasal surgeries as well as numerous sutures.

Petitioner testified that it would have cost $195/hr. to rent a Cessna 182 through Lewis University to obtain her flight hours. Respondent provided the plane and paid for the gas. Petitioner testified that Mr. Jensen would text Petitioner regarding her hours each week and would tell her how many jumps remained during the day. Petitioner testified that Mr. Jensen told her the route to fly and the general areas to avoid due to noise complaints from neighbors. He told Petitioner at what altitude to fly and where the skydivers should jump. Petitioner testified that Mr. Jensen also told her what to do while descending the plane. Mr. Jensen told her to put 10 gallons of fuel in the

20IWCC0081

plane every two jumps.

Under cross-examination, Petitioner agreed that she chose to fly on Sundays due to her limited availability. She did not sign an employment contract and agreed to be an unpaid pilot. She testified this was a mutually beneficial relationship because she did not have to pay to rent a plane to obtain her flight hours, and during her flights Mr. Jensen was able to instruct additional skydivers. She neither received nor expected any money. She testified that Mr. Larson told her he volunteered occasionally for Respondent. Petitioner testified that Mr. Jensen gave some guidance regarding operating the plane because she had never previously flown that model. She already had logged 250-300 hours before she began flying for Respondent. Petitioner testified that she never received any tax documents from Respondent. Respondent was not responsible for keeping track of the hours Petitioner logged in her logbook and did not have to approve her logbook entries. Petitioner testified that she believed her arrangement with Respondent would last until either party wanted it to stop. She told Mr. Jensen she wanted to fly for as long as the weather held. Petitioner assumed the relationship would last the entire summer, but admitted there was no defined time frame.

Dennis Jensen Testimony

Mr. Jensen testified on behalf of Respondent. He has owned the skydiving business for 20 years and has never paid any of Respondent's pilots. He testified that none of his pilots have ever expected payment for their services. Mr. Jensen testified that Petitioner never received any compensation for her flights. He testified that Petitioner chose to fly on Sundays. There was no written employment agreement and the terms of his arrangement with Petitioner were identical to the arrangements he had with other pilots. Mr. Jensen further testified that Petitioner was already qualified to fly the Cessna 182 and he just gave instructions regarding things the tower wanted and ways to best preserve the plane and avoid damaging the engine.

He testified that pilots are not required to log hours; instead, this is something they choose to do to further their careers. He denied ever promising Petitioner a specific number of flight hours. He testified that Respondent did not withhold any federal or state taxes for any of its pilots. Mr. Jensen admitted he never obtained workers' compensation insurance because he never had employees. He knew Petitioner wanted to accumulate hours toward her commercial pilot license. Mr. Jensen acknowledged he could have ended the relationship with Petitioner at any time. He denied controlling the manner in which Petitioner flew.

Brandon Larson Testimony

Mr. Larson testified on behalf of Respondent. He is currently a corporate pilot and flew for Respondent in 2013. He flew for two jump seasons (two years) and was never paid. He testified that he never had an expectation of being paid while he flew for Respondent. He logged hours but did not consider that a benefit provided by Respondent. He testified that his relationship with Respondent was simply an opportunity for him to log additional flight hours and gain experience. Mr. Larson took a training flight to make sure he knew how to operate the plane. He testified the introductory training also went through the special procedures required for skydiving flights. He testified that he referred Petitioner to Respondent because he thought it would be a good

opportunity for her to gain more flight experience. Under cross-examination, Mr. Larson agreed that flight hours are helpful and are an essential need for pilots. He testified that if he did not volunteer with Respondent, there were other places where he could volunteer and obtain flight hours.

Jesup Miskinis Testimony

Mr. Miskinis also testified on behalf of Respondent. He is currently a pilot for FedEx. Mr. Miskinis previously flew for Respondent for two years from 2002-2004. He testified that he never received any compensation. He further testified that although he is a skydiver, he never received any additional benefits such as discounts on skydiving. Mr. Miskinis testified that everything was voluntary, and he told Respondent when he was available for flights.

Gary Aho Testimony

Mr. Aho testified on behalf of Respondent. He is a pilot and a retired mechanical engineer. Mr. Aho has never worked professionally as a pilot, but he has voluntarily flown for Respondent since 2010. He testified that he never received any payments from Respondent. The only benefit he ever received was attending an annual banquet. Mr. Aho does not fly professionally, but volunteers as a pilot with other entities such as a regional blood center and the US Civil Air Patrol.

Conclusions of Law

Petitioner bears the burden of proving each element of her case by a preponderance of the evidence. *Sisbro, Inc. v. Indus. Comm'n*, 207 Ill. 2d 193, 203 (2003). This includes the existence of an employer/employee relationship with Respondent on the date of accident. After carefully considering the evidence and legal precedent, the Commission finds Petitioner did not meet her burden of proving an employer/employee relationship existed on June 29, 2014. Thus, the Commission reverses the Decision of the Arbitrator in its entirety.

The Act generally defines an employee as a person in the service of another under any contract of hire, whether express or implied, and oral or written. 820 ILCS 305/1(b). While the definition is broadly construed, "there can be no employer/employee relationship, and therefore, no liability under the Act absent a contract for hire, either express or implied." *Pearson v. Indus. Comm'n*, 318 Ill. App. 3d 932, 935 (2001). In a case with analogous, the Illinois Supreme Court wrote:

> "The underlying purpose of workmen's compensation legislation in this and other States is to provide financial protection in various forms, including the restoration of lost wages, for workers whose earning power is interrupted or terminated as a consequence of injuries arising out of and in the course of their employment. Consistent with the philosophy of the legislation which assumes that a worker is gainfully employed at the time of his injury, it is generally recognized that a true employer-employee relationship does not exist in the absence of the payment or expected payment of

> consideration in some form by employer to employee. As a consequence, the workmen's compensation statutes throughout this country have uniformly been construed to exclude from coverage purely gratuitous workers who neither receive, nor expect to receive, pay or other remuneration for their services."

Bd. of Educ. v. Indus. Comm'n, 53 Ill. 2d 167, 171 (1972) (internal citations omitted).

In *Bd. of Educ. v. Indus. Comm'n*, the claimant, a college student interested in becoming a teacher in the future, volunteered at a public school in Chicago. Volunteers in the program received no pay and no other form of compensation. The claimant had a set schedule and intended to volunteer 100 hours through the program. The claimant kept a log of her volunteer hours and activities as a requirement for her undergraduate degree in elementary education. She performed some of the same duties as regularly employed teachers at the school. Following an injury that occurred while she covered a class for a teacher, the claimant sought workers' compensation benefits. The court considered the question of whether the claimant was an employee as the initial threshold the claimant had to pass. The court wrote:

> "Upon consideration of the facts and circumstances in the case before us, we have come to the conclusion that to hold that the claimant was an 'employee' of the Board of Education would be to extend the scope and coverage of the [Act] beyond that contemplated by the legislature. As between the claimant and the Board of Education, the element of consideration for her services was totally lacking. It is undisputed that her activities at the [school] were strictly on a voluntary basis with no expectation of any monetary compensation."

Id. at 171. The court's conclusion that there was no consideration for the claimant's services was also based on its determination that there was insufficient evidence that in exchange for the 100 volunteer hours, the Board agreed to hire the claimant in the future. The court also determined there was no evidence that the claimant's donation of her time was in any way a condition precedent to future employment. Instead, the court concluded the claimant's performance of 100 hours of volunteer work in the Chicago Public Schools was a "DePaul University requirement which students were expected to complete in the course of their academic training for a Bachelor of Science degree in elementary education." *Id.* at 172.

Much like the college student in *Bd. of Educ.*, Petitioner readily admits she had absolutely no expectation of receiving payment for the hours she flew for Respondent. It is also clear that Petitioner did not expect this volunteer opportunity would lead to future gainful employment by Respondent. Instead, Petitioner chose this volunteer opportunity because it presented a chance to gain the additional flight experience and training that she needed to obtain her airline transit certificate. Based on the totality of the evidence and relevant legal precedent, the Commission finds there was no consideration, payment, or other compensation in exchange for Petitioner volunteering to fly Respondent's plane. Thus, the Commission finds Petitioner failed to meet her burden of proving the existence of an employer/employee relationship on the date of accident.

20IWCC0081

For the foregoing reasons, the Commission reverses the Decision of the Arbitrator and denies benefits to Petitioner because an employer/employee relationship did not exist on June 29, 2014, the date of accident.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 5, 2018, is reversed in its entirety and all benefits are denied.

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

DATED: JAN 30 2020

o: 12/3/19
TJT/jds
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Maria Elena Portela
Maria E. Portela

Kathryn A. Doerries
Kathryn A. Doerries

DISSENT

I respectfully dissent from the opinion of the majority and would affirm and adopt the Decision of the Arbitrator in its entirety. After carefully considering the evidence, I believe Petitioner met her burden of proving that on the date of accident an employer/employee relationship existed between Petitioner and Respondent.

In Illinois, an offer, an acceptance, and consideration are required to form a contract. *See Melena v. Anheuser-Busch, Inc.*, 219 Ill. 135, 151 (2006). Furthermore, consideration is defined as any act or promise which benefits one party or is a detriment to the other party. *See Vassilkovska v. Woodfield Nissan, Inc.*, 358 Ill. App. 3d 20, 26 (2005). In this matter, the offer and acceptance are not in dispute. Instead, the majority concluded an employer/employee relationship did not exist solely due to its conclusion that there was no consideration for Petitioner's services. I interpret the evidence differently.

On the date of accident, Petitioner was a young pilot with the aspiration of becoming a commercial pilot. In order to reach the next level in her career, Petitioner needed to log a large amount of flight hours. Petitioner testified that absent volunteering as a pilot, it would be extremely costly to rent a plane through Lewis University, the closest flight school. Petitioner testified that Lewis University charges $192/hr. to rent a Cessna 182 for training. Respondent does not dispute this fact. Furthermore, it is abundantly clear that Respondent's business model relies on saving money by not compensating its pilots monetarily. The consideration is clear—Petitioner received

20IWCC0081

the benefit of obtaining additional flight hours without having to spend $192/hr. to rent a plane from a flight school. Likewise, Respondent received the benefit of eliminating the cost of paying pilots. Mr. Jensen also was free to train more skydiving groups—and thus make more money—because he did not have to personally fly the plane. These facts distinguish this case from the volunteer program at issue in *Bd. of Educ. v. Indus. Comm'n*, 53 Ill. 2d 167 (1972). After all, in *Bd. of Educ.*, while the claimant performed some of the same duties as the school's regular teachers, the Board still employed full-time teachers. Contrarily, Respondent in this matter *solely* relies on volunteer pilots.

As there is clear consideration for Petitioner's services, the Commission must next determine whether Petitioner was an independent contractor or an employee on the date of accident. The Illinois Supreme Court has identified several factors important to determining whether an employment relationship existed. These factors include but are not limited to: 1) whether the employer may control the manner in which the person performs the work; 2) whether the employer dictates the person's schedule; 3) whether the employer compensates the person on an hourly basis; 4) whether the employer withholds income and social security taxes from the person's compensation; 5) whether the employer may discharge the person at will; and, 6) whether the employer supplies the person with materials and equipment. *See Ware v. Industrial Comm'n*, 318 Ill. App. 3d 1117 (2000). Courts also consider the nature of the work performed by the person in relation to the general business of the employer. Finally, the level of control an employer exerts is a key factor. After considering the totality of the evidence, I agree with the Arbitrator's well-reasoned conclusion that an employer/employee relationship existed between Petitioner and Respondent on the date of accident.

For the forgoing reasons, I would affirm and adopt the Decision of the Arbitrator and find that Petitioner was Respondent's employee on the date of accident. The Arbitrator thoroughly addressed the remaining disputes regarding temporary total disability, medical expenses, and the nature and extent of Petitioner's injury.

Thomas J. Tyrrell

STATE OF ILLINOIS)
) SS.
COUNTY OF LAKE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Chantoun Jones,

Petitioner,

vs.

NO: 15 WC 28812

Waukegan Park District,

20IWCC0082

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 5, 2017, 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: JAN 30 2020
MP:yl
o 1/21/20
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Marc Parker

Maria Elena Portela

Kathryn A. Doerries

S8v0C0WI0S

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

JONES, CHANTOUN
Employee/Petitioner

Case# **15WC028812**

WAUKEGAN PARK DISTRICT
Employer/Respondent

20IWCC0082

On 12/5/2017, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 1.45% 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:

0013 DUDLEY & LAKE LLC
PETER SCHLAX
325 N MILWAUKEE AVE SUITE 202
LIBERTYVILLE, IL 60048

0766 HENNESSY & ROACH PC
EDWARD HENNESSY
140 S DEARBORN ST SUITE 700
CHICAGO, IL 60603

STATE OF ILLINOIS)
)SS.
COUNTY OF LAKE)

20 IWCC0082

☐ 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

Chantoun Jones
Employee/Petitioner

v.

Waukegan Park District
Employer/Respondent

Case # **15** WC **28812**

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 **Waukegan, Illinois**, on **10/31/2017**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ 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 **06/05/2015**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did*** 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 $**11,139.00**; the average weekly wage was $**382.23**.

On the date of accident, Petitioner was **35** years of age, ***married*** with **3** dependent children.

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

Respondent shall be given a credit of $**8,050.08** for TTD, $**0**for TPD, $**0**for maintenance, and $**0** for other benefits, for a total credit of $**8,050.08**.

ORDER

Respondent shall pay reasonable and necessary medical services of $159,502.69, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $330/week for 86-2/7 weeks, commencing 08/06/2015 through 03/31/2017, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $330.00 per week for 150 weeks because the injuries caused the 30% loss of use 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

12/4/17
Date

DEC 5 - 2017

STATEMENT OF FACTS

Petitioner was employed for 10 years as a park maintenance worker with Respondent. His duties included picking up and emptying trash and using a leaf blower. Physical demands included carrying weights up to 80 pounds. (Pet. Group Ex. 10).

Petitioner testified that on June 5, 2015, he lifted a 25 pound, "messed-up" ill-fitting backpack type leaf blower onto his back. Petitioner stated that he had difficulty adjusting the straps and "it pulled back on me." As a result, he experienced a sudden sharp pain in his upper back neck area. He also felt sharp radiating pain to his chest. Petitioner indicated he was directed by his supervisor to be evaluated at Vista Corporate Health.

Petitioner testified that he had experienced back pain prior to the June 5, 2015 incident. Records from Visa Health show Petitioner treated there on November 5, 2009, for right back pain and pain to the left trapezius muscle after shoveling for two days and lifting a heavy post. The Initial Visit Questionnaire reflects Petitioner was working in maintenance and was pushing a sign post on a forklift when he experienced "back pain and chest is hurting from the back every time I inhale." Petitioner was diagnosed with trapezius strain. (PX 1 pp. 35-36) Vista Health Services also reflect that Petitioner treated there for a thoracic strain that he experienced on July 2, 2010. He described the pain as intermittent, a degree of 6 on a 0 – 10 scale. He reported experiencing pain in the left shoulder/upper back after lifting, twisting and throwing a bag of sand. (PX 1 p.19-20) Petitioner testified that the pain he experienced in 2009 and 2010 resolved and the chest pain he experienced on June 5th "was different than any other time."

On June 5, 2015, Petitioner presented to Vista Corporate Health. Petitioner completed a Work Injury Questionnaire indicating he had an onset of back pain with difficulty breathing while using a backpack leaf blower. He localized his pain in the middle back and also wrote he experienced the same pain five (5) years ago. (PX. 1, p. 10) The Vista charting notes indicate complaints of pain to the upper left back after Petitioner was jerked forward while trying to lift an object. An examination revealed tenderness to palpation over the left thoracic paraspinal muscle. There was also palpable muscle spasms. Petitioner was diagnosed with an upper back strain and given a temporary 10 pound lifting/no use of left arm work restrictions. It was felt that Petitioner would be able to return to regular work as of June 9, 2015. (PX. 1, p. 11)

On June 29, 2015, Petitioner followed up with his family physician, Dr. Mathangi Sekharan. According to the records submitted, Petitioner reported that he was "blowing maintenance outside had back pain for one day...had injury earlier at work went to their doctor." An examination revealed tenderness to the upper back. Otherwise the examination was normal. Dr. Sekharan assessed backache and recommended physical therapy for his upper back. (RX. 2)

Petitioner returned to Dr. Sekharan for a follow-up visit on August 5, 2015. The doctor recorded that Petitioner "has back pain lower neck and upper back[;] seeing physical therapy[;] doing all the work with no restriction[;] back is bothering today." An examination revealed tenderness to the "upper back left more than right and also lower neck." Also noted was subjective radiculopathy in the left. Petitioner was assessed with 1.) backache – upper back; and 2.) neck pain. Petitioner was prescribed medications and further diagnostics were ordered. The doctor also took Petitioner off work at that time. (RX 2) On August 13, 2015, the doctor provided that Petitioner could return to restricted work effective August 17, 2015. (PX 5, p.5) By August 27, 2015, Petitioner reported increased pain. Dr. Sekharan recommended an MRI to be followed by a neurosurgical evaluation. He was also advised to stay off from work. (RX. 2, PX. 5, p.6) The prescribed MRI was completed on September 2, 2015 revealing findings consistent with central stenosis, moderately severe at C6-7 and

moderate at C4-5 and C5-6. Also noted was mild bilateral foraminal stenosis at C5-6 and moderate bilateral foraminal stenosis at C4-5. Lastly, at C3-4 there was minimal central spinal stenosis and foraminal stenosis secondary to minimal generalized disc osteophyte complex. (RX 2) After the completion of the MRI, Dr. Sekrahan reiterated the recommendation for a neurosurgical evaluation. Petitioner was continued off work. (RX 2)

Petitioner presented to Dr. Jonathan Citow on November 6, 2015. Dr. Citow documented an onset of significant neck and upper back pain between the shoulder blades after using a backpack blower in June. He documented that three days later, Petitioner developed pain in his upper extremities, left greater than right, towards the thumb with numbness and parasthesis. Dr. Citow noted Petitioner's symptoms progressed until he saw his primary physician. Also noted was that Petitioner had not improved despite three weeks of physical therapy. Dr. Citow reviewed the MRI and opined same demonstrated C4-7 severe spondylosis with disc protrusions significantly compressing the spinal cord with signal change in the spinal cord at C6-7. After performing an examination, Dr. Citow believed that Petitioner had symptomatic cervical myelopathy and recommended surgical intervention to include a C4-7 anterior decompression and stabilization. (PX 3, p. 23)

At Respondent's request, Petitioner underwent a Section 12 examination with Dr. Bryan Neal on November 11, 2015. In his report dated November 13, 2015, Dr. Neal chronicled his review of Petitioner's medical records including but not limited to Petitioner's cervical spine MRI. Dr. Neal recorded that Petitioner reported injuring his neck and both sides of his outer neck while at work in early June 2015. The doctor recorded Petitioner related that he was leaf blowing with "a kind of heavy leaf blower...bad straps...not able to be adjusted...basically just walking [Referencing walking and twisting while leaf blowing]..." Dr. Neal also recorded Petitioner reported he had been performing the leaf blowing activity for approximately ten (10) minutes before his "neck went out." (RX 3, Dep Ex. 2)

On examination, Dr. Neal documented that Petitioner described symptoms in his neck, spine and both hands. He also described a pins and needles type sensation in his legs, with numbness in the left leg but not the right. Petitioner also related that in the preceding month he had diminished capability to maintain an erection, something he perceived to be fully normal one year earlier. Dr. Neal opined that Petitioner's subjective complaints in the arms and legs appeared to be neurological in nature. The doctor noted that Petitioner's diminished capability to maintain an erection was a relatively new observation by Petitioner which the doctor believed raised the possibility of an ongoing neurological process involving his spinal elements. (RX 3, Dep Ex. 2)

Dr. Neal proffered an opinion that he did not believe there was an accident. The doctor stated, "[h]e did not trip, fall or receive any blow or strike from any object. Rather, his history was not of an accident but rather wearing a leaf blower with some kind of strap issue for ten minutes, after which he sat down secondary to symptoms." Dr. Neal opined a diagnosis of multilevel degenerative cervical spinal stenosis. The doctor stated Petitioner had a degenerative bony processes about the cervical spine which led to diminished cervical spine space. Dr. Neal indicated the MRI imaging revealed multilevel spinal stenosis of a significant degree. The spinal stenosis, according to Dr. Neal, caused compression on the spinal cord tissue and producing the upper and lower extremity symptoms. Dr. Neal did not believe that the MRI findings were attributable to the 10 minutes of back pack blower use on June 5, 2015. He explained that Petitioner may have experienced pain and discomfort while wearing a leaf blower, but this process could only be expected to produce soft tissue discomfort, which would heal in time. Dr. Neal stated it would be impossible for the process he described to lead to the spinal stenosis, a longstanding or even congenital condition. Dr. Neal concludes his opinion indicating that cervical spinal stenosis is not caused by or permanently worsened or accelerated by the work activity described or due to the work activities he does overall. Dr. Neal added that Petitioner was born with an element of congenital cervical stenosis and over time superimposed degenerative changes converted the asymptomatic congenital cervical stenosis to symptomatic cervical stenosis. (RX 3, Dep Ex. 2)

Dr. Neal agreed that Petitioner was a surgical candidate with respect to the cervical spine stenosis and that would involve a multilevel cervical decompression. However, Dr. Neal opined that such intervention would not be secondary to any work event or work activities on June 5, 2015. Dr. Neal opined that Petitioner could at that time perform his regular job on a full duty basis. He also stated, "This is not to state he would at all time be without symptoms." (RX 3, Dep Ex. 2)

Petitioner testified that due to lack of pre-approval from workers' comp., the proposed surgery was not completed until April 14, 2016. Dr. Citow performed a three-level discectomy/foraminal decompression/fusion with placement of Cornerstone implants, three level cervical fixation plate, and a total of 8 screws. The post operative diagnosis was, "C4-5, C5-6, and C6-7 cervical spondylosis with disk protrusions with severe cord compression and myelopathy."(PX 3 pp.31-33) All medical and surgical costs in dispute were processed and paid through the group insurance of Petitioner's spouse, Blue Cross Blue Shield. (PX 4)

Post-operatively, Petitioner continued to follow up with Dr. Citow. Physical therapy was prescribed. By July 27, 2016, Dr. Citow documented that Petitioner's neck pain was minimal and he had no radicular pain. The doctor noted that although Petitioner had completed physical therapy, he reportedly did not feel strong enough to return to work. An examination revealed his motor strength was at 5/5 and his sensation was grossly intact. Dr. Citow prescribed work hardening to be followed by a functional capacity evaluation. Dr. Citow noted Petitioner was remain off work until the work hardening and FCE was completed. Dr. Citow released Petitioner to follow up "prn." (PX 3, pp.29, 36-38)

Petitioner testified that he inquired with Athletico about Work Hardening and a Functional Capacity Examination but was told that his insurance would not cover it. Petitioner testified he was able to complete the bulk of his physical therapy but, due to lack of pre-approval from both workers' comp. and his own group health carrier, he was unable to undergo work hardening or the functional capacity evaluation. Petitioner testified that after accumulating out of pocket co-pay expense while attending therapy, he was thereafter unable to afford further therapy, work hardening or a functional capacity evaluation on his own.

Dr. Citow testified via deposition in this matter. Dr. Citow testified that he first saw Petitioner on November 6, 2015. At that time, Petitioner reported that he had a work injury on June 6, 2015 while using a backpack blower. Petitioner reported that he developed neck pain as well as pain between the shoulder blades extending into his chest, and three days later the pain extended through both arms, left more than right, toward the thumbs with numbness and pins and needles, as well intermittent numbness of his legs. (PX 8 p.5) Dr. Citow testified that upon examination Petitioner was very hyper-reflexic which suggested pressure on his spinal cord consistent with myelopathy. Dr. Citow testified that he reviewed an MRI of Petitioner's cervical spine which he felt demonstrated C4-7 three-level severe spondylosis with disk protrusion severely compressing the spinal cord with signal change within the cord itself at C6-7. Dr. Citow stated he assessed symptomatic cervical myelopathy and recommended three-level anterior decompression and stabilization. The surgery was ultimately carried out on April 14, 2016. (PX 8, pp.6-7) Post-operatively, Petitioner's care was uneventful. Dr. Citow stated he last saw Petitioner on July 27, 2016. At that time, he ordered work hardening followed by a FCE indicating Petitioner was not yet strong enough to return to work. (PX 8, p.8) When questioned regarding his causal relationship opinion Dr. Citow stated, relying on the history provided, Petitioner's examination and the imaging studies, "I believe he likely had preexisting cervical spondylosis exacerbated by his work injury causing a new constellation of symptoms of significant severity that ultimately required surgical intervention." (PX 8, p. 9)

Dr. Citow testified that he did not review any treatment records or any physical therapy records, just the MRI imaging. (PX 8 p.12) Dr. Citow had no record or recollection of discussing with Petitioner whether he had experienced similar problems with his back or his neck in the past. (PX 8 p.14) Dr. Citow also testified that if

Petitioner did not have neck symptoms, arm symptoms or numbness; and if he was asymptomatic after the incident and then symptoms didn't occur for months on end, he would be hard-pressed to determine there to be a causal connection. (PX 8 p.20) During the deposition, Dr. Citow was asked to review the June 5, 2015 entry from Vista Corporate Health. The follow questioning and answers are as follows:

Q. And after taking the opportunity to review those, tell me if you find those records to be consistent with the history he provided to you.

A. Yes. This states time of injury, 8:05 a.m., using backpack blower to blow park, and back started hurting, difficulty breathing, back pain. So yes, it appears from his description to corporate health that he was complaining of pain in a timely fashion.

Q. It indicates he was complaining of pain in his back?

A. Yes, middle back, thoracic region, between the shoulder blades, which is a classic place to have pain when you have cervical issues.

Q. That's what he complained to you about when he saw you; is that correct?

A. Correct.

Q. The diagnosis was upper back pain by the corporate health personnel?

A. Yes.

Dr. Citow testified that the MRI revealed a fairly significant myelopathy. The doctor indicated same was at a degree that he would expect someone would not be able to put up with that on years and months without seeking medical attention. When asked if he would find it hard to believe that somebody could work his physical job emptying park trash cans and carrying a backpack leaf blower around for weeks and months, the doctor replied, "[n]ot with the pressure on the spinal cord and being spastic as he was…" The doctor indicated that leads him to believe Petitioner had an acute exacerbation of his preexisting degenerative condition in his cervical spine at or about that time. Dr. Citow explained that "…the changes are definitely long-standing in many ways because you're not going to have one injury and all of sudden blow out three disks the way he has. It looks like something he had degenerative disease ahead of time, but something happened to cause it to worsen and protrude farther, pinch the spinal cord more and force him to become myelopathic. (PX 8, pp.21-23)

Dr. Neal testified via deposition on September 19, 2017. Dr. Neal testified that at Respondent's request, he examined Petitioner on November 13, 2015. In preparation for the examination, he reviewed medical documentation from June 5, 2015 through September 3, 2015, including the records from Vista Health Occupational, the records of Dr. Sekharan, the physical therapy notes and the cervical spine MRI of September 2, 2015. (RX 3 p.7-8) Petitioner related at the time that he was experiencing discomfort in his neck and spine, with shooting symptoms into both hands. Petitioner also described numbness and a pins and needles-type sensation into his legs. Petitioner also reported erectile dysfunction, which the doctor felt could be an important sign neurologically. (RX 3 pp.11-12)

Dr. Neal testified that Petitioner related he developed his symptoms after carrying a leaf blower for 10 minutes on the morning of June 5, 2015. (RX 3, p.10) Dr. Neal stated that he did not consider the event described as an injury "per se." The doctor stated that in his opinion "…there was no accident." Dr. Neal felt Petitioner's history was not consistent with the earliest records. Instead he felt the reported history "…might be consistent with irritating or contusing or straining a thoracic region, which is what he had on the day that he

presented, but it did not injure his neck or upper extremity..." Dr. Neal further stated that he assumed Petitioner felt discomfort carrying the leaf blower, but same was irrelevant with respect to the cervical spine condition which progressed over time. The doctor added, "It was at the very most a thoracic region soft tissue contusion, and that is a completely different anatomic area. And no injury to the thoracic level would have affected the cervical spine because it is below the level of the cervical spine." Dr. Neal stated the Vista Health record of June 5, 2015 did not note neck pain and that any reported cervical or upper extremity complaints did not occur until two months later, or August 2015. (RX 3, pp. 13-15)

Dr. Neal testified that he offered a diagnosis of multilevel degenerative cervical spinal stenosis. The doctor provided that same was confirmed by the MRI of September 2, 2015. He stated the stenosis was extremely tight, 6-7 millimeters, longstanding in nature. He could not identify any acute findings on the MRI. (RX 3, pp. 16-17) Dr. Neal testified that he agreed that Petitioner would benefit from decompression surgery for the stenosis, but same was not secondary to a work event or the activities described to have occurred on June 5, 2015. Irrespective of causation, Dr. Neal felt Petitioner could work at that time without restriction, although he may be symptomatic. (RX 3, pp. 17-18)

On cross examination Dr. Neal was asked whether the activity of carrying a leaf blower could be a competent cause for an aggravation of Petitioner's cervical spine condition. Dr. Neal testified that it was his opinion that such activity would not be an aggravation of Petitioner's preexisting congenital stenosis. When asked the following:

Q. "Is it a competent cause of aggravating symptoms or function, his ability to function as a consequence of the cervical myelopathic condition?

A. Well, he may have symptoms carrying the backpack just like anybody can. And a normally old-age person or a morbidly obese patient may have symptoms with a – with a backpack. But those – the expression of these symptoms are not an aggravation, in the sense that I define aggravation as a permanent worsening. If you're asking me did he feel discomfort wearing a leaf blower, I will say he said he donned it for 10 minutes and he felt discomfort, and I will believe him. If you're asking me did that permanently worsen his condition, the answer would be no..."

(RX 3, pp. 35-36)

Dr. Neal testified that he disagreed with Dr. Citow's causality opinion. Dr. Neal testified, "In my opinion, there's no causal relationship, nor would that activity aggravate a congenital condition, in my opinion. The earliest records did not support there was any neck or upper extremity sensation problems. You're going to have to have those if you're going to have significant upper extremity, cervical contribution. The earliest record didn't even recognize lower extremity neurologic complaints. The earliest two records by two different providers referenced a soft tissue discomfort or contusion or strain of the thoracic region, which is anatomically below the neck, and would not, in and of itself, have any mechanism of injury. So this is a clear-cut case, in my opinion..." (RX 3, pp.38-39)

Petitioner testified that he applied to return to work for Respondent in the winter of 2016/17. He was not rehired. Petitioner testified that he looked for alternative employment with several employers before successfully finding employment on April 1, 2017 as a school bus aide for disabled children earning $10.90 per hour for a 31-hour work week. Petitioner testified that he has not seen Dr. Citow since his July 27, 2016. He complained of ongoing daily discomfort in his neck and arms, more pronounced with activity. He has difficulty assisting his disabled students off the bus. He has difficulty sitting, standing and walking for extended periods of time. He takes regular over the counter pain medications.

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

Petitioner was employed for 10 years as a park maintenance worker with Respondent. As a maintenance worker, Petitioner performed a multitude of tasks including but not limited to picking up and emptying trash as well as using a leaf blower. The physical demands included carrying weights up to 80 pounds. Petitioner testified that on June 5, 2015, he lifted a 25 pound, "messed-up" ill-fitting backpack type, leaf blower onto his back. As he was attempting to adjust the straps and "it pulled back on me." He experienced a sudden sharp pain in his upper back neck area.

According to Petitioner's testimony and the medical records submitted, he had experienced back pain prior to the June 5, 2015 incident. In November 2009, Petitioner treated for a diagnosis of trapezius strain. At that time he had complaints of right back pain and pain to the left trapezius muscle. Petitioner also treated for a thoracic strain that he experienced in July 2010. According to Petitioner, the pain he experienced in 2009 and 2010 resolved and that the pain he experienced on June 5th "was different than any other time."

The dispute in this matter is two-fold. One, Respondent's disputes that Petitioner had cervical complaints contemporaneously with the stipulated accident; and two, there's no causal relationship between Petitioner's cervical condition of ill-being and the stipulated accident. It's undisputed that Petitioner had multilevel degenerative cervical spinal stenosis. Respondent's examining physician, Dr. Neal, did not consider Petitioner's description of the event as an injury "per se." He felt "there no accident." Dr. Neal felt Petitioner's history was not consistent with the earliest records which references "upper back pain." He felt the reported history "...might be consistent with irritating or contusing or straining a thoracic region..." Dr. Neal assumed Petitioner felt discomfort carrying the leaf blower, but same was irrelevant with respect to the cervical spine condition which progressed over time. The doctor added, "It was at the very most a thoracic region soft tissue contusion, and that is a completely different anatomic area. And no injury to the thoracic level would have affected the cervical spine because it is below the level of the cervical spine." Dr. Neal stated the Vista Health record of June 5, 2015 did not note neck pain and that any reported cervical or upper extremity complaints did not occur until two months later, or August 2015. However, Dr. Neal himself noticed that when Petitioner used the word "back" he was referring both to his neck and thoracic region. The Vista records from the date of the accident refer to "upper left back" pain. Dr. Citow testified that Petitioner's description of his neck pain as well as pain between the shoulder blades is commonly understood as "back pain." Dr. Citow further testified that the "middle back thoracic region between the shoulder blades, which is a classic place to have pain with cervical issues."

The MRI revealed Petitioner suffered from the most significant degree of stenosis at the C6-7 level with severe cord compression causing signal change within the cord at that level consistent with Petitioner's myelopathic symptoms and hyperaflexia. Dr. Citow stated that the history, his examination, and the MRI were "very much" consistent with the complaints voiced by Petitioner. As noted above, Petitioner had previous bouts of back pain following lifting incidents at work. The medical records from Vista was reviewed by Dr. Citow during depositional testimony. Dr. Citow acknowledged Petitioner had pre-existing spondylosis but saw no previous evidence of radicular or myelopathic symptoms. In contrast, the significant myelopathy and spasticity evident upon his exam following the June 5, 2015 accident was of a degree that Petitioner would unlikely have been able to fulfill his physical job duties nor avoid seeking medical attention. Dr. Citow testified, "The changes are definitely longstanding in many ways because you are not going to have one injury and all of a sudden blow out three discs the way he has. It looks like something he had degenerative disease ahead of time, but something happened to cause it to worsen and protrude farther, pinch the spinal cord more and force him to become myelopathic..." The doctor agreed the history of the injury provided by Petitioner is consistent with that process The doctor added, "I believe he likely had preexisting cervical spondylosis exacerbated by his work

injury causing a new constellation of symptoms of significant severity that ultimately required surgical intervention."

The Arbitrator finds Dr. Citow's opinions are more persuasive than Dr. Neal's. As such, the Arbitrator therefore finds that a causal relationship exists between Petitioner's cervical condition of ill-being and the accident sustained on June 5, 2015.

With respect to issue J.) Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds as follows:

In evidence without objection is Petitioner's Group Exhibit 4, an itemization of the medical services related to Petitioner's surgery and rehabilitation. The Exhibit lists gross payments of $159,502.69 by Petitioner's group medical carrier on total charges of $272,843.06. The Exhibit is supported by individual HCFA formatted bills. Respondent denies liability for Petitioner's medical expenses, only on the basis of disputed causation, and not the reasonableness or necessity of the treatment itself. Having found Petitioner's condition of ill-being is causally connected to his work injury, the Arbitrator further finds that Respondent is liable for medical expenses in the amount of $159,502.69.

With respect to K.) What temporary benefits (TTD) are in dispute, the Arbitrator finds as follows:

The parties stipulated that Petitioner was temporarily totally disabled from August 6, 2015 through November 25, 2015. Having found Petitioner's condition of ill-being being causally connected and Petitioner's surgery and rehabilitation to have been reasonable and necessary, the Arbitrator finds Petitioner was temporary totally disabled for a further period between November 26, 2015 and July 27, 2016. On July 27, 2016, Dr. Citow ordered work hardening to be followed by an FCE. Petitioner was to be off work until these were completed and his return to work was "TBD". (Pet. Ex. 12, p. 5). Respondent elected not to preapprove the work hardening or FCE. Petitioner testified his group health carrier refused to pay as well. Petitioner testified that he was unable to afford the treatment and therefore attempted to return to work. Respondent refused to rehire him and he sought alternative employment which he secured after a self-directed job search on April 1, 2017.

Based on the above, the Arbitrator finds Petitioner is entitled to temporary total disability benefits for the period between August 6, 2015 and March 31, 2017.

With respect to issue L.) What is the nature and extent of the injury, the Arbitrator finds as follows:

In determining the level of permanent partial disability for injuries incurred on or after September 1, 2011, the Commission shall base its determination on the following factors: (i) the reported level of impairment pursuant to the most current edition of the AMA's 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; (v) evidence of disability corroborated by the treating medical records. (820 ILCS 305/8.1b)

No single enumerated factor shall be the sole determinant of disability. 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)

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

a. A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but are not limited to: loss of range of motion; loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment.

b. Also, the Commission shall base its determination on the following factors:

(i) The reported level of impairment;
(ii) The occupation of the injured employee;
(iii) The age of the employee at the time of injury;
(iv) The employee's future earning capacity; and
(v) Evidence of disability corroborated by medical records.

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

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as a park maintenance worker at the time of the accident and that he did not able to return to work in his prior capacity subsequent to his injury. The Arbitrator notes that Petitioner applied to be rehired but was not, in fact, taken back by Respondent. He ultimately secured employment as a school bus aide for disabled children The Arbitrator therefore gives some weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 35 years old at the time of the accident. Because of his relatively young age and the fact he will be living with an instrumented three-level cervical fusion for a lengthy period of time, the Arbitrator therefore gives greater weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that because Petitioner is earning slightly more per week than at the time of the accident, the Arbitrator gives no weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that Petitioner underwent a three-level instrumented cervical fusion. At his last visit with Dr. Citow on July 27, 2016, it was noted that Petitioner's neck pain was minimal and he had no radicular pain. The doctor noted that although Petitioner had completed physical therapy, he reportedly did not feel strong enough to return to work. An examination revealed his motor strength was at 5/5 and his sensation was grossly intact. Dr. Citow prescribed work hardening to be followed by a functional capacity evaluation. Petitioner was otherwise unable to complete a work hardening program or functional capacity evaluation. Petitioner testified that he has ongoing discomfort with respect to his neck and arms that is increased with physical activity. Petitioner testified that he uses over the counter pain medications to attempt to alleviate ongoing symptoms. The Arbitrator therefore gives greater weight to this factor.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained a permanent partial disability to the extent of 30% loss of use of a man as a whole pursuant to §8(d)(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

MAUREEN MCARTHUR,

Petitioner,

vs.

NO: 17 WC 20120

20IWCC0083

KOHL'S DEPT. STORES,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review of the Decision of the Arbitrator having been filed by the Petitioner herein, and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical services, prospective medical care, temporary total disability and temporary partial disability, and being advised of the facts and law, affirms and adopts the §19(b) Decision of the Arbitrator, filed on February 14, 2018, and corrects a scrivener's error, said Decision being attached hereto and made a part hereof.

The Commission corrects a scrivener's error in the form of an omission of the word "not" in the Arbitrator's Decision at page 18, first full sentence, in the paragraph continued from page 17, wherein it should read that "...the employee simply would not have been equally exposed to apart from his or her employment." (Arb. Dec., p. 18) Any other reading of this sentence is inconsistent with the Courts' decisions in the referenced cases, and with the Arbitrator's Decision.

All else otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on February 14, 2018, is hereby modified for the reason of correcting a scrivener's error as stated herein, and otherwise affirmed and adopted.

e80ccsios

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 bond requirement in Section 19(f)(2) is applicable only when "the Commission shall have entered an award for the payment of money." *820 ILCS 305/19(f)(2)*. Based upon the denial of compensation herein, no bond is set by the Commission. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JAN 30 2020
KAD/bsd
O121019
42

Kathryn A. Doerries

Thomas J. Tyrrell

Maria E. Portela

Contents

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

McARTHUR, MAUREEN
Employee/Petitioner

Case# **17WC020120**

KOHL'S DEPT STORES
Employer/Respondent

20IWCC0083

On 5/23/2018, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.08% 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:

1357 RATHBUN CSEVENYAK & KOZOL LLC
NICK JERDE
3260 EXECUTIVE DR
JOLIET, IL 60431

0766 HENNESSY & ROACH PC
GUY N MARAS
140 S DEARBORN ST SUITE 700
CHICGO, IL 60603

Specimen

20IWCC0083

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

20IWCC0083

☐ 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)

Maureen McArthur
Employee/Petitioner

v.

Kohl's Dept. Stores
Employer/Respondent

Case # **17** WC **20120**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Ketki Steffen**, Arbitrator of the Commission, in the city of **Geneva**, on **2/14/18**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☐ What were Petitioner's earnings?

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

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

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

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

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

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

N. ☐ Is Respondent due any credit?

O. ☐ Other _____

FINDINGS

On the date of accident, **May 2, 2017**, Respondent ***was*** operating under and subject 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 $**18,239.00**; the average weekly wage was $**350.73**.

On the date of accident, Petitioner was **56** 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 $**1,937.44** for TTD, $ for TPD, $ for maintenance, and $ for other benefits, for a total credit of $.

Respondent is entitled to a credit of $**7,140.75** under Section 8(j) of the Act.

ORDER

Respondent shall be given a credit of $**1,937.44** for TTD, $ for TPD, and $ for maintenance benefits, for a total credit of $.

Respondent shall be given a credit of $**7,140.75** for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall be given credit for $ for benefits paid under Section 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.

KSSteffen
Signature of Arbitrator

5/21/18
Date

ICArbDec19(b)

MAY 23 2018

FACTUAL HISTORY

On the date of hearing, Maureen McArthur, Petitioner, testified she was working for Respondent, Kohl's Department Store on May of 2017. She began working for Respondent in October of 2010 and currently worked as a sales associate in the shoe department. Petitioner is currently working for Respondent as a shoe lead. She indicated that in the first 3 years of work for Respondent, she had been a sales associate working the floor in different departments.

Petitioner testified that she performs multiple tasks as a shoe lead. Her first priority is taking care of customers and helping them find what they are looking for by checking the stockroom, calling other stores and searching on the kiosk. She is also responsible for ensuring that all the shoes in the store are in the right place with the correct tags attached to them. Petitioner is also responsible for making sure the part-time employees get everything done. On truck days, Petitioner is responsible for new shoe shipments and places the shoes in the stockroom or on the floor. She is also responsible for collecting mismatched shoes and placing them on a designated shelf. Twice a week she receives a list of information that contains what is supposed to be on the "ESLs" throughout the store. She described "ESLs" as the electronic price signs in front of products.

She indicated that her position was not always contained within the show department. She stated that she would help other departments when associates went on break or lunch, accept phone calls, help customers in other departments and step in at the registers to check customers out with their items. Further, she would go to

customer service and get anything from the return baskets to take it back to her department. She stated she walks around the entire time while at work.

Ms. McArthur worked 32-36 hours per week. Her shift began at different times every week depending on whether or not she was assigned the morning, afternoon or night shift. She is paid $11.01 per hour of work and does not work overtime. Her time for breaks and lunch vary depending on the length of her day. She takes either two breaks for 15 minutes and an hour lunch when she works an 8 hour day, a 15 minute break when it is a 5 hour day or a 20 minute break when she works for 6 hours. She indicated that she does not sit down at work besides for break and lunch and is not allowed to do so otherwise. Petitioner explained that she felt the reason for taking breaks was to relax due to the constant walking around involved in a retail sales job. She indicated she used her breaks to rest her legs, feet, and mind due to the running around required by her job.

When she started work, her boss showed her the break and lunch room she can use during breaks. She did not clock out when she was on break and was required to clock out when she was at lunch. The break room contained chairs, tables, two refrigerators, microwave, TV, vending machines and a sink.

The chairs in the breakroom were described as thin metal framed chairs with a plastic mold back and seat that sits on the metal frame. Petitioner labeled them as sled based chairs. She indicated there were no arms on the chairs. The chair was normal height of about 2 feet off the ground. She also indicated the metal legs/bars do not touch the floor on these particular chairs. She indicated four clips are located on the

metal bars on the base of the chair about two inches from the ends and cause the chair to rock.

On the date of accident, May 2, 2017, Petitioner was working in her capacity as shoe lead. On that date, she was doing clearance. She described that process as going around placing tickets on items that are on clearance. This involved working throughout the entire store while moving all day without resting. She believed she was working a six-hour work day. She testified she took a mandatory break after working and being on her feet for 3 hours.

Ms. McArthur took her break in the designated break room at the store as she always does when working. She went to the refrigerator, grabbed her lunch bag and sat down. She then got up from her seat to go get her phone out from her purse. Upon returning to her seat, she sat on the chair and it slid out from under her and she landed on her left side. She believed she didn't sit all the way back in the chair and was almost dumped out of the chair. She stated she believed the chair tipped forward, she fell hard and fast and landed on her left hip and shoulder. The chair ended up behind her and was tipped over on its side. She also indicated that the plastic mold remained intact on the metal frame.

In regard to her cell phone, Petitioner testified she retrieved it from her purse to check her messages. She was not allowed to use her cell phone during work hours except on break and at lunch. She indicated she was checking for messages from her children. She explained she uses her phone at lunch to see what her kids are doing, call them or go on Facebook to relax. It was further testified that other employees do the same at break time.

Petitioner indicated that she hurt her neck, shoulder and left side of her body due to the left side impact. She was initially startled and worried due to sciatica in her back. She finished her workday and had the next day off. She figured she could shake it off, but everything continued to get sore and went to work Thursday and reported it to her boss Erin that it was getting worse. An accident report was filed and she did not work on that day.

Petitioner first sought medical treatment on May 5, 2017 with her primary care doctor, Dr. Kunchala. She indicated she saw her for pain on the left side of her body from a fall from a chair at work. Dr. Kunchala noted her history as a fall from a chair at work and that she has not been feeling better since then with back pain and left shoulder pain. (PX4) After a physical examination, the doctor assessed her with acute left shoulder pain and acute left-sided low back pain without sciatica. (PX4). Dr. Kunchala recommended avoiding lifting, pulling, pushing anything heavy and believed she would benefit from physical therapy. (PX4)

On May 19, 2017, Petitioner followed-up with Dr. Kunchala indicating her left shoulder had become worse as well as pain radiating from her back into her buttock and left thigh and knee. She was also experiencing neck pain at this time. She performed a physical examination and found tenderness in her left shoulder as well as decreased range of motion in her lumbar spine. The doctor continued to recommend physical therapy and wanted her in for an evaluation with a pain clinic to address her neck and back pain. She also prescribed imaging for her neck and tramadol for pain. (PX4)

When Petitioner saw Dr. Kunchala again on June 12, 2017, she testified she was still having problems with her shoulder and neck, but also experiencing problems in

her left hip. The records indicate left knee problems with inability to bear weight with mild relief from NSAIDs. Her shoulder pain was 5/10 and she indicated limited range of motion. Further, she now presented with left hip problems including inability to bear weight. A physical examination continued to indicate left shoulder tenderness and decreased range of motion in her left hip. Dr. Kunchala again prescribed physical therapy and referred her to an orthopedic. (PX4)

Petitioner saw Dr. Robert Thorsness at Hinsdale Orthopaedics on June 20, 2017. She gave a history of her fall off of a chair at work onto her left side. Her pain was reported as a 5/10 especially in the posterior superior region and down the side of her arm. The doctor performed a physical examination and found positive findings regarding her left shoulder. His impression was she suffered from left shoulder subacromial impingement, a.c. joint arthroplasty, glenohumeral arthritis, extensive labral tear, and biceps tendinitis. He recommended she get a left shoulder MRI and limited her work to 10 pounds lifting. (PX2)

Almost one week later she saw Dr. Bradley Dworsky at Hinsdale on June 26, 2017 and presented with left knee, hip and lower back pain. She did indicate her accident and denied any history of left sided pain prior to the accident. However, she did indicate she has stenosis in her lower back and previously underwent epidural steroid injections. Her physical exam revealed tenderness over the medial and lateral joint line in her left knee and pain with range of motion in her left hip. The doctor ordered a left hip MRI and restricted her to be off- work. (PX2) She did undergo MRI's on her left hip and shoulder on June 29, 2017.

Dr. Thorsness reviewed her MRI of her left shoulder with her on July 3, 2017. The MRI demonstrated a.c. joint arthropathy, rotator cuff tendinosis, extensive labral tear, and degenerative glenohumeral joint. Dr. Thorsness had the same impression as her previous visit and felt some of the pain complaints were a result of chronic conditions including a.c. joint arthroplasty and glenohumeral arthritis. However, he did indicate that he believed the work related injuries caused an acute exacerbation of her chronic conditions. He recommended, based on his findings, that she undergo a subacromial injection and physical therapy for the left shoulder. She did undergo that injection and he restricted her work to a 5 pound maximum lift with her left arm as well as no lifting above her left shoulder. (PX2)

When she saw Dr. Dworsky on July 12, 2017 she was still experiencing pain in her hip and butt, medial and lateral knee and lower back. The MRI demonstrated labral changes possibly consistent with FAI, but showed a lot of fluid within trochanteric bursa and tendon inflammation. Based on the findings, he recommended physical therapy and a possible future injection. Dr. Dworsky gave her a work restriction of no prolonged standing, squatting and a 10 pound weight restriction. (PX2)

Petitioner returned back to work on restricted duty around July 23, 2017. She indicated that Respondent was accommodating and didn't place her in a position that would harm her. She testified that she was getting sore faster when she returned to work as compared to when she was off of work.

On August 8, 2017, Petitioner reported to Dr. Thorsness that her pain had increased to 7/10 and physical therapy was working on her neck and shoulder. The doctor recommended an anti-inflammatory for her neck and limited her to 20 hours a

week at work. Petitioner indicated at trial that she did receive relief in her shoulder from the injection. (PX5)

Petitioner saw Dr. Dworsky on August 25, 2017 and indicated her pain was at 4/10 and no longer radiating into her left thigh. He recommended she keep at physical therapy and continue with his previous restrictions. She was also indicating slight improvement when she saw Dr. Thorsness on September 19, 2017. Her range of motion was better, but continued with neck pain and shoulder pain that could reach 8/10. Dr. Thorsness also wanted her to continue with physical therapy and same restrictions as well as 20 hour work weeks. (PX5)

Her complaints of outer aspect hip pain lead Dr. Dworsky to perform an injection in her hip on September 20, 2017. (PX5) Petitioner indicated that she believed that the injection was performed in order to allow her some pain relief during physical therapy. However, between her September 20, 2017 visit and her October 16, 2017 visit, she only had two physical therapy sessions due to lack of approval by Respondent. Petitioner indicated to Dr. Dworsky in October that she did get relief from the injection and Dr. Dworsky recommended that she try to continue physical therapy and wanted her restrictions to remain. (PX7) Petitioner testified that she became more sore and painful without the physical therapy.

When Dr. Thorsness saw Petitioner on November 3, 2017, she indicated that physical therapy had not been approved and she continued to have pain in her shoulder. He continued to recommend physical therapy over a potential surgery and kept her restrictions the same. (PX7) Dr. Dworsky reported her pain complaints in her left hip had decreased on January 3, 2018, but wanted her to maintain her current

restriction of no squatting or prolonged standing. He indicated there may be an expected shoulder surgery and wanted to wait until after for more physical therapy. On that same date, Dr. Thorsness recommended surgery for her left shoulder after failed conservative care. He requested a left acromioplasty, distal clavicle excision, possible rotator cuff repair depending on intraoperative findings, and open biceps tenodesis. He continued her restrictions. (PX8)

On the date of hearing, Petitioner testified her surgery was denied. She indicated as of January 26, 2018, Dr. Thorsness recommended creams and acupuncture to try to help while waiting for surgery approval. She testified she was receiving some relief from the cream. In regard to her time in physical therapy from June 14, 2017 until September 27, 2017, she indicated her neck manipulations made her feel better. However, since therapy was stopped, she indicated the pain in her shoulder, neck and hip has increased as well pain when in her hip when standing too long and going up stairs. She is planning to have the surgery as recommended by Dr. Thorsness.

Respondent sent Ms. McArthur to Dr. Daniel Troy for a Section 12 examination on July 24, 2017. (PX9) She indicated a history of injury to her cervical spine, left shoulder, low back and left hip. She reported the accident to the doctor and he indicated in his report the medical history. He also took her past medical history and performed a physical examination along with a review of her MRIs for her left shoulder and hip. (PX9)

After reviewing everything, he diagnosed Petitioner with left shoulder pain with mild impingement symptomatology, left-sided cervical strain with secondary radiating

into the trapezial and left periscapular region, left greater trochanteric bursitis, lumbrosacral junctional pain in the L5-S1 level without radiculopathy and a resolved knee strain. He further indicated her pain complaints could have been sustained from the type of injury she suffered and believed her complaints were causally connected to the date of accident. (PX9)

Dr. Troy also concluded that all medical treatment had been reasonable, necessary and related to the accident. Further, he believed an additional four weeks of physical therapy and a hip injection could be needed. He indicated she should return to work with a 10-pound lifting restriction with no over the shoulder lifting and return to work full duty in four weeks. He did not believe she was at maximum medical improvement. (PX9)

Petitioner testified that she returned to work light duty in July of 2017 and was working 32 hours per week and then subsequently 20 hours per week based on Dr. Thorsness's restrictions. Petitioner was shown her paystubs from Kohl's and testified they had come directly from the Respondent's website and that they were an accurate reflection of her wages. She also indicated that she has not carried group insurance through Kohl's since July of 2016

FINDINGS/ANALYSIS

On the issue of whether the petitioner sustained an accident arising out of and in the course of her employment, the Arbitrator finds as follows:

The Arbitrator finds that the Petitioner did not sustain an accident arising out of and in the course of her employment. In order for an employee to recover benefits under the Illinois Workers' Compensation Act, they must demonstrate that the injury arose out of and in the course of their employment. *Orsini v. Industrial Comm'n*, 117 Ill.2d 38, 44 Ill.Dec. 166, 509 N.Ed.2d 1005 (1987). The risk of injury must be a risk peculiar to the work or a risk to which the employee is exposed to a greater degree than the general public by reason of their employment. *Orsini*, 117 Ill.2d at 45, 109 Ill.Dec. 166, 509 N.E.2d 1005.

The Arbitrator recognizes that under the personal comfort doctrine, the Petitioner was in the course of her employment in the breakroom at the time of the accident at issue. Therefore, she has satisfied the "in the course of" prong of the accident analysis. However, the Petitioner must also demonstrate that her accidental injury arose out of her employment. *Karastamatis v. Industrial Commission*, 306 Ill.App.3d 206, 713 N.E.2d 161, 238 Ill.Dec. 915 (1st Dist. 1999)

The Arbitrator finds that she did not prove that the incident arose out of her employment. The Petitioner did not testify that there was any moisture or debris at or around the location of the chair at issue. The Petitioner also did not testify that the chair was broken or defective in any way. The record shows that Petitioner was in the designated lunch/break room. Petitioner was not required to clock out when she was on break and was required to clock out when she was at lunch. Although Petitioner testified that she retrieved her lunch from the fridge just prior to her accident, the evidence in not

clear if this was a paid break or a lunch break. Petitioner was only working 6 hours and not a full 8-hour work day when she was injured. Additionally, the Petitioner testified that she was retrieving her personal cell phone from her purse to check her personal (none work-related) messages. Her testimony is that the injury occurred after she got her phone and was in the process of sitting down on the chair. There was no evidence presented that the chair was defectively designed. There are no photographs or testimony from the Petitioner that the chair or the floor defect caused or contributed to the injury. Petitioner simply bent to sit in the chair and either misjudged the location of the seat or the chair shifted as she tried to sit on it. The Petitioner fell a distance of two feet on her side and fell on the floor. Petitioner claims that the fall caused injury to multiple body parts including her shoulder, neck, back, hip and knee.

Based on the factual evidence and the relevant case law, the Arbitrator finds that the Petitioner did not meet her burden that her fall arose out of her employment.

In denying compensation, the Arbitrator notes the facts and findings in *Nunzia Maciacci v. PartyLine Distributions*, 13 WC 206, 14 I.W.C.C. 0246. *Maciacci* was on break in the company cafeteria much like the petitioner in the instant matter. In *Maciacci,* the Commission noted that under the personal comfort doctrine, the petitioner was in the course of her employment.

Maciacci testified that she was sitting in a chair. She described it as a chair with case plastic and a metal frame that did not have wheels. The Arbitrator finds similarity between the chair described in the *Maciacci* case and the instant case. *Maciacci* testified that she stood up, the chair slid and she fell to the ground. *Maciacci's* supervisor testified

that the cafeteria floor was neither slippery or wet. The supervisor further testified that there were no debris or objects on the floor and the chair was not broken.

The fact pattern in *Maciacci* and the instant case are indistinguishable on the relevant points. The Commission found that *Maciacci* failed to prove that her injuries arose out of her employment. Here, the Arbitrator finds that the Petitioner has failed to prove that her injuries arose out of her employment. Petitioner was, most likely, on her unpaid lunch break. There is no requirement she remain on the premises. The chair was not broken or damaged and the Petitioner was sitting down to use her personal phone and eat lunch. Petitioner McArthur's fall happened during her time of personal comfort.

Additionally, the Arbitrator finds that her case is distinguishable from cases where the 'arising out of' element in the context of the 'personal comfort doctrine' have been interpreted to include a favorable finding for Petitioners. In situations where a worker is engaged in a personal comfort that helps an employee carry on the remainder of their employment duties, the courts have often supported a finding of compensation for an injured employee. In Union Starch, Div. of Miles Labs., Inc. v. Indus. Comm'n, 56 Ill. 2d 272, 276, (1974) the Claimant was on break after working in a warm environment. Many employees, including the Claimant, often sought cool relief from that environment at break time. The Union Starch employees would retrieve beverages from a machine and step out on to a roof of one of the buildings on the premises. Id. at 274. On the date of accident, claimant took his break and went on to the roof to escape his work environment. Id. However, the roof collapsed on that date and he was injured. Id.

The Court analyzed the "arising out of" element in that case and concluded claimant had met his burden. The Court found that seeking relief from the work

environment on the premises showed the cause of the injury was related to the employment and not simply a hazard he would have been equally exposed to apart from his employment. Id. at 276.

The Scheffler case followed similar reasoning. Scheffler Greenhouses, Inc. v. Indus. Comm'n, 66 Ill. 2d 361, 367 (1977) The claimant in Scheffler worked in a hot environment at a greenhouse in the summer. During lunch hour, the employer allowed the employees to use a pool on a nearby property. Scheffler, 66 Ill. 2d at 364. This was next to a greenhouse roof in which the employees often rested during lunch time. Id. On the date of accident, claimant was on the roof of the greenhouse near the pool when a glass panel broke and she experienced an injury. Id. The court found the injury "arose out of the employment"

The Court concluded that the use of the pool could be found to be a benefit to the employer. Id. at 367. Also, the Court found it reasonable to infer that the work environment was a causative factor in the injury considering the use of the pool was necessitated in order to provide relief from the work environment. Id. Therefore, claimant was exposed to a risk she would not have been exposed apart from her work environment and the injury "arose out of the employment".

In light of the above cases (Union Starch and Scheffler) it may appear, at first blush, that an employee who is injured during a break which helps the employee relax and continue the work duties, has suffered a compensable injury. However, upon a more keener reading, it is evident, that the employer's liability, among other factors, hinges on the added risk of hazard. If the environment that the employer controlled or provided causes the employee to be exposed to an additional risk or hazard that they otherwise

would not be exposed to, the injury may be compensable. In both these cases, the court found that the 'defective collapsing roof' and the 'breaking glass panel' were hazards that the employee simply would have been equally exposed to apart from his or her employment. A shifting chair is simply not such a hazard.

In Petitioner McArthur's case, the facts show that the Petitioner simply misjudged the location of the chair as she was attempting to sit down after retrieving her lunch and personal cell phone. There is no defect in the chair. The act of misjudging the seat of a chair is not a unique hazard of employment but rather a happenstance that is personal to the Petitioner and may follow her at work or home. To find liability under these circumstances creates a result that does not comport with standing caselaw.

Therefore, while sympathizing with Petitioner's plight and giving due credit to the tiring nature of a sales associate's job, the Arbitrator finds that Petitioner's injury did not "arise out of" her employment.

Based on the foregoing, the Arbitrator denies that the petitioner sustained a work-related accident and compensation is denied. All other issues are moot.

ILLINOIS WORKERS' COMPENSATION COMMISSION

Illinois Workers' Compensation Commission Petitioner, v. Roman Popovych, Individually and as President and Secretary of VP Interlink, Inc. Respondent.	)	15 INC 360 18WC 27988

ORDER

This matter, after oral request by the Petitioner, The Illinois Workers' Compensation Commission – Insurance Compliance Division, by and through its attorney, the Office of the Illinois Attorney General, is dismissed. The Office of the Attorney General has advised this Commission it no longer seeks to proceed in this matter against Respondents, as this matter has settled.

JAN 10 2020

Stephen J. Mathis

Commissioner Stephen Mathis

Dated: 12/19/2019

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

STATE OF ILLINOIS)

COUNTY OF COOK)SS.

AMADOR CASAS,

Petitioner,

v.

CHEVY'S FRESH MEX,

Respondent.

NO. 08 WC 036905

19IWCC0491

ORDER

This cause comes before the Commission on Petitioner's Motion to Correct Clerical Error Pursuant to Section 19(f) of the Act. The Commission, after having been fully advised in this matter, finds and orders as follows:

1) The Commission issued a Decision and Opinion on Review in this matter on September 10, 2019.

2) The Decision and Opinion on Review was emailed per Commission Rules to each party on September 10, 2019.

3) The parties both received an email from the Commission on September 10, 2019, containing the Decision and Opinion on Review.

4) Petitioner filed his Motion to Correct Clerical Error Pursuant to Section 19(f) of the Act on September 27, 2019 which is 17 days after the receipt of the Decision and Opinion on Review.

The Commission finds that on September 27, 2019, the 15 day period during which a party could file a Motion to Correct Clerical Error Pursuant to Section 19(f) had expired, and for this reason Petitioner's Motion is denied as untimely.

In addition, the Commission has reviewed the Commission's award of wage differential benefits pursuant to Section 8(d)(1) and finds that there was no clerical or computational error made in the calculation of the award.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's Motion to Correct Clerical Error Pursuant to Section 19(f) of the Act is hereby denied.

IT IS FURTHER ORDERED BY THE COMMISSION that the Decision and Opinion on Review of the Commission filed on September 10, 2019, shall remain the Decision of the Commission.

Dated: JAN 3 1 2020
SJM/msb
44

Stephen J. Mathis

D. Douglas McCarthy

Douglas McCarthy

L. Elizabeth Coppoletti

L. Elizabeth Coppoletti

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

STATE OF ILLINOIS)
COUNTY OF KANKAKEE)SS.

LORNA MOSLEY,

Petitioner,

v.

STATE OF ILLINOIS/ SHAPIRO DEVELOPMENTAL CENTER,

Respondent.

NO. 09 WC 15059
19IWCC0612

ORDER

This matter having come up for hearing on Respondent, State of Illinois Shapiro Developmental Center's Motion to Reconsider the Commission's denial of Respondent's Motion To Recall under Section 19(f) of the Act, entered December 23, 2019, due notice having been given and both parties represented by counsel; and the Commission being advised in the premises;

Respondent's Motion for Reconsideration is hereby denied on the basis that there was no error in the Commission's application of the law.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent's Motion for Reconsideration filed January 8, 2020 is hereby denied.

JAN 31 2020

STEPHEN J. MATHIS

DOUGLAS McCARTHY

L. ELIZABETH COPPOLETTI

SJM/msb
44

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Juan Zamora, a/k/a Clemente Camacho,
Petitioner,
vs.

NO: 15 WC 26630

20IWCC0084

Oss Services 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 nature and extent and being advised of the facts and law affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 16, 2019, is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $27,200.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: JAN 31 2020
o012320
BNF/mw
045

Barbara N. Flores

Deborah L. Simpson

Marc Parker

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ZAMORA, JUAN B A/K/A CLEMENTE CAMACHO
Employee/Petitioner

Case# **15WC026630**

OSS SERVICES LLC
Employer/Respondent

20IWCC0084

On 7/16/2019, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 2.01% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0800 BARRY E BLUMENFELD
3424 W 26TH ST
CHICAGO, IL 60623

0532 HOLECEK & ASSOCIATES
STUART PELLISH
131 N CLARK ST SUITE 800
CHICAGO, IL 60601

J. Zamora a/k/a Clemente Camacho v. OSS Services, LLC, 15 WC 026630

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Juan Zamora a/k/a Clemente Camacho
Employee/Petitioner

v.

OSS Services, LLC
Employer/Respondent

Case # **15** WC **026630**

20IWCC0084

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Jeffrey Huebsch**, Arbitrator of the Commission, in the city of **Chicago**, on **December 12, 2018 and January 10, 2019**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

20IWCC0084

FINDINGS

On **August 3, 2015**, Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did*** exist between Petitioner and Respondent.

On this date, Petitioner ***did*** sustain an accident that arose out of and in the course of employment.

Timely notice of this accident ***was*** given to Respondent.

Petitioner's current condition of ill-being ***is*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$19,722.56**; the average weekly wage was **$379.28**.

On the date of accident, Petitioner was **29** years of age, ***married*** with **1** dependent children.

Petitioner ***has*** received all reasonable and necessary medical services.

Respondent ***has not*** paid all appropriate charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$18,335.14** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$18,335.14**. The Parties agreed that all TTD benefits have been paid.

ORDER

Upon Petitioner's tendering proper bill forms with CPT codes to Respondent, Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $300.00 to Advocate Illinois Masonic Medical Center (DOS: 9/7/2016) and $309.00 to Advocate Illinois Masonic Medical Center (DOS: 1/27/2017), as provided in Sections 8(a) and 8.2 of the Act and as set forth below.

Respondent shall pay Petitioner permanent partial disability benefits of $286.00/week for 94.875 weeks, because the injuries sustained caused the 37.5% loss of the left arm, as provided in Section 8(e) of the Act.

Respondent shall pay Petitioner all compensation that has accrued from 8/3/2015 to 1/9/2019 in a lump sum and shall pay the remainder of the award, if any, in weekly benefits.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

July 16, 2019
Date

JUL 16 2019

FINDINGS OF FACT

20IWCC0084

Petitioner testified via a Spanish/English interpreter.

The Parties stipulated that Petitioner, Clemente Camacho also known as Juan Zamora, suffered accidental injuries, arising out of and in the course of his employment by Respondent, OSS Services, LLC, on August 3, 2015.

Petitioner worked for Respondent, a labor service company. He was assigned to work at a meat packing company where he would wash a conveyor machine with a power hose.

While performing his work assignment, the glove on Petitioner's left hand got caught in the conveyor machine. Petitioner suffered a crush injury to his left arm. Petitioner noticed that his left arm started to swell. He also noticed pain on the medial side of the left arm.

Petitioner received initial medical care at Holy Cross Hospital. He was transferred by ambulance to Mount Sinai Hospital. On August 4, 2015, Dr. Kaymakcalan performed a left arm dorsal fasciotomy and debridement of a hematoma. On August 7, 2015, Dr. Kaymakcalan performed a secondary closure of the left forearm fasciotomy with skin relaxing incisions. Petitioner was discharged from Mount Sinai Hospital on August 8, 2015. (PX 1, RX 10)

Post surgery, Petitioner underwent a course of physical therapy. He remained under the care of Dr. Kaymakcalan. (PX 1)

Petitioner started complaining of tingling and numbness in his left elbow and he underwent a EMG/NCV test on November 23, 2015, which demonstrated partial lesion to the left posterior interosseous nerve with no findings of ulnar nerve abnormality. (RX 12)

Petitioner underwent flexion block splinting of the left elbow. A subsequent EMG/NCV performed on May 20, 2016 was interpreted as showing no electrodiagnostic evidence of left sided mononeuropathy, brachial plexopathy or cervical radiculopathy. (PX 1)

Petitioner underwent a Functional Capacity Evaluation, performed at Nova Care, on September 26, 2017. He demonstrated the ability to function at a medium physical demand level.and was found to be able to lift 50 pounds from floor to wait, 45 pounds waist to shoulder, carry up to 50 pounds, push 55 pounds and pull 60 pounds. (RX 5)

Petitioner was also seen by Dr. Kenneth Candido, a pain specialist, who on December 28, 2016 injected his left elbow with Depo-Medrol. This did not provide any relief to Mr. Camacho. (PX 2)

On November 22, 2017, Dr. Candido released Petitioner to return to work consistent with the restrictions noted in the FCE. When released from Dr. Candido's care, Petitioner was not taking any prescribed medication. (PX2, RX 4)

For the two years prior to hearing, Petitioner has been working full time. He is working in the same position he was working on the date of accident. He cleans, sweeps and mops, using both of his hands. He is working the

same number of hours as he was working at the time of accident. He is earning more money now than he earned at the time of the work accident, August 3, 2015.

Petitioner testified he currently uses his left hand to clean the conveyor machines with a hose. He writes with his right hand. He cleans, sweeps and mops, using both of his hands. Dr. Kaymakcalan's records state that Petitioner is right hand dominant. (PX 1)

Petitioner has no pending medical appointments. His last medical appointment was November 22, 2017.

Petitioner testified he continues to have pain below the elbow to his fingers. He feels more pain on the medial side of the elbow while working. He testified to experiencing tingling into his middle and ring fingers. He continues to play soccer. He takes over the counter Tylenol for pain. He wears no brace on his arm. He is able to feed and dress himself.

The Arbitrator viewed Petitioner's left arm. The Arbitrator noted scarring of about eight inches in lengths, beginning on the lateral side of the left elbow. The Arbitrator noted the scarring was raised a bit. The Arbitrator noted at its widest point, measuring half an inch, there was scarring in the upper end of the elbow measuring two inches. The scarring was dark in color.

Petitioner was examined on three occasions by Dr. Robert Wysocki at Respondent's request; February 29, 2016, November 18, 2016 and August 10, 2018. (RX 1, 2 and 3)

CONCLUSIONS OF LAW

The Arbitrator adopts the above Findings of Fact in support of the Conclusions of Law that follow.

To obtain compensation under the Act, Petitioner has the burden of proving, by a preponderance of the evidence, all of the elements of his claim. O'Dette v. Industrial Commission, 79 Ill. 2d 249, 253 (1980)

Decisions of an arbitrator shall be based exclusively on evidence in the record of proceeding and material that has been officially noticed. 820 ILCS 305/1.1(e)

Is Petitioner's current condition of ill-being causally connected to the August 3, 2015 accident?

Petitioner's current condition of ill-being regarding his left upper extremity is causally related to the injury. The Arbitrator bases this finding on the unrebutted testimony of Petitioner and the medical records.

Is Respondent liable for unpaid medical bills?

Petitioner's Bills Exhibit was PX 4. The Parties advised the Arbitrator that all bills had been paid, with the exception of two bills from Advocate Illinois Masonic Hospital. Respondent agreed to pay the said bills when they are submitted in the correct form.

The awarded bills are:

Date of Service	Amount
September 7, 2016	$309.00
January 27, 2017	$300.00

20IWCC0084

Respondent shall pay the same, in accordance with §§8(a) and 8.2 of the Act (per the fee schedule or negotiated rate), upon receipt of the correct documentation from Petitioner.

Respondent shall, of course, be entitled to a credit for all awarded bills that it has paid.

What is the nature and extent of the injury?

Consistent with the requirements of §8.1b of the Act, 820 ILCS 305/8.1b(b)(West 2014), the Arbitrator explains the weight placed upon the enumerated factors in reaching his conclusion regarding the award of PPD.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no permanent partial disability impairment report and/or opinion was submitted into evidence. The Arbitrator therefore gives no weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as a Janitor/Laborer at the time of the accident and that he is able to return to work in his prior capacity as a result of the injury. Petitioner has returned to his pre-accident position. The Arbitrator gives appropriate weight to this factor

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes Petitioner was 30 years of age on the date of accident. The Arbitrator observes Petitioner is still relatively young, has many work years ahead of him and will therefore have to deal with the effects of his injury for a longer period of time. The Arbitrator gives greater weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes Petitioner testified that he makes more money at the time of hearing than what he was earning at the time of the accident. The accident did not cause any economic harm to Petitioner. The Arbitrator gives greater weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes Petitioner is a right hand dominant male who suffered a crush injury to his left arm. He underwent surgery. Electrodiagnostic studies failed to show any nerve entrapment at the elbow to explain Petitioner's ongoing complaints of elbow pain. The Functional Capacity Evaluation demonstrated that Petitioner was able to work at the medium physical demand level. Respondent's examiner, Dr. Robert Wysocki, in his August 10, 2018 report noted grip strength of 88 pounds on the right, 55 pounds on the left. Petitioner is working full time. He returned to working the same job position he worked at the time of the accident. He is working the same number of hours he was working at the time of the accident, earning more money than at the time of accident. He takes OTC medications for pain complaints. There are no current doctor's appointments. The Arbitrator gives more than moderate weight to this factor.

20IWCC0084

Based on the above factors, and the Record taken as a whole, the Arbitrator finds that as a result of the injuries sustained, Petitioner suffered permanent partial disability to the extent of 37.5% loss of use of his left arm pursuant to §8(e) of the Act.

STATE OF ILLINOIS	)	☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
	)SS.	☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
COUNTY OF MCLEAN	)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
		☐ Modify	☐ PTD/Fatal denied
		☒ ON REMAND FROM APPELLATE COURT	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Melanie Martin,

Petitioner,

vs. NO: 15 WC 29983

AT&T, a/k/a AT&T Services, Inc.,

Respondent.

20IWCC0085

DECISION AND OPINION ON REMAND

This matter now comes before the Commission on remand from the Appellate Court. The Commission, in relevant part, affirmed the Arbitrator's ruling that Petitioner did not sustain an accident that arose out of and in the course of employment. The Circuit Court of Peoria County affirmed the Commission's ruling. On appeal, the Appellate Court reversed the Circuit Court's order confirming the Commission's decision, vacated the Commission's decision, and remanded the matter for further consideration consistent with its opinion.

The Commission hereby incorporates by reference the findings of fact contained in the arbitration decision to the extent it does not conflict with the Appellate Court's order dated May 2, 2018. The Commission also incorporates by reference the Appellate Court's order, which delineates the relevant facts and analysis, attached hereto and made a part hereof.

The Appellate Court ruled that Petitioner's accident occurred "in the course of" her employment. *Martin v. Illinois Workers' Compensation Comm'n*, 2018 IL App (3d) 170344WC-U, ¶ 24. The court relied upon the rule that "'accidental injuries sustained on an employer's premises *within a reasonable time before and after work* are generally deemed to arise in the course of the employment.'" (Emphasis added.) *Id.* ¶ 23 (quoting *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill. 2d 52, 57 (1989)). The court also rejected the argument that Petitioner's decision to return for her personal cell phone was outside the scope of her employment, given that the stairs on which she fell remained on Respondent's premises. *Martin*, 2018 IL App (3d) 170344WC-U, ¶ 25.

20IWCC0085

Turning to whether Petitioner's accident "arose out of" her employment, the Appellate Court referred to the types of risk to which an employee may be exposed. *Id.* ¶ 27. "There are three categories of risk to which an employee may be exposed: (1) risks that are distinctly associated with one's employment, (2) risks that are personal to the employee, such as idiopathic falls, and (3) neutral risks that have no particular employment or personal characteristics, such as those to which the general public is commonly exposed." *Dukich v. Illinois Workers' Comp. Comm'n*, 2017 IL App (2d) 160351WC, ¶ 31.

In this case, the Appellate Court rejected Respondent's contention that this matter should be analyzed as a neutral risk. *Martin*, 2018 IL App (3d) 170344WC-U, ¶ 31. The court acknowledged that "injuries suffered by an employee while traversing stairs are generally non-compensable, having arisen from a neutral risk." *Id.* However, the court reasoned that "if an employee falls on stairs and the employer's premises are found to be defective *and* determined to have contributed to cause the accident, the risk of injury will be considered an employment related risk and not a neutral risk." (Emphasis in original.) *Id.*

The Appellate Court then rejected as "not entirely correct" Respondent's assertion that "'the Commission found that the small missing area of grip tape did not constitute a defect that created an increased risk of injury.'" *Id.* ¶ 32. Although the Commission had adopted the Arbitrator's decision describing the stair missing a piece of the strip of tread in unremarkable terms, the court observed that the Commission had not explained the significance of that finding. See *id.* Indeed, the Arbitrator issued no such explanation in her decision.

Accordingly, the Appellate Court ruled that to determine whether Petitioner was exposed to an employment-related risk, the Commission must determine whether the condition of the step contributed to her fall. *Id.* The court "thus remand[ed] the cause for the Commission to determine whether the *defect* in the step contributed to cause claimant's fall." (Emphasis added.) *Id.* It is this question to which the Commission now turns.

In this case, Petitioner testified that when she ascended the stairs to retrieve her cell phone, her "boot *** caught on a *** safety strip that has *** a little rolled area." Petitioner also testified that her foot had cleared the overhang or lip on the stair when she tripped on the stair tread. Petitioner testified she photographed other stairs in the stairwell that had "bad strips where they were turning up and likely to cause an accident ***." Petitioner identified Petitioner's Exhibit 5B as the stair upon which she fell; the photograph depicts a stair with an irregular chunk of tread missing away from the end of the strip. When shown another photograph of the stair at issue, Petitioner testified, "[T]he strip that I fell on had been scraped off and removed." Petitioner further testified that she thought it was unusual that several of the strips were removed from the stairwell tops after her accident. When Petitioner first sought treatment from a chiropractor, the medical records indicated Petitioner reported she "tripped on loose stair tre[a]d ***."

Petitioner's supervisor, Dawn Hayes, testified that she inspected the area where Petitioner fell. Hayes noticed missing grip tape "on the edges" but opined that it was "[n]ot defective enough for someone to trip on the edges by the stairwell." However, Hayes made her inspection

a day or two after Petitioner fell. Hayes testified that a maintenance person was able to show her "what was clipped off the edges." Hayes also testified that she considered the missing or pulled up grip tape was a defect. Hayes later stated that there were parts sticking up on the ends of the tread strips that were removed, not in the middle of the stair.

In sum, the unrebutted testimony from Petitioner was that she tripped on a rolled area of the safety strip on the stair. Hayes did not testify that the stair treads were not defective, only that, in her opinion, they were not defective enough to cause Petitioner's fall. However, Hayes did not inspect the area until after a maintenance person had performed remedial work in the stairwell. Hayes characterized the problems with the tread as being at the edges of the tread, not the middle of stairs. Yet Petitioner's Exhibit 5B depicts a missing chunk of tread which was not at the end of the tread strip. Given this record, and pursuant to the order of the Appellate Court, the Commission concludes the condition of the stair as described and depicted in the record was defective and contributed to Petitioner's accident. Therefore, the Commission further concludes that Petitioner's injury not only occurred in the course of her employment, but also arose out of her employment with Respondent.

The Commission also finds that Petitioner's current condition of ill-being is causally connected to the injury at issue, consistent with the finding of accident above and as Petitioner and Respondent so stipulated in the Request for Hearing in this matter.

The Commission next finds that regarding the issue of temporary total disability benefits, the parties stipulated both in the Request for Hearing and in the transcript of proceedings that Petitioner received payments under Respondent's short-term disability insurance policy for the period Petitioner was off work, from July 24, 2015 to November 12, 2015. The parties also stipulated that these payments were equal to or greater than what she would have received as temporary total disability benefits and Respondent is due a credit. Accordingly, the Commission concludes that Petitioner is entitled to $14,465.88 in temporary total disability benefits for the period from July 24, 2015 to November 12, 2015. The Commission also concludes that Respondent is entitled to a credit, pursuant to section 8(j) of the Act, for this same amount.

Regarding the issue of necessary and reasonable medical expenses, the Commission observes that Respondent raised no objection in its Response to Petitioner's Statement of Exceptions other than to argue the Arbitrator was correct to find there was no accident. The Commission finds Respondent responsible for the payment of Petitioner's reasonable and necessary charges for reasonable and necessary medical services. The Commission also affirms the Arbitrator's award of a credit to Respondent of $7,864.27 for payments of medical bills through Respondent's group medical plan, pursuant to §8(j) of the Act. The parties stipulated to this credit in the Request for Hearing.

Regarding the issue of prospective medical care, the Commission finds that on November 16, 2015, Dr. Robbye Bell sought to schedule an appointment for Petitioner with a Dr. O'Leary for the evaluation of a surgical intervention to address her pain in the right low back, right hip and thigh. On January 27, 2016, Dr. Michael Bruns notified Petitioner's attorney that due to the lack of authorization for a surgical consultation, Petitioner's orthopedic treatment was placed on hold. Petitioner testified that she still sought authorization for the consultation with Dr. O'Leary. The

20IWCC0085

Commission finds that Petitioner is entitled to the consultation with Dr. O'Leary and any associated treatment recommended by Petitioner's physicians, as it is causally connected to Petitioner's work-related accident.

IT IS THEREFORE FOUND BY THE COMMISSION that Petitioner proved she sustained an accident arising out of and occurring in the course of her employment with Respondent on January 6, 2015.

IT IS FURTHER FOUND BY THE COMMISSION that Petitioner proved her current condition of ill-being is causally connected to the accident requiring additional medical care to alleviate her from the effects of her injury.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay Petitioner's necessary and reasonable medical expenses related to her right low back, right hip and thigh pursuant to §8(a) and §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is liable for Petitioner's prospective medical care prescribed by Dr. Bruns and Dr. O'Leary for the right low back, right hip and thigh as it is causally related to the accident.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $14,465.88, representing $767.13 per week for a period of 18 and 6/7th weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall be awarded a credit of $14,465.88 pursuant to §8(j) of the Act, for payments made under Respondent's short-term disability insurance.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall be awarded a credit of $7,864.27 for payments of medical bills through Respondent's group medical plan, pursuant to §8(j) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this decision, 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.

20IWCC0085

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: JAN 31 2020
d: 01/09/20
BNF/kcb
045

Barbara N. Flores

Deborah L. Simpson

Marc Parker