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

Thomas Pettit,

Petitioner,

vs. NO: 11 WC 04788

State of Illinois/Menard Correctional Center,

16IWCC0627

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

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

No bond or Summons required for State of Illinois cases.

DATED: SEP 30 2016

MB/mam
o9/8/16
43

Mario Basurto

David L. Gore

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

PETTIT, THOMAS
Employee/Petitioner

Case# **11WC004788**

16IWCC0627

SOI/MENARD CORRECTIONAL CENTER
Employer/Respondent

On 2/11/2016, 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 0.42% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

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

0558 ASSISTANT ATTORNEY GENERAL
KENTON OWENS
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

1350 CENTRAL MANAGEMENT SYSTEMS
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

FEB 11 2016

16IWCC0627

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

Thomas Pettit
Employee/Petitioner

Case # **11** WC **04788**

v.

Consolidated cases: **N/A**

State of Illinois/Menard Correctional Center
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Herrin**, on **September 11, 2015 and December 8, 2015.** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **10/5/09**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident ***was 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 $**46,835.67**; the average weekly wage was $**900.68**.

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

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

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

Respondent shall be given a credit of $**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 general credit for any medical bills paid by its group medical plan for which credit is allowed under Section 8(j) of the Act.

ORDER

Petitioner failed to prove that he sustained an accident on October 5, 2009 that arose out of and in the course of his employment with Respondent or that his condition of ill-being in his feet was causally connected to his accident or his employment with Respondent. Petitioner further failed to prove that he gave timely notice of his accident as required under the Act. Petitioner's claim for compensation is denied and no benefits are awarded.

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

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

[signature]
Signature of Arbitrator

February 8, 2016
Date

FEB 1 1 2016

Thomas Petit v. SOI Menard Correctional Center, 11 WC 004688

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Arbitrator finds:

From 1998 to 2004 Petitioner worked as a Corrections Officer approximately 35.5 hours per week. His job duties were to patrol "lie" movements and to walk the cells. His primary concern was the safety of the other corrections officers. (PX G)

Petitioner presented to the office of Dr. Hess, a podiatrist, on April 22, 2004 on referral from Dr. Davis. Petitioner reported pain in the center of his right heel of three months' duration. Petitioner reported that when he would get up in the morning his right heel would be very sore and he felt a sharp pain in the heel. Petitioner reported always being up and down on his feet. He denied any injury. Petitioner also complained of discoloration in his little toe on the right foot which had been present for six months. Petitioner was diagnosed with mild plantar fasciitis of the right foot. He was given an injection. (RX 2)[1]

From 2004 to 2008 Petitioner continued working 35.5 hours per week but his job duties changed significantly as he spent most of his time walking on catwalks which are "still [sic] grates." (PX G)

Beginning some time in 2008 Petitioner began serving as an acting sergeant for the Department of Corrections and held a more sedentary job although his overtime hours increased "dramatically." (PX G)

Dr. Hess re-examined Petitioner on July 27, 2009 after being referred by Dr. Workman. Petitioner reported the bottom of his right heel had been hurting for several months. He was given a second injection. (RX 2)

Petitioner returned to see Dr. Hess on October 5, 2009 reporting ongoing right heel pain. He was wearing orthotics prescribed by his chiropractor, Dr. Baxter. He was given another injection. (RX 2)

Petitioner again returned to Dr. Hess on January 26, 2010 for a wart on the side of his left big toe. No mention of any heel pain was made. Petitioner returned to see the doctor on February 2nd and February 9, 2010 for the issue with the left toe. No heel complaints were noted. (RX 2)

Petitioner stopped working as an acting sergeant in the summer of 2010 and returned to work as a Correctional Officer working 55 hours a week, with some mandatory overtime. (PX G)

Petitioner returned to see Dr. Michael Workman, at Logan Primary Care Services, on June 22, 2010. On that date Petitioner was examined for elevated blood pressure and related complaints. Appropriate testing for those complaints was ordered. Petitioner was next seen on September 22, 2010 for gastroenteritis. At neither of these visits was there any mention of foot problems. (PX B)

Petitioner returned to Dr. Workman's office on October 31, 2010 with a history of right heel pain of 2 -3 months' duration. He denied any trauma or injury and noted the pain was aggravated by running or other weight bearing activity. In response to the question of "Occupational/recreational activity with repetitious movements

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[1] Yellow highlighting in RX 2 was not done by the Arbitrator. The records came that way.

of ankle/feet:, it stated "no." On exam there was tenderness to palpation on the sides of Petitioner's right heel. X-rays were ordered. Petitioner's diagnosis was right foot pain. (PX B)

Petitioner underwent a right foot x-ray on October 31, 2010 and it revealed a tiny plantar surface calcaneal spur possibly of no clinical significance. The x-ray was otherwise unremarkable. (PX B)

On November 3, 2010 Petitioner returned to see Dr. Workman regarding his right heel pain which had recently increased with increased walking. He reported that orthotics given to him by the chiropractor had not helped and he had even taken time off of work. Dr. Hess had injected the heel twice with the first injection helping, but not the second one. Petitioner had also been given stretches to perform. On exam Petitioner had right heel pain medially and pain over the lateral right posterior foot. Petitioner was advised to follow up with Dr. Hess and a referral was made. (PX B)

Petitioner presented to Dr. Hess on November 4, 2010 regarding a 1-2 week history of bilateral pain in his right heel. Petitioner reported undergoing an x-ray that revealed a bone spur. Petitioner also reported that he began having problems with his feet after working on a ramped metal catwalk. He also told the doctor that the last treatment to his heel had provided no relief but this pain was different as it was sharp, intense, and shooting and located around his arch and both inside and outside of his heel area. He was compensating for the pain by walking on the outside of his foot. Dr. Hess felt Petitioner was suffering from Tarsal Tunnel Syndrome. He was taken off work until November 10, 2010 and given medication. (RX 2)

Dr. Workman treated Petitioner again on November 11, 2010 for sinus problems. (PX B)

Petitioner followed up with Dr. Hess on November 16, 2010 reporting that the bottom of his right heel was sore and the outside of his heel felt like it was pulling and being stabbed with a knife while walking. Petitioner's medications had worked initially but then quit. Dr. Hess felt Petitioner possibly had entrapment or a neuroma of the right heel with plantar fasciitis. He injected Petitioner's heel and released him to return to work as of November 17, 2010. (RX 2)

On January 26, 2011 Petitioner presented to Dr. Brown with upper extremity complaints. As part of the examination Petitioner completed a general questionnaire that included a description/discussion of Petitioner's job duties. Petitioner noted that there were times throughout his shift he would have to get off of his feet due to severe heel pain and he had tried different work boots and gel inserts to no avail. He had also undergone multiple heel injections in his right foot but the pain would return and had taken multiple days off from work because the pain was so bad he could hardly walk. Petitioner further noted that approximately three years earlier he had worked the west catwalk five days a week for about three years and that was when he started having severe trouble with his feet. Petitioner described the catwalk as approximately 3-4 galleries in the air and one walks on a caged platform with a base of about 1.5 to 2 feet in width of expanded steel gridwork carrying a loaded shotgun and constantly striking the insides of his elbows on the steel bars). Dr. Brown's notes indicate that the cause of Petitioner's symptoms was not entirely clear although Petitioner was describing symptoms consistent with a possible peripheral compression neuropathy. He ordered additional nerve conduction studies which were normal and he recommended nothing further from a surgical perspective. Petitioner was advised to be re-evaluated should his symptoms fail to improve over the next six to twelve months. (RX 3)

On January 26, 2011 Petitioner was also examined by Dr. Krause for bilateral foot pain. Petitioner reported "pain in his heels for 5-6 years." Petitioner was noted to stand for long periods of time at work. He denied any specific trauma and was currently wearing semi-rigid orthotics. On physical examination, Petitioner had full ankle and hindfoot range of motion bilaterally with tenderness around his posteromedial hindfeet.

Petitioner had a negative Tinel's sign over his tarsal tunnel but mild tenderness at his plantar medial insertion of his plantar fascia into his calcaneus. He lacked any posterior heel, mid foot, or forefoot tenderness. Pulses were palpable and he had normal sensibility. Nerve conduction studies performed by Dr. Phillips did not show evidence of Tarsal Tunnel Syndrome[2]. Bilateral foot and ankle x-rays were normal. Petitioner was diagnosed with bilateral nonspecific hindfoot pain and it was recommended that he wear soft cushioned orthoses with a medial wedge to help tilt his hindfoot into varus and unload his medial hindfoot. He was instructed to engage in activities as tolerated and to return in 4-6 weeks if not improved. (RX 3)

According to Commission records, Petitioner filed his Application for Adjustment of Claim herein on February 9, 2011.

Petitioner returned to see Dr. Workman on March 2, 2012 regarding left wrist pain which began that day when he hit it on a trailer. Petitioner was given a cock-up splint. X-rays were pending. (PX B)

Petitioner presented to Dr. Workman's office on March 16, 2012 regarding ongoing left wrist pain. They reviewed the MRI. According to the doctor's note, Petitioner noted tingling and pain in his feet and hands and wanted a nerve conduction study which was ordered. Petitioner was given work restrictions regarding his upper extremities and was referred to Dr. Young regarding his wrist. His feet were not examined. (PX B)

Petitioner underwent electrodiagnostic testing on April 13, 2012 due to "excruciating" pain in both of his heels as well as burning, numbness, and tingling. Petitioner reported that the podiatrist had diagnosed him with tarsal tunnel syndrome. Petitioner also reported numbness/tingling in his upper extremities in the ulnar distribution of his elbows. The needle EMG study was within normal limits. The electrodiagnostic study suggested possible focal tibial neuropathies at the ankles (ie. tarsal tunnel syndrome). The upper extremities were normal. (PX B)

Dr. Workman's office notes contain referral appointment notes dated April 18, 2012 and April 30, 2012 for an appointment with Dr. David Wood on April 18, 2012. No details of any office visit or exam were provided. (PXB)

Petitioner completed an Incident Report on April 19, 2012 regarding an incident on April 18, 2012. Petitioner wrote, "On the above date and approximate time this R/O was told by R/O's [doctor] Dr. Workman that this R/O had a positive testing for tarsal tunnel on both feet on 4-13-12. This R/O notified supervisor and workers comp." A work comp packet was filled out. An Employee's Notice of Injury was also completed. (PX J)

Contained within the records of Dr. Brown and Dr. Krause are copies of letters from CMS dated May 9, 2012 and addressed to Petitioner advising him that CMS had received "notification of [his] injury" and it had been determined that the injury was not compensable. The accident date is listed as April 18, 2012. (RX 3)

Petitioner saw Dr. David Wood in June of 2012. However, there is no office record/note for that visit. On July 20, 2012, Petitioner underwent a tarsal tunnel decompression on his left foot. (PX D)

[2] Dr. Phillips did note right greater than left demyelinative lateral plantar motor neuropathies typical for pes planus with pronation. (RX 3)

On October 26, 2012, Petitioner underwent a tarsal tunnel decompression on his right foot. On January 7, 2013 Dr. Wood returned Petitioner to work without restrictions. On February 25, 2013, Dr. Wood released Petitioner from his care. Petitioner was doing fairly well but was not completely back to where he eventually wanted to be; however, ongoing improvement with time was noted. Petitioner was working full duty. He was to return if needed. (PX D)

On November 4, 2013, Petitioner returned to Dr. Wood complaining of mild pain in his feet/ankles for the last few months. He described the pain as sharp. Dr. Wood noted that Petitioner's bilateral radiating foot pain cleared completely after the tarsal tunnel releases but this new pain was predominantly in his forefeet and, secondarily, in the anterior ankle joint region. X-rays revealed a fairly normal bony anatomy and, on exam, Dr. Wood really couldn't note any symptoms in Petitioner's ankle. He suspected some metatarsalgia in the forefoot pain and "poorly defined" ankle pain. Petitioner wanted to know if his symptoms were related to his previous surgeries and the doctor noted it was certainly reasonable to think that after surgery, when he got going on his feet, he had an adaptive gait pattern that led to his pain. He wrote, "The problem is that it has now been quite some time since surgery....and he has only had symptoms of these problems with his forefoot for about 3 months." He recommended orthotics for possible relief and allowed Petitioner to remain on full duty. Petitioner was to return after being fitted with the orthotics. (PX D)

The deposition of Dr. William Hess was taken on January 9, 2015. Dr. Hess is a podiatrist who has practiced in Marion Illinois for 34 years. (PXI, p. 4) Dr. Hess described tarsal tunnel syndrome as an inflammation of the major nerve that runs into the foot. (PXI-pp. 5-6) Dr. Hess testified that over the course of his 34 years of practice he has treated hundreds of patients for tarsal tunnel syndrome. (PX-p6) Dr. Hess testified that a patient is more likely to get tarsal tunnel syndrome if he spends a substantial amount of time on his feet. (PX I-p.9) In about five percent of the cases tarsal tunnel syndrome becomes so severe that surgical intervention becomes necessary. (PXI- p.-12)

Dr. Hess testified that he first began treating Petitioner on April 22, 2004 for right heel pain of three months' duration. (PXI- p.13) At that time he diagnosed Petitioner with plantar fasciitis of the right heel. (PX I – pp. 13-14, 16) Dr. Hess further testified that Petitioner also had some complaints of mild discoloration at that time which was "something else." (PX I – pp. 15, 28-29)

Dr. Hess acknowledged that he next saw Petitioner on July 27, 2009. When asked if it was unusual for there to be a five year hiatus in treatment for someone afflicted with "this type of condition" Dr. Hess responded, "Well, that's a tough question. Is it unusual? Yes, it is unusual." (PX I – p. 16) Dr. Hess further testified that Petitioner's diagnosis changed from July 27, 2009 to January 26, 2010 and from November 4, 2010. As of November 4, 2010 Petitioner's diagnosis was tarsal tunnel syndrome. (PX I – p. 16) Dr. Hess explained that carpal tunnel syndrome and tarsal tunnel syndrome are very similar disease processes (PX- p.-14-15) Dr. Hess testified that Petitioner's diagnosis had changed over time because his level and type of pain was different. (PX I – p. 16) When asked if he had an opinion as to whether or not Petitioner had tarsal tunnel syndrome when he initially saw him in April of 2004 Dr. Hess replied, "That would be hard to correlate at this time." (PX I – p. 17)

Dr. Hess further testified that he reviewed the records of Southern Orthopaedic Center and that they were the type of records one would customarily rely upon in making a diagnosis of a patient's condition. He acknowledged that the records reflected Petitioner's surgery on his feet which consisted of bilateral decompressions of Petitioner's tarsal tunnel and partial plantar fasciectomies. (PXI -pp.17-19)

Dr. Hess acknowledged that he was provided with a copy of Petitioner's job description just prior to the deposition. (PXI – pp.19 - 21) The doctor was asked to assume that the job description accurately reflected Petitioner's work history with Respondent and the amount of time he spent on his feet, walking, and the type of surface he walked on. Based upon those assumptions, Dr. Hess testified that, in his opinion, Petitioner's work conditions as described therein caused or substantially contributed to Petitioner's tarsal tunnel syndrome. (PXI– pp. 19-21) He based his opinion on the change in the nature of the type of work Petitioner did and "again, detailing on the surfaces and the type of walking that he was expected to perform in his duties." (PX I – p. 21) Dr. Hess testified that the amount of walking and standing described in the job description was sufficient to cause the development of the condition. (PX I – p. 21) Dr. Hess related the surgeries performed by Dr. Wood to Petitioner's work. (PXI – pp. 21-22)

Dr. Hess further testified that Petitioner is more susceptible to developing the condition in the future due to scar tissue which may or may not resolve. (PXI – p. 22) The articles discussed in Dr. Hess's deposition relating tarsal tunnel syndrome to repetitive trauma are set forth in PXJ.

On cross-examination Dr. Hess acknowledged that his last visit with Petitioner was on November 16, 2010. (PX I – p. 23) He acknowledged that Petitioner's attorney gave him a copy of Petitioner's written job description the day of the deposition. Other than that, he only knew about Petitioner's job duties based upon earlier information Petitioner had given to him (he mentioned having problems with his feet after working on a ramped metal catwalk) and in general conversation from time to time outside the office. (PX I – pp. 25, 26, 27) Dr. Hess also acknowledged that the job description referred to more sedentary job duties from 2008 through 2010 and that it would be possible for Petitioner's condition to have improved during that time. (PX I – pp. 27-28)

Dr. Hess further acknowledged that he was unaware of any acute trauma to Petitioner's feet. He was unaware of Petitioner's height or weight but didn't feel it would be a contributing factor to Petitioner's tarsal tunnel syndrome. (PX I – p. 29) He felt the type of surface Petitioner worked on and the change in his job duties were the contributing factors to Petitioner's condition. Dr. Hess' opinion is based upon Petitioner telling him he changed his job duties. (PX I – pp. 30, 32) Dr. Hess admitted he has never been inside Menard Correctional Center. (PX I – p. 31) He further acknowledged that plantar fasciitis can be a contributing factor to the etiology of tarsal tunnel syndrome. (PX I – p. 32)

On/about July 13, 2015 Petitioner amended his Application for Adjustment of Claim herein to allege an accident date of October 5, 2009 and a new attorney. (AX 2)

Petitioner's case proceeded to hearing on September 11, 2015. The issues in dispute were accident, causal connection, notice, medical bills, temporary total disability, and the nature and extent of Petitioner's injury. Two witnesses testified at the hearing: Petitioner and Respondent's representative at the hearing, Cindy Cowell.

Petitioner began working for the State of Illinois as a corrections officer in August of 1998. Initially, he worked at Menard Correctional Center but in June of 2014 he transferred to Shawnee Correctional Center. Petitioner testified that he first began experiencing issues or problems with his feet "probably around 2004." He went to his primary physician and then a podiatrist, Dr. Hess. He saw Dr. Hess in 2004. He then did not return to Dr. Hess until 2009.

Petitioner testified that his job duties changed between 2004 and 2009. In 2008 Petitioner went to the midnight shift and was temporarily assigned as a sergeant which reduced the amount of walking he did as he

focused on paperwork and sitting. Petitioner identified PX G as the job description he prepared at his attorney's request. He acknowledged that between 2008 and 2010 he was a sergeant. Petitioner testified that he returned to Dr. Hess in 2009 because he started to work a significant amount of overtime which required more walking as the overtime occurred during the day shift.

Petitioner testified that his hobbies include camping and boatir ither of which involved walking or put stress on his feet.

Petitioner testified that he underwent two tarsal tunnel decomp ons, performed by Dr. David Wood, in 2012. He testified that Dr. Workman referred him to Dr. Wood. Pet ner was put on light duty, and the Respondent accommodated his restrictions. He testified that he missed nly one week of work per surgery.

Petitioner testified that he has been working full duty since being released to do so in February of 2013. He does not take any prescription medicine for his feet; however, he did use Ibuprofen once or twice a week between February of 2013 and June of 2014. Petitioner further testified that he has been working the midnight shift since June of 2014 and that doesn't create any stress on his feet.

Petitioner testified that he has unpaid bills with Southern Illinois Orthopedic Center in the amount of $497.51 and an anesthesiologist. (See PXA)

Petitioner testified that in 2009 he complained to one of his supervisors, Lieutenant Olsen, that he was experiencing foot pain. He believed that he complained to Lt. Olsen about his foot pain even before 2009. He further testified that he complained thereafter at least once or twice a week and the "understanding" between the two was that the work environment and walking was causing the pain.

On cross-examination Petitioner testified that he told Lt. Olsen his foot pain was caused by his job at Menard but he didn't fill out a Form 45 at that time. He did acknowledge filling out a packet in 2012 for his injury of 2009. He filled it out in the medical unit.

With regard to his job duties, Petitioner testified that between 2008 and 2010 he spent about 55 hours a week as a sergeant and out of that about half his time was spent with sedentary job duties and the other half was spent walking. He believed that he treated with Dr. Hess between 2004 and 2009 for his feet.

On redirect Petitioner acknowledged that he would defer to Dr. Hess' records if there was any conflict between his testimony and what's in the records. On further cross-examination Petitioner again testified that he continued to treat for his feet between 2004 and 2009.

Respondent called Cindy Cowell as a witness. Ms. Cowell testified that she is the individual responsible for monitoring workers' compensation injuries and has been the workmen's compensation coordinator for the last five years. Her job involves helping employees process their paperwork for worker's compensation injuries. She testified that employees generally go to the health care unit and receive a packet, complete it, and then the healthcare unit forwards it to her and she submits it to Tri-Star. Petitioner testified that she never received a workers' compensation packet for Petitioner and that the first time she became aware of Petitioner's claim was when she received a representation letter from his attorney in February of 2011. She further testified that she has a Form 45 from Tri-Star that she received on January 12, 2015.

On cross-examination Ms. Cowell identified Tri-Star as the third party administrator for workers' compensation claims. The Form 45 is generated when the employee calls the 800 number to report an injury.

The employee doesn't fill it out. She acknowledged that she didn't make any inquiry to see if anybody at the health care unit would confirm that Petitioner asked for a Form 45 packet.

In rebuttal Petitioner testified that in 2012 he actually talked with Ms. Cowell several times about his injury over the phone. He further testified that he got a packet from the health care unit and completed it and gave it to Aunna Schott.

On cross-examination during rebuttal, Petitioner acknowledged that the conversations with Ms. Cowell were around June or July of 2012. According to Petitioner, the paperwork had already been filled out by then as it was done around June or July of 2012. Petitioner claimed he had filled out the packet and it had been turned in to "workmen's comp."

Ms. Cowell was again called to testify and she could not recall speaking with Petitioner in the summer of 2012. She admitted that she monitored several claims at any given time and that she could not recall all of her conversations. She further testified that she did not have an Employee's Notice of Injury regarding Petitioner and that would have been the form that the employee actually signed.

Ms. Cowell could not recall how many claims she was handling for the correctional facility during the summer of 2012 but it could have been more than 100. She could not recall how many employees she might speak with regarding claims on a typical day and she agreed that she couldn't recall each and every conversation.

"PX G" is a written job description prepared by Petitioner and introduced into evidence at the time of the hearing. It is unclear when he prepared it. Of note:

From 2004 to 2008 Petitioner walked on catwalks and described them as difficult to work on because they were subject to mild movement and he would have to adjust his gait to recover his balance. He felt the job was more difficult due to the amount of time spent on his feet. He first began noticing pain in his feet during that time.

From 2008 to the summer of 2010 Petitioner worked in the more sedentary position of an acting sergeant and spent about half of his time with desk work and the other half walking. During this time his feet still hurt but his condition "stabilized" and his pain decreased.

From the summer of 2010 to August of 2012 Petitioner resumed working as a Correctional Officer working 55 hours per week plus mandatory overtime. There were times when the pain in his feet became very severe and unbearable. At time, he would have to get off his feet altogether due to severe pain. He tried different work boots, gel inserts, and orthopedic inserts from his chiropractor but none helped. He also underwent multiple injections in his right foot only to have the pain return. Petitioner took multiple days off during this time because he was barely able to walk.

Petitioner denied spending any significant amount of time on his feet when not working during these times. He liked to attend sporting events that his children were participating in and they enjoyed camping and boating but didn't engage in any hiking. (PX G)

Subsequent to the hearing on September 11, 2015 the attorneys for both parties submitted a stipulation to reopen proofs and an Order was entered on November 19, 2015. (See AX 5, 6) On December 8, 2015 the attorneys for both parties appeared before the Arbitrator for the purpose of admitting additional exhibits (PX J and RX 6) into evidence. Proofs were then closed.

Ms. Cowell executed an Affidavit on November 24, 2015 (RX 6) stating that the documentation attached to Respondent's Motion to Reopen Proofs was for claim number 1221124 which had an accident date of 4/18/12 and claimed a bilateral foot injury. She had paperwork on that claim in her possession. She further

stated that the claim number assigned to the accident date at issue herein is claim number 15572380 with an accident date of 1.26.11 (later amended to 10.5.09) and alleges bilateral upper extremity injuries and bilateral foot/ankle injuries. She had no paperwork on that claim other than a Form 45 generated on January 12, 2015. (RX 6)

The Arbitrator concludes:

Issue (C) Whether Petitioner sustained an accident on October 5, 2009 that arose out of and in the course of his employment with Respondent?

Did Petitioner's repetitive trauma accident manifest itself on October 5, 2009?

Petitioner is alleging a repetitive trauma injury. In such instances the initial focus of inquiry is on the date of accident or "manifestation." It is axiomatic that the date of manifestation in a repetitive trauma injury is the date on which the fact of the injury and its causal relationship of the injury to the claimant's employment would have become plainly apparent to a reasonable person. It is equally axiomatic that in a repetitive trauma case, the unique and peculiar facts of each case must be closely analyzed.

Petitioner failed to prove he sustained an accident on October 5, 2009 that arose out of and in the course of his employment with Respondent. Petitioner provided no testimony as to the significance of that date. Petitioner had an office visit on that date for ongoing right heel pain. Dr. Hess' office note of that date lacks any reference to left foot/heel complaints. With regard to Petitioner's right heel complaints, there is no reference to work duties causing/aggravating his complaints or symptoms. The note is devoid of any discussion of Petitioner's work for Respondent. There is no diagnosis listed. Additionally, it appears that the office visit of October 5, 2009 was a follow up visit from an earlier one on July 27, 2009 wherein Petitioner related right heel pain of several months duration. Based upon this record the Arbitrator is unable to conclude that Petitioner sustained a repetitive trauma injury to his feet that manifested itself on October 5, 2009.

Did Petitioner's repetitive trauma accident manifest itself on November 3, 2010 or November 4, 2010?

Petitioner had an appointment with Dr. Workman on November 3, 2010 for right heel pain that had recently increased with increased walking at work. He then saw Dr. Hess on November 4, 2010 for the same heel pain and reported his problems began while working on a ramped metal catwalk. Either date could arguably be a viable manifestation date as on both visits to doctors, Petitioner associated his right heel complaints with his job duties for Respondent – most notably, walking on the metal catwalk.

Did Petitioner's repetitive trauma accident manifest itself on January 26, 2011?

Petitioner originally alleged an accident date of January 26, 2011 (see Affidavit of Cindy Cowell – RX 6) This is the original accident date claimed by Petitioner in his Application for Adjustment of Claim. Petitioner provided no testimony as to the significance of that date. It was, however, the date on which Petitioner presented to Dr. Brown with upper extremity complaints and Dr. Krause with bilateral foot complaints, the latter of which Petitioner associated with his work duties. However, Dr. Krause was unclear as to the cause of Petitioner's nonspecific hind foot pain, ruled out a diagnosis of bilateral tarsal tunnel syndrome, and provided no causation opinion between Petitioner's work duties and his bilateral foot symptoms. Thus, while January 26, 2011 could arguably be a manifestation date, as on that date Petitioner associated his symptoms in his feet with his work duties, Petitioner failed to prove he sustained an accident arising out of his employment on that date or the

requisite causal connection. Dr. Krause was not deposed. Petitioner did not follow up with him as advised. Dr. Hess' opinion is not persuasive. See Issue (F) below.

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

D/A: October 5, 2009.

Even, assuming arguendo, that Petitioner did prove he sustained an accident on October 5, 2009, Petitioner failed to prove that he gave timely notice of an accident occurring on October 5, 2009. Petitioner acknowledged during the arbitration hearing that he gave notice of his 2009 accident in 2012 which is significantly beyond the 45 day period for reporting an injury. Petitioner also sought to establish timely notice through his frequent conversations with his supervisor, Lt. Olsen. The Arbitrator, however, doesn't view those conversations as meeting the requirement under the Act. Petitioner identified no specific date within 45 days of October 5, 2009 on which he gave detailed information concerning an alleged accident (ie. that he felt he had a problem in his feet related to his work duties) to Lt. Olsen. Furthermore, Petitioner failed to establish that Lt. Olsen was the person to whom notice of an alleged accident was to be provided. Ms. Cowell provided credible testimony as to the giving of notice.

D/A: November 3 or 4, 2010.

Petitioner failed to prove that he gave timely notice of an alleged accident on either of those dates. He filed his Application for Adjustment of Claim herein on February 9, 2011 which is beyond the 45 day limit for giving notice. Furthermore, he alleged a different accident date.

D/A: January 26, 2011.

Petitioner did give timely notice of a January 26, 2011 accident as he filed his Application for Adjustment of Claim herein on February 9, 2011.

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

Regardless of the accident date, Petitioner failed to prove that his current condition of ill-being in his feet was causally connected to his accident or his employment with Respondent. While Respondent did not have Petitioner examined by a doctor of its choosing and submitted no expert opinion negating causation that does not mean that Petitioner prevails. Petitioner has the burden of proving all the requisite elements of his claim. If Petitioner fails to meet his burden of proof, Petitioner's claim may be denied.

Tarsal tunnel syndrome, like carpal tunnel syndrome, is an injury wherein causation needs to be based upon an expert medical opinion and not simply a chain of events. Petitioner has failed to submit a persuasive, well-reasoned and fully informed causation opinion in support of his claim.

Petitioner worked as a corrections officer from 1998 to 2004. Based upon his job description he had no pain or problems with his feet during that time. It was also during that time that he first saw Dr. Hess for right heel pain that would bother him first thing in the morning when he woke up. He made no association with his work.

Based upon Petitioner's job description he then worked on the metal catwalk from 2004 through 2008. While he stated in his job description that he began having problems in his feet during that time, he sought no medical

treatment during that time period. While he testified that he thought he saw his chiropractor during that period no records were introduced to corroborate his testimony. Petitioner returned to see Dr. Hess on October 5, 2009 (after a gap of over five years) and again complained of right heel pain. During this time period Petitioner was working as the acting sergeant with less walking involved and, by his own admission, his feet hurt but the pain decreased during this time. (PX G) Petitioner then returned to Dr. Workman in early October of 2010 regarding right heel pain but he denied any problems with his feet that he associated with repetitive movements of his ankles or feet, trauma or injury. (PX B)

The Arbitrator is aware that beginning in the summer of 2010 Petitioner returned to work as a correctional officer and worked a large number of hours a week plus mandatory overtime. His job description is silent as to whether or not he was walking the catwalk during that time. He referenced his chiropractor (whose records aren't in evidence) and different things he did to try and alleviate his complaints. It was at the November of 2010 visit that Dr. Hess diagnosed tarsal tunnel syndrome and took Petitioner off of work for approximately one week. The diagnosis changed to that of possible plantar fasciitis when he re-examined Petitioner on November 16, 2010. Petitioner did not treat with Dr. Hess again.

As noted above, Petitioner was seen by Dr. Krause on January 26, 2011. Dr. Krause did not diagnose Petitioner with any work-related foot problem. Dr. Workman, Petitioner's primary care physician, was never deposed. Dr. Wood, Petitioner's treating surgeon, was never deposed. Indeed, there is no mention of a correlation between Petitioner's symptoms and his work duties anywhere within Dr. Wood's records.

In support of his claim, Petitioner relies upon the testimony and opinions of Dr. Hess, Petitioner's podiatrist in 2004, 2009 and 2010. Dr. Hess had not seen Petitioner since November 16, 2010. He never treated Petitioner for any left foot complaints. While Dr. Hess was provided with Dr. Wood's records to review and a job description prepared by Petitioner, he was not provided with all of Petitioner's treating medical records. Had Dr. Hess been provided with all of Petitioner's records he would have seen that Dr. Krause had performed electrodiagnostic studies in January of 2011 that were negative for tarsal tunnel syndrome. While Dr. Hess believed that Petitioner was suffering from tarsal tunnel syndrome during one visit in November of 2010 he ordered no objective tests to confirm the diagnosis at that time. Dr. Hess originally diagnosed Petitioner with plantar fasciitis. He acknowledged that plantar fasciitis can contribute to the development of tarsal tunnel syndrome. After he saw Petitioner in 2004 he again saw Petitioner in 2009 and his diagnosis remained unchanged – ie. plantar fasciitis. Dr. Hess further testified that Petitioner's pain on November 4, 2010 was different and he diagnosed him with tarsal tunnel syndrome as a result. Dr. Hess did not provide any explanation to the change in diagnosis at their next visit two weeks later. While he opined that the surgery Dr. Wood performed for tarsal tunnel syndrome was causally related to the job duties found in Petitioner's job description, there is a significant missing piece of information. Petitioner's job description ends in August of 2012. Petitioner first presented to Dr. Wood in June of 2012 and there are no records of any of Petitioner's visits pre-surgical visits with Dr. Wood. Thus, there is no information pertaining to any history Petitioner might have provided Dr. Wood at that time. In summary, there is no evidence in the record explaining why Petitioner went to Dr. Wood or what his job duties were after August of 2012. This lack of information, combined with the inconsistencies in the histories Petitioner actually provided to Dr. Hess when he was treating Petitioner and what Petitioner suggests in his job description, undermines Dr. Hess' causation opinion. Dr. Hess was unfamiliar with Petitioner's treatment since he last saw him in November of 2010 and knew very little about Petitioner's job other than what was provided to him on the day of his deposition when Petitioner's attorney gave him Petitioner's written job description. In the end, Dr. Hess' opinion is not persuasive.

In addition to missing information pertaining to Petitioner's job duties after August of 2012 and what, if anything, may have led him to present to Dr. Wood, the Arbitrator also notes that there are references to

Petitioner being treated by a chiropractor for his foot/heel complaints. However, no chiropractic records were submitted by Petitioner. The Arbitrator reasonably infers that Petitioner's failure to submit these records may be because they contained information that would not be in his best interests with regard to this claim.

Thus, Petitioner failed to prove he sustained a repetitive trauma injury that manifested itself on October 5, 2009 or November 3 or 4, 2010. Even if he established any of those dates as accident dates, Petitioner failed to provide timely notice of those accidents to Respondent. With regard to January 26, 2011 as a possible accident date, the Arbitrator concludes that Petitioner failed to prove he sustained a repetitive trauma injury to his feet that arose out of and in the course of his employment with Respondent or that his condition of ill-being in his feet was causally connected to his accident or his job duties for Respondent.

Petitioner's claim for compensation is denied and no benefits are awarded.

****

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Cynthia R. Gadberry,

Petitioner,

vs.

NO: 11 WC 39600
11 WC 40039

Illinois State Police,

Respondent,

16IWCC0628

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 30, 2015 is hereby affirmed and adopted.

No bond or summons required for State of Illinois cases.

DATED: SEP 30 2016

MB/mam
o9/8/16
43

Mario Basurto

David L. Gore

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GADBERRY, CYNTHIA R
Employee/Petitioner

Case# **11WC039600**

11WC040039

ILLINOIS STATE POLICE
Employer/Respondent

16IWCC0628

On 12/30/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.55% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in 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
RUSHVILLE, IL 62681

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

5300 ASSISTANT ATTORNEY GENERAL
CODY KAY
500 S SECOND ST
SPRINGFIELD, IL 62706

2202 ILLINOIS STATE POLICE
801 S 7TH ST
SPRINGFIELD, IL 62703

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

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

DEC 30 2015

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

Cynthia R. Gadberry
Employee/Petitioner

v.

Illinois State Police
Employer/Respondent

Case # **11** WC **39600**

Consolidated cases: **11 WC 40039**

An *Application for Adjustment 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 **Springfield**, on **October 28, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the 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 26, 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.

In the year preceding the injury, Petitioner earned **$55,092.00**; the average weekly wage was **$1,059.46**.

On the date of accident, Petitioner was **38** years of age, ***married*** with 0 dependent children.

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

Respondent is entitled to a credit for **all amounts paid under group health plan** under Section 8(j) of the Act.

ORDER

Petitioner failed to prove that she sustained an accident that arose out of and in the course of her employment with Respondent and, as such, all benefits are denied. The remaining issues are moot and the Arbitrator makes no conclusions as to those issues.

Respondent is entitled to a credit for **all amounts paid under group health plan** 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.

Melinda M. Rowe-Sullivan
Signature of Arbitrator

12/22/15
Date

DEC 3 0 2015

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Cynthia R. Gadberry
Employee/Petitioner

Case # 11 WC 39600

v.

Consolidated cases: 11 WC 40039

Illinois State Police
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that on April 26 of 2010, she was employed by the Illinois State Police as an Administrative Assistant II. Petitioner testified that she has been employed by the State Police since October 15, 1994. Petitioner testified that on April 26, 2010, she was working on files contained in lateral cabinets. Petitioner testified that the cabinet that she was working in was the bottom drawer. Petitioner testified that she was picking up the files out of the bottom drawer and when she picked them up, she leaned over to the side and twisted. Petitioner testified that she was sitting in a chair, was reaching to her left and reaching down, and she pulled up the files and used her foot to close the drawer when she felt a pop in her back.

When asked how many files or how much paper she was picking up at that time, Petitioner testified that it was a hanging file folder that was full and was approximately 18 inches wide. When asked if she had any idea how much it would have weighed, Petitioner testified that she did not recall. Petitioner testified that she felt a pop sensation in her low back and a lot of pain. Petitioner testified that she called for a co-worker who was in the next cubicle and asked her to get the supervisor, they contacted 9-1-1, and the paramedics took her to the hospital. Petitioner testified that she was not able to walk out on her own, and that she had low back pain and pain radiating down her left leg. Petitioner testified that she was taken to the emergency room at Memorial Medical Center.

Petitioner testified that prior to April 24, 2010 she had difficulties with her back, that she had had low back pain since 1989 when she was 17 and suffered a compression fracture when she was in the Army. Petitioner testified that since 1989 she has had a dull ache in her low back, whereas the pain that she experienced in 2010 was a sharp, stabbing pain that radiated down her leg and was a sensation that she had never experienced before. When asked if she had experienced pain radiating down her left leg with her previous chronic back problem, Petitioner denied having had pain radiating down her legs. When asked if she had missed any work prior to this accident because of back pain, Petitioner admitted that she had and indicated that she did not recall the exact amount of time she had missed, but it was a sporadic day off from time to time.

Petitioner testified that following this incident she received treatment at the Veterans Administration, where she also received general medical care. Petitioner testified that they had been treating her chronic back pain from her injury in the Army. Petitioner testified that she had an MRI of her low back in November of 2010 at the VA. Petitioner testified that before she even got out of Danville she was called and told that she needed to see a neurosurgeon immediately. Petitioner testified that she got a

referral from her primary care doctor to see Dr. Brian Russell, and that it took some time to get an appointment.

Petitioner testified that while she was waiting for her appointment with Dr. Russell, she had another incident on January 26, 2011. Petitioner testified that she was filing and was down on the floor, and that when she went to get up she felt another popping sensation and was unable to get up. When asked if she was lifting anything at that time, Petitioner testified that she had multiple files in her hands when she was standing up to move to work on the next drawer up. When asked if she recalled how many folders or how much paper she was holding at that time, Petitioner testified that the stack was maybe a foot tall. Petitioner testified that it was a sharp pain sensation in the low back which was radiating. Petitioner testified that she was taken by ambulance to Memorial Medical Center following the January 26, 2011 accident.

Petitioner testified that following the January 26th incident she had several other visits to the ER for back pain and she also treated with Dr. McKay, a chiropractor at Springfield Clinic. Petitioner testified that she was finally able to get in to see Dr. Russell on March 1, 2011. Petitioner testified that Dr. Russell directed her to undergo electrodiagnostic tests by Dr. Trudeau, and that she also received a couple of injections into her low back in May and June of 2011. Petitioner testified that Dr. Russell performed surgery on July 11, 2011. Petitioner testified that she was off work until September 1 following surgery. Petitioner testified that she continued to follow up with Dr. Russell after surgery until approximately January of 2012, at which point he began treating her for an unrelated problem of carpal tunnel syndrome. Petitioner testified that she went back to Dr. Russell one other time in November of 2012 for her low back.

When asked what she noticed about herself after the surgery, Petitioner testified that she has limited range of motion. Petitioner testified that she cannot bend as far as she used to either forward, backward or to the side, that she is limited in her activities of daily living, and that she has a roommate now who does her housekeeping because one of the first things she noticed was that she could not even vacuum her own house anymore because of the twisting sensation. Petitioner testified that vacuuming caused sharp pain in her low back and down her leg.

Petitioner testified that cannot sit for long periods of time at work, and that she has to get up at least once an hour and walk because otherwise her back pain is intolerable. Petitioner testified that she can sit approximately 45 minutes, then she gets up and walks around for 5-10 minutes and returns to her desk. Petitioner testified that she no longer had intimate relationships due to her back pain. Petitioner also testified that she no longer does any landscaping, and that she used to have a beautiful yard.

Petitioner testified that with the second injury she started experiencing incontinence more when she was sleeping. Petitioner testified that it is still a problem even after surgery, and that she had undergone testing. Petitioner testified that the State had modified her work to accommodate some of the difficulties she has with her low back, including buying her chairs, foot rests, and lumbar supports. Petitioner testified that if she had to travel the State lets her use her personal vehicle, because she had to have heat on her back when she drives or other otherwise her back will spasm or she has to get out every 45 minutes. Petitioner testified that the modifications that had been made had all been after her work accidents.

Petitioner testified that she has back pain every day, that it comes and goes, and that it gets worse with activities like lifting, bending, or sitting too long. Petitioner testified that she limits her lifting because of her problem with her back, and that she lifts no greater than 10 pounds. With respect to medications, Petitioner testified that she is on a Fentanyl patch that she wears 24 hours a day, which she started in 2012. Petitioner testified that the problems she described with her daily activities, with her work

and the accommodations at work were all problems that developed after her work accidents, and that she did not have such issues prior.

On cross-examination, Petitioner testified that prior to April 2010 she only had a dull ache in her low back. When asked to further explain the dull ache, Petitioner indicated that she did not know how to explain it, that it was just a dull pain. Petitioner testified that on a scale of 1 to 10 in the ten years prior to April of 2010, the highest pain level her dull pain would reach was that of a 3 or 4. When asked if there were instances where it ever reached a level higher than 3-4, Petitioner testified that there were occasions such as when she fell on ice. When asked what year the fall occurred, Petitioner testified that she did not recall.

On cross-examination, when asked if there were any instances of something causing her to have sharp pain prior to April of 2010, Petitioner denied previously having had the sharp pain she was experiencing after the accident. Petitioner testified that when it happened in April of 2010 it was a pain that she had never felt before, and that she had never had sharp, stabbing pain. Petitioner testified that before the accident it had always been a dull, aching pain. When asked if, prior to April 2010, there were some of instances where her pain was at least an 8, 9 or 10 out of 10, Petitioner testified that when she fractured it in 1989 it was 10 out of 10 but that in the five years prior to the April 2010 accident, she did not recall a specific situation. When asked if prior to April of 2010 she had any idea how long it had been since she had an increase in pain above a 3 to 4 level, Petitioner testified that she did not recall. When asked if she would say that there was at least one time in the six months prior to the April 2010 accident, Petitioner testified that it was possible but she did not recall.

On cross-examination, when asked if she had testified earlier that she had never experienced pain radiating down her leg prior to April of 2010, Petitioner testified that she did not previously have pain down to her knee the way that it did after the accident. When asked if she had had pain radiate down into the leg prior to April of 2010, Petitioner testified that her prior pain would radiate to her buttock which was the lowest it ever went, and that the pain the lasted maybe 24 hours and then went away.

On cross-examination, Petitioner testified that when she would have increases in pain prior to April of 2010 she would use heating pads and ice packs, and admitted that she had previously sought chiropractic care for her neck and upper back. When asked if, in the five years prior to April of 2010 she could think of specific instances where she saw the chiropractor because of lower back pain specifically, Petitioner testified that she did not know dates and times but admitted that she knew she had seen a chiropractor many times over the years. Petitioner admitted that she saw a chiropractor after April of 2010, but testified that after her chiropractor saw the MRI she would no longer treat her because of the bulging disc.

When asked on cross-examination whether there were any specific instances between her two accidents that caused a flare-up in pain, Petitioner testified that there were instances where the pain was worse but she did not recall specific dates. When asked if she remembered what she was doing that caused her to seek out treatment in that timeframe, Petitioner testified that she did not recall the exact reason that she sought treatment.

On cross-examination, when asked if prior to April of 2010 she was taking any medication for her low back pain, Petitioner testified that she was taking Hydrocodone. When asked if she remembered any bending over or kneeling incidents that caused sharp pain, Petitioner testified that she did not recall. Petitioner then testified that when she bent over in her car and felt her back give out in 2009, this was the time that she felt pain in her buttock area. Petitioner testified that she was leaning over to pick up items off the floorboard.

With respect to the April 26, 2010 accident, Petitioner testified on cross-examination that she felt the increase in pain after she had picked up the files and was sitting back up. Petitioner testified that she was sitting in her chair when she bent down to pick up the files out of the file cabinet. When asked if she was sitting in her chair at that point, Petitioner then testified that she did not recall if she sat in her chair or whether she was on her knees and fell to the floor, but she thought she fell to the floor.

Petitioner testified that the cabinet was quite a ways back from her desk, and that she rolled from her desk to the filing cabinet. Petitioner testified that she moved the chair over away from her desk and toward the filing cabinet, bent down to pick up the file and then she felt pain as soon as she lifted the file. Petitioner testified that then she fell to the ground and that was when she called for her co-worker. When asked what happened to all the papers in the 18-inch folder, Petitioner testified that she did not know, and that she did not recall whether they went all over the floor. Petitioner agreed that an 18-inch wide folder would have a lot of papers in it, but did not know where the papers went as she was not worried about where the papers went at that point. Petitioner testified that she picked up the papers and was closing the cabinet with her foot at which time she felt the pain, that she did not know where the papers went and that she did not know if they fell in the cabinet or on the floor.

As to the January 26, 2011 incident, Petitioner testified on cross-examination that she was kneeling down filing vouchers, that the cabinet had multiple drawers, and that she had some papers that went in the bottom drawer as well as the drawer above it. Petitioner testified that when she picked up the papers that went in the drawer above the bottom drawer and stood up from the kneeling position, she had papers in hand and felt the same popping sensation and pain when she was standing up from a kneeling position. When asked if she remembered going to the emergency room approximately two weeks prior to that, Petitioner testified that it was possible but she did not recall. Petitioner testified that she recalled going the day she got hurt at work, but did not recall specific dates and times of going to the emergency room every time her back hurt.

On cross-examination when asked how many times in the ten years prior to the April 2010 accident she thought she had to go to the emergency room just because of low back pain, Petitioner testified that she did not recall. Petitioner testified that it was maybe more than five times, but did not know and could not recall. Petitioner testified that she had no estimate for how many times she went to the emergency room between April 26, 2010 and January 26, 2011. When asked if she remembered any times she was at home where she bent over and had sharp pain and had to go to the emergency room, Petitioner testified that she did not recall the specific incidents. Petitioner testified that there were times she had gone to the emergency room from home, but she could not recall any examples of what she would have been doing at home that caused her to need to go to the emergency room on any of those instances.

On cross-examination, Petitioner testified that since the surgery there had been some pain, some sharpness, and some radiating pain but that there was no further treatment that could be done to improve the situation any more than it had. Petitioner testified that the radiating pain is was sporadic. Petitioner denied being able to think of any instances where she was doing something that caused the radiation to occur. Petitioner testified that she remembered being in a car accident in 2013, but that it did not cause her any low back pain.

On cross-examination, Petitioner admitted that she also worked at Target at some point after 2011, and that she had had an accident which involved breaking her wrist after she fell off a ladder. Petitioner testified that she was two steps up on the ladder and was changing a sign. Petitioner testified that that the sign was one foot by three feet in size and weighed perhaps six ounces as it was a piece of cardboard. Petitioner testified that she worked on the sales floor at Target, that she straightened shelves which consisted of pulling items to the front and making the shelves neat and straight, and that she also helped customers.

On cross-examination, Petitioner testified that her inability to have sex started in 2011, and that she had not had sex since 2011. Petitioner admitted that she undergoes yearly mammograms, and that in 2014 she would have undergone a mammogram with Cheryl Brown. Petitioner testified that she remembered telling Ms. Brown that she was divorced from her husband but was still having physical relationships a few times a week.

On cross-examination, Petitioner admitted that in the early- to mid-2000's, she played volleyball during the winter at the high school. Petitioner testified that it was recreational adult volleyball, but was not competitive. Petitioner admitted that in 2009 she stopped playing volleyball because of her back. When asked whether in the early- to mid-2000's she had ever picked mushrooms occasionally, Petitioner testified that she did not know, that her dad was a farmer and that she may have gone with him to pick mushrooms somewhere, but that she did not recall. Petitioner then admitted that she had gone mushrooming with her dad, but could not remember any instances of doing it without her father. When asked if the motions associated with picking mushrooms -- for example, bending down or kneeling -- would be a similar motion to when she was bending over to get a file, Petitioner indicated that they were not the same because she was not sitting in a chair when she picked up mushrooms. Petitioner admitted that she was not in a chair in January of 2011 and that she was kneeling down, but she indicated that she did not kneel down to pick up mushrooms. Petitioner indicated that she pulled her foot up to the seat of the chair in order to tie her shoe.

On redirect examination, Petitioner testified that if she experienced a flare-up or increase in pain prior to April of 2010, such increases would typically last a day or two and would respond to treatment. When asked to explain about the comment she made to Cheryl Brown during her mammogram about her physical relationship, Petitioner testified that she and Dr. Brown were very good friends, and that Dr. Brown was very involved with relationships. Petitioner testified that she was trying to give the impression that everything was fine because she did not want Dr. Brown to think that she was not being intimate because of other issues.

With respect to mushrooming, Petitioner testified on redirect examination that mushrooms did not weigh much and that you picked up a mushroom like you picked up a golf ball, which was substantially different than picking up a stack of papers like those she described.

Petitioner's Application for Adjustment of Claim for Case Number 11 WC 39600 was entered into evidence at the time of arbitration as Arbitrator's Exhibit 2. The Application for Adjustment of Claim alleges injury to the back as a result of bending and lifting on April 26, 2010. The Application was signed by Petitioner on October 11, 2011. (AX2). The Application for Adjustment of Claim for Case Number 11 WC 40039 was entered into evidence at the time of arbitration as Arbitrator's Exhibit 3. The Application for Adjustment of Claim alleges injury to the back as a result of bending and lifting on January 26, 2011. The Application was signed by Petitioner on October 11, 2011. (AX3).

The medical records of Memorial Medical Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 1. The records reflect that Petitioner underwent a lumbar epidural steroid injection on February 17, 2015 with a noted History of bulging disc, pain extending to left leg. The records reflect that Petitioner underwent a lumbar epidural steroid injection on January 16, 2015 with a noted History of back pain extending down left leg. The records reflect that Petitioner underwent an MRI of the lumbar spine on December 24, 2014 for a noted History of low back pain and left leg pain, as well as a history of microdiscectomy. The Impression of the interpreting radiologist was that of left asymmetric protrusion at L5-S1 abutting the left L5 nerve root; no other significant change since October 23, 2013. (PX1).

The records reflect that Petitioner underwent an Initial Evaluation at Memorial's Rehabilitation Services at Koke Mill on October 31, 2013 with a noted medical diagnosis of lower back pain. The Medical Records Summary List noted Current Medical Problems of pain in the lower back and in the left and right lower extremity more in the left lower extremity in the hamstring area, and that Petitioner's Past Medical Problems were significant for pain in the back since 17 years of age. It was noted that Petitioner had undergone a microdiscectomy in 2011. It was noted that functional issues included sitting, sleeping and bending. The Discontinuation Summary dated November 21, 2013 noted that Petitioner did not attend her follow-up appointments on November 5, 2013 or November 6, 2013, and that the patient/client or caregiver declined to continue care. (PX1).

The Interdisciplinary History – Rehab Services dated October 25, 2013 noted that Petitioner was a 41-year-old female who had a known history of lumbar disk disease, and that she had a history of microdiscectomy in the past. The records reflect that Petitioner stated that her current symptoms started approximately one month ago in the first week of September when she noticed severe back pain. It was noted that Petitioner had presented to the Emergency Room on September 20, 2013 and was discharged after some pain medications, and that Petitioner continued to have significant pain, described as a sharp, shooting type of pain down her left leg and also throbbing pain in the sides of the back. It was noted that Petitioner was also having some incontinence of the bowel and bladder, especially with the bladder. (PX1).

The Memorial Medical Center records reflect that Petitioner was admitted for observation for the timeframe of October 23, 2013 through October 25, 2013 for acute on chronic back pain related to an old back injury which occurred when she was age 17. It was noted that Petitioner had surgery in 2011 with Dr. Russell. Petitioner underwent an ultrasound of the kidneys on October 23, 2013 for a noted History of bilateral flank pain and urinary incontinence, and the Impression was negative. Petitioner also underwent an MRI of the lumbar spine on the same date, which was interpreted as expected postoperative appearance at L5-S1; no compressive disc herniation; no spinal canal or neural foramina stenosis. (PX1).

The Memorial Medical Center records reflect that Petitioner presented to the Emergency Department on October 23, 2013 at which time she complained of lumbar pain with a history of same, and she denied new injury but noted incontinence. Petitioner noted a sharp pain to the mid-back and a burning pain to the sides of her back, and that walking exacerbated her pain. Petitioner reported bladder/bowel incontinence since September 2, 2013, and that the incontinence occurred every day. Petitioner also noted tingling pain down the back of her left leg, and it was noted that she took Oxycodone with minimal relief. Petitioner denied new injury/trauma, and stated that Dr. Florence referred her for pain control and/or direct admission. It was noted that Petitioner had her last surgery in July of 2011 (which was a microdiscectomy) with Dr. Russell, and that she had an appointment with him scheduled for November 5, 2013. It was also noted that Petitioner had also seen a neurosurgeon in Indianapolis who did not recommend surgery due to a possible worsening of her symptoms. The records reflect that Petitioner also had testing performed through the VA hospital in September 2013 including a cystoscopy, bladder scan and lumbar MRI which were all normal. The records reflect that the onset was noted to be chronic, and it was further noted that Petitioner had constant back pain since an injury at age 17, and that it had been worse since September 2013. It was noted that there was a concern for worsening pain and worsening bowel/bladder symptoms, so Petitioner was admitted for pain control and Physical Therapy/Occupational Therapy/Therapy evaluation. (PX1).

The Memorial Medical Center records reflect that Petitioner presented to the Emergency Department on September 6, 2013, at which time Petitioner presented with a chief complaint of a history of bulging disc, that her pain had increased and that she was having trouble controlling her bowels and bladder, especially during sleep. The records reflect that Petitioner reported a history of a previous L5 fracture and presented to the Emergency Department complaining of chronic lower back pain, which had

worsened over the past three days. Petitioner denied new injury to cause exacerbation. Petitioner reported that the pain was sharp in the middle and burning in her lower back, and that she had radiation of pain down the left lower extremity. The records reflect that Petitioner stated that she never had incontinence before. Petitioner stated that she had been on narcotics for the past 20 years and they were not working. Petitioner's diagnosis was sciatica, and she was discharged home. (PX1).

The Memorial Medical Center records reflect that Petitioner was seen in the Emergency Department on July 25, 2013, at which time Petitioner reported low back pain since that morning and she denied injury. It was noted that Petitioner had a history of chronic back pain since she was 17 after a motor vehicle collision, and that she had undergone one surgery with Dr. Russell in the past. The records reflect that Petitioner reported that she woke up that morning and the pain was so bad she could not walk. Petitioner also reported that for the past 2-3 months she had been having loss of bladder control at night. Petitioner underwent an MRI of the lumbar spine, which was interpreted as revealing mild degenerative disk disease at L5-S1; postop left hemilaminotomy L5-S1; slight asymmetric disc protrusion towards the right at L3-4; motion compromised exam; no spinal stenosis or foraminal narrowing at any level. Petitioner was discharged with a diagnosis of back pain and lumbar herniated disc. (PX1).

The Memorial Medical Center records reflect that Petitioner was seen in the Emergency Department on October 17, 2012, at which time Petitioner stated that she had chronic low back pain and that her pain was worse since the day prior but she denied new injury. Petitioner stated that the pain was radiating down both legs, and that she had fallen three times that day. It was noted that Petitioner had a lumbar microdiskectomy last year, but that her pain was worse now than before the surgery. It was noted that Petitioner had taken a Vicodin at 7:00 a.m. with no relief, and that Petitioner denied bladder/bowel dysfunction or leg weakness. Petitioner underwent an MRI of the lumbar spine on that date, which was interpreted as revealing degenerative disc disease greatest at L5-S1. (PX1).

The Memorial Medical Center records reflect that Petitioner underwent lumbar facet injections, bilateral, at L3, L4 and L5 on February 13, 2012, for which the diagnosis was noted to be lumbar facet arthropathy. The records reflect that Petitioner underwent a pain consult with Dr. Salvacion on January 20, 2012, at which time it was noted that Petitioner was referred to the pain clinic because of persistent low back pain. It was noted that Petitioner had chronic low back pain following an injury while on active duty, and that she fell down some stairs at the age of 17 and had a compression fracture of the L5 vertebral body. It was noted that up until recently she also had pain extending down her leg but following a microdiskectomy by Dr. Russell in July 2011 that pain had resolved. Petitioner still had persistent low back pain, and she described a sharp, aching pain at times across her low back. The Impression was that of lumbar degenerative disk disease, epidural fibrosis, and lumbar facet arthropathy. Petitioner was recommended to try Lidoderm patches to the affected area, and she was also recommended to undergo a trial of lumbar facet blocks for continued axial low back pain. (PX1).

The Memorial Medical Center records reflect that Petitioner underwent an L5-S1 microdiskectomy by Dr. Brian Russell on July 11, 2011, with pre- and post-operative diagnoses of disk herniation, L5-S1. (PX1).

The Memorial Medical Center records reflect that Petitioner presented to the Emergency Department on July 21, 2011 complaining of chronic back pain and a history of bulging disc. Petitioner denied new injury, and also denied new numbness or tingling or weakness in the lower extremities. It was noted that there was no change in bowel movements or in urination, and she denied any incontinence. Petitioner stated that she had a history of chronic back pain, secondary to filing papers at work one year ago. Petitioner stated that her pain felt like her normal chronic pain, and that the course/duration was constant and worsening. Petitioner's diagnosis at the time of discharge was back pain, and she was discharged home. (PX1).

The Memorial Medical Center records reflect that Petitioner underwent nerve conduction studies by Dr. Trudeau on March 31, 2011, at which time it was noted that Petitioner had an injury while working for the state police in January 2011 and had had problems in the low back and bilateral lower extremities since, particularly on the left side as compared to the right. It was noted that Petitioner had previously been documented to have some element of disk abnormality at L5-S1 but had never been documented to have radiculopathy. It was noted that one year prior the VA did an EMG test and there was no evidence whatsoever of nerve damage and it was completely negative, and that Petitioner was not felt to have any problems involving the nerve roots until the January 2011 injury. It was noted that since that time, Petitioner had severe low back and bilateral leg pain that radiated down both legs, left greater than right, and that it did radiate somewhat proximately down the right lower extremity but the worse was the left. The studies were interpreted as revealing (1) left S1 radiculopathy, moderately severe in electroneurophysiologic testing terms; (2) no current evidence of left L5 radiculopathy; (3) no current evidence of other radiculopathy; (4) no current evidence of entrapment neuropathy; (5) no current evidence of lumbar plexopathy; (6) no current evidence of mononeuritis multiplex. (PX1).

The Memorial Medical Center records reflect that Petitioner was seen in the Emergency Department on February 23, 2011, complaining of pain in the lower back and the left lower extremity. It was noted that Petitioner had undergone an MRI in November, and that she had an appointment with Dr. Russell the next week. The onset was noted to be chronic. The diagnosis was noted to be back pain, and Petitioner was discharged home. (PX1).

The Memorial Medical Center records reflect that Petitioner was seen in the Emergency Department on January 26, 2011, at which time she complained of back pain. It was noted that Petitioner had a history of a compression fracture at L5 at age 17. It was noted that Petitioner was at work and bent over, and her back locked when getting up. It was noted that Petitioner was recently seen on January 15, 2011 for the exact same exacerbation, and that Petitioner had a neurosurgeon consultation scheduled for March 1, 2011 with Dr. Russell. It was noted that this was a chronic issue that had occurred since Petitioner was 17 years old, and that it had been getting worse over the past year. Petitioner reported that her back pain had been well controlled on her home regimen, but it acutely worsened with recent kneeling and bending over. (PX1).

The Memorial Medical Center records reflect that Petitioner was seen in the Emergency Department on April 26, 2010, at which time it was noted that Petitioner arrived per EMS after bending over at work and could not get up from muscle spasms. The records reflect that Petitioner had chronic back problems, bent down at work, and developed severe lower back pain and spasm. (PX1).

The medical records of Springfield Clinic were entered into evidence at the time of arbitration as Petitioner's Exhibit 2. The records reflect that Dr. Kirkwood prepared a Discharge Summary on October 25, 2013, which noted that Petitioner was a 41-year-old female with known history of lumbar disk disease who came in with intractable low back pain. It was noted that Petitioner had a known history of opioid dependence, and that an MRI had been done which did not show significant changes. It was noted that Petitioner was discharged home in stable condition. (PX2).

The History and Physical dated October 23, 2013 noted that Petitioner had a known history of lumbar disk disease, and that she had a history of microdiskectomy done at the L5-S1 area in the past. Petitioner stated that her current symptoms started approximately one month ago in the first week of September when she noticed severe back pain. Petitioner was noted to have been seen in the Emergency Room, where she was discharged after some pain medications were given. Petitioner continued to have significant pain, described it as a sharp, shooting pain down her left leg and also throbbing pain on the sides of the back. Petitioner stated that her back pain started at the age of 17 when she was involved in an

accident, and that since then she had been having on-and-off episodes of back pain. Petitioner was admitted to the general floor and started on pain medications. (PX2).

The Springfield Clinic records reflect that Petitioner was seen by Dr. Russell on November 30, 2012, at which time Petitioner reported that she had had a couple of episodes where her legs gave out on her. On examination, it was noted that Petitioner had good strength in both lower extremities and no significant radiating leg pain. It was noted that the old back incision had healed very well, and that reflexes were maintained. The records reflect that Dr. Russell reviewed her recent MRI findings, which showed some bulging of the disc but there was no significant re-herniation. Petitioner as encouraged to take non-steroidals, work on her flexibility and try her best to strengthen her core. (PX2).

The Springfield Clinic records reflect that Petitioner was seen by Dr. Russell on January 4, 2012 in follow up for her back. It was noted that Petitioner was "doing ok" and that she still had some low back pain but no leg pain. It was noted that Petitioner looked like she was doing very well, and that she had no significant radiating leg pain. It was noted that Petitioner still had some occasional back pain. Petitioner was instructed to return on an as-needed basis. (PX2).

The Springfield Clinic records reflect that Petitioner was seen by Dr. Russell on November 18, 2011, at which time Petitioner stated that her low back in the middle had been in increased pain the last few days, that it felt like there was a knife in her back, and that she continued to have left leg pain. A follow-up MRI scan failed to show any significant compromise of the nerve root, that there were some postoperative changes and there was perhaps some epidural scarring, but no significant disc herniation. Petitioner was instructed to continue with stretching, exercise, strengthen her core and work on her flexibility. A course of physical therapy was reinitiated. (PX2).

The Springfield Clinic records reflect that Petitioner was seen by Dr. Russell on October 12, 2011, at which time it was noted that Petitioner stated that she was "not doing very good." Petitioner stated that she had low back pain and left leg pain, and that the Vicodin every 4-6 hours was not controlling the pain. Petitioner stated that she had been doing recommended stretching and exercises without improvement. Petitioner was not aware of any one particular trauma or injury, and it was noted that she began having some discomfort about two weeks prior. Petitioner was getting pain into her left buttock and proximally into the left leg, but no distal leg symptoms. Petitioner was given a script for physical therapy. (PX2).

The Springfield Clinic records reflect that Petitioner was seen by Dr. Russell on August 24, 2011, at which time Petitioner stated that she was doing much better. Petitioner denied any significant radiating leg pain, and it was noted that she had great strength in both of her lower extremities. Petitioner was instructed to return in 6-8 weeks. (PX2).

The Springfield Clinic records reflect that Petitioner was seen by Dr. Russell on July 26, 2011, at which time Petitioner looked to be doing very well. Petitioner's leg pain seemed much improved. Petitioner was cleared to lift up to 10 pounds and was cleared to drive. Petitioner was instructed to return in 3-4 weeks. (PX2).

The Springfield Clinic records reflect that Petitioner was seen by Dr. Russell on April 29, 2011, at which time it was noted that Petitioner had been identified on EMG and nerve conduction studies to also have a left-sided S1 nerve root irritation. Petitioner had a laterally bulging disc at L5-S1, and she had tried several different modalities of conservative treatment to see if it would improve her symptoms. It was noted that Petitioner had an option of either continuing to observe, stretch and exercise, work on her flexibility, strengthen her core or undergo surgery. Petitioner was to consider her options. (PX2).

The Springfield Clinic records reflect that Petitioner was seen on March 1, 2011 at the referral of Dr. Hazelwood for low back pain radiating into both legs. It was noted that Petitioner fell in 1989, had an L5 compression fracture and had back problems since. Petitioner stated that recently her back pain had increased and was constantly hurting, and that she had been in the ER three times in the last few months. Petitioner stated that her low back, left leg and right buttock hurt with some numbness and tingling in her legs at times. Petitioner stated that she had EMG studies done in December 2009 at the VA which were negative, and she had not had any recent epidural injections. Petitioner stated that the chiropractor would not touch her. EMGs and nerve conduction studies were ordered in order to identify a root irritation. (PX2).

The Springfield Clinic records reflect that Petitioner was seen by Dr. McKay on February 18, 2011, stating that her neck and lower back had both been bothering her. Petitioner underwent chiropractic treatment on that date. (PX2).

The Springfield Clinic records reflect that Petitioner underwent an MRI of the lumbar spine on October 21, 2011, which was interpreted as revealing no compressive disc herniation; expected postoperative changes at L5-S1 with enhancing scar surrounding the left S1 nerve root sleeve. (PX2).

The Springfield Clinic records reflect that Petitioner was seen on December 22, 2011 for physical therapy. Petitioner reported feeling better than before physical therapy. It was noted that Petitioner was able to sleep through the night most nights but did occasionally wake from discomfort. Petitioner reported that she continued to have mild discomfort in the low back off and on, but reported 75% improvement. Petitioner was discharged to a home exercise maintenance program at that time. The records reflect that Petitioner underwent physical therapy on December 19, 15 and 12 at which time it was noted that Petitioner stated that she had to take a Vicodin the day prior but attributed it to cleaning her carpets on Saturday, stating that motion always bothered her. Petitioner also underwent physical therapy on December 9, 7 and 2 as well. The records reflect that Petitioner underwent a physical therapy evaluation on November 30, 2011, at which time it was noted that Petitioner had been having low back and left leg pain for the past several years. Petitioner stated that she underwent an L5-S1 microdiscectomy on July 11, 2011 after which she was doing very well, but six weeks post-surgery she noticed that the low back and left leg pain returned. Petitioner stated that the left leg pain was intermittent, but the low back pain was always there. (PX2).

Various Health Status Forms were included in the Springfield Clinic records. The return to work slip dated October 12, 2011 indicated that Petitioner was allowed to return to work/school on October 12, 2011 with restrictions of half days for a week then return to full duty. The return to work slip dated August 24, 2011 indicated that Petitioner could return to work/school on August 29, 2011 with restrictions of half days for the week of August 20-September 2, then full duty beginning September 5. (PX2).

Various Illiana HCS medical records were included within the Springfield Clinic records, including an interpretive report for lumbosacral spine x-rays performed on July 21, 2009. The x-rays were interpreted as revealing slight probably chronic loss of height of the L2 vertebral body. An MRI of the lumbar spine performed on November 24, 2010 was interpreted as revealing a linear annular tear at L5-S1. An interpretive report for cervical spine x-rays performed on December 16, 2009 were interpreted as revealing a normal cervical spine; the history noted was that of chronic neck pain. (PX2).

The Operative Report pertaining to an L5-S1 left-sided repeat epidural injection performed on June 2, 2011 at St. John's Hospital was included within the Springfield Clinic records. The pre-operative diagnosis noted was that of L5-S1 disk protrusion producing left-sided radiculopathy. The records reflect

that another L5-S1 fluoroscopically-guided epidural steroid injection was performed on May 12, 2011. (PX2).

The medical records of Koke Mill Medical Associates were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The records reflect that Petitioner was seen on December 1, 2014 with a chief complaint of back pain for five days. It was noted that the condition was not related to a specific injury but Petitioner had increased activity which may have exacerbated it. It was noted that Petitioner appeared to be uncomfortable, that her range of motion was abnormal and that she had limited lumbar range of motion diffusely by pain. Petitioner was given a Fentanyl patch and prescribed muscle relaxants. (PX3).

The Koke Mill Medical Associates records reflect that Petitioner was seen on May 27, 2014, at which time she presented with complaints of gradual onset of moderate left lower back pain, radiating to the left buttock and left thigh starting May 24, 2014. It was noted that Petitioner had been seen in the past in neurosurgery and physical therapy. It was noted that Petitioner had been working in the yard mowing and had some increased pain. It was noted that Petitioner stated that Dr. Russell was "waiting until the disc ruptures to do anything else." Petitioner was prescribed a Lidocaine patch and given a prescription for Prednisone. (PX3).

The Koke Mill Medical Associates records reflect that Petitioner was seen on February 14, 2014, at which time she was seen for management of her chronic back pain, migraines and medications. Petitioner was instructed to keep a food diary, and it was noted that her Gabapentin was discontinued. (PX3).

The Koke Mill Medical Associates records reflect that Petitioner was seen on November 8, 2013, at which time she presented for FMLA papers. It was noted that Petitioner had papers filled out by her VA physician allowing 3 absences/year with 1-2 days per event for lumbar radiculopathy. Petitioner stated that she had been in the hospital September 9 through September 11 and October 23 through October 25 for back pain, and that she talked with the person who handles FMLA at work and was told that she had already exceeded her allowance. Petitioner stated that she needed updated papers to show that she had been incapacitated for more than 3 days. It was noted that Petitioner had been missing partial or full days 2-3 times weekly, and that she was doing physical therapy before work. FMLA papers were updated and faxed as requested. (PX3).

The Koke Mill Medical Associates records reflect that Petitioner was seen on November 1, 2013 for follow up from the hospital and a urology referral. It was noted that Petitioner was adherent to her medication regimen, that she had undergone a urine drug screen, and that her opioid contract had been renewed. Or was given a Fentanyl patch and recommended to undergo therapy. The records reflect that that Petitioner was also seen on October 23, 2013 with a chief complaint of back pain. It was noted that Petitioner had a long history of back disease with herniated disc and procedure by Dr. Russell years prior, and that she had a pain contract with the VA in Danville but stated that her current pain regimen was inadequate. Petitioner was sent to the ER for further pain control and possible admittance, and it was noted that her observed mood and affect included excessive crying, frustrated and despairing. Petitioner was also seen on October 1, 2013 complaining of severe back pain for one month, and that Petitioner had failed more epidural injections and had a possible second procedure pending. The records reflect that Petitioner was to call pain management for possible addiction of Fentanyl patch, and that Petitioner was referred to Dr. Russell. At the time of the October 19, 2012 visit, it was noted that Petitioner had been seen at the Memorial Medical Center Emergency Room on October 17, 2012 with a diagnosis of low back pain. Petitioner was assessed with lumbar radiculopathy and given a prescription for Prednisone. (PX3).

The medical records of the Veterans Administration Clinic ("VA") were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. The records reflect that Petitioner underwent an MRI of the lumbar spine on September 9, 2013 with a noted history of back pain and bowel/bladder incontinence. The films were interpreted as revealing a central disc protrusion extending slightly to the left measuring approximately 5 mm at L5-S1 compromising the thecal sac ventrally; left neural foraminal narrowing and possible mild impingement on the left nerve root; no evidence of spinal stenosis. (PX4).

The VA records reflect that Petitioner was seen at Urgent Care on October 2, 2013, at which time it was noted that Petitioner was being seen for an ultrasound of her kidneys. It was noted that Petitioner had been in a lot of pain with her back, and that she had a history of chronic back pain. It was noted that Petitioner had seen several people to include outside facilities for this as well, and that she was crying and said her pain was so bad that she was going to end her life. The records reflect that Dr. Juhala spoke with Petitioner and verified that she was not suicidal at that time. It was noted that Petitioner's pain was in her back, right at the lower lumbar area. It was noted that Petitioner was able to sit and stand, and that everything except for her subjective pain was "pretty much normal." The assessment was noted to be acute on chronic low back pain. Her renal ultrasound was normal. She was instructed to see her primary care physician to discuss changing pain medications. (PX4).

The VA records reflect that Petitioner was seen for a Physical Medicine and Rehab consult on September 18, 2013 for intervention addressing low back pain. It was noted that Petitioner was issued a Lumbar/Core Muscle Strengthening, Bilateral Lower Extremity AROM/Stretching home exercise program with written instructions for home use. It was noted that no skilled physical therapy was required at that time. (PX4).

The VA records reflect that Petitioner was seen at the Springfield Medical Clinic on September 17, 2013 at which time she presented with back pain. It was noted that Petitioner had recently been evaluated in Indianapolis, and that she had an annular tear. It was noted that Petitioner's continued low back pain was improved, and that she had upcoming physical therapy. It was noted that FMLA paperwork was filled out. The records also reflect that Petitioner was seen on February 21, 2012 with a chief complaint of low back and neck pain. Petitioner stated that she had multiple facet injections during the previous week which had greatly reduced her pain. Petitioner was assessed with low back pain and neck pain, and she had acupuncture to the low back and cervical spine as well as manual manipulation to the thoracic and cervical spine. Petitioner was also seen on February 17, 2012 for ongoing treatment for low back pain and neck pain for which acupuncture was performed to the low back and cervical spine, as well as manipulation to the thoracic and cervical spine. (PX4).

The VA records reflect that Petitioner was seen for a chiropractic consult on February 10, 2012 with a chief complaint of back pain. Petitioner stated that her pain began in 1989 following a fall which reportedly caused a fracture of L5. Petitioner stated that in July of 2011 she had a discectomy at L5-S1 which gave her minimal relief. Petitioner stated that the low back pain was achy and sent an electrical sensation down the back of the left leg ending just above the knee, and that she was having multiple therapies including physical therapy and chiropractic care which had not given any significant relief. Petitioner also stated that she had neck pain which she stated was achiness but did not radiate into the upper extremity. Petitioner reported that all movement aggravated the pain, and that while her pain medication did not decrease her pain it helped symptomatically. The assessment was that of low back pain and neck pain, and she underwent acupuncture to the lumbar spine and neck as well as manual manipulation to the thoracic spine and flexion distraction L4-L5. It is also significant to note that an Addenda was added for the same date of service pertaining to the chiropractic consult. The Addenda noted that the cervical compression was negative for neck pain but it elicited pain in the lumbar spine which suggested a lack of organic basis for the lower back complaint. Petitioner was also issued a cane on February 10, 2012 by Physical Medicine and Rehabilitation. (PX4).

The VA records also reflect that Petitioner was seen on February 10, 2012 as a surgery consult with a chief complaint of back pain. It was noted that Petitioner presented with a long history of low back pain, history of L5 compression fracture, L5 microdiscectomy in August 2011 that relieved left S1 radicular complaints entirely, though she walked with a cane in her right hand. Petitioner did not complaint of lower extremity weakness but rather pain in the upper hips when walking. It was noted that Petitioner had been on Hydrocodone for more than three years at her current dose, she admitted to depression and anxiety and appeared depressed and distressed. The impression was noted to be that of (1) left longer than right, slight leg length discrepancy; (2) right more than left sacroiliitis (SIJ): positive Patrick's, positive Faber, positive PSIS tenderness, leg length discrepancy; (3) L4-5, L5-S1 posterior element tenderness; (4) nighttime lumbosacral spasm; (5) depression, anxiety related to pain, but functional related to full time work. The records reflect that (1) a podiatry consult was recommended for the leg length discrepancy; (2) a referral was recommended for bilateral SIJ injections: do right SIJ first, then left SIJ, should take precedence over facet injections, but both are indicated; (3) recommend L4-5, L5-S1 facet injections, with probable ablation procedure to follow; (4) recommend Tizanadine for nighttime spasm; (5) recommend frequent counseling for depression and anxiety, patient has very external locus of control; (6) recommend discontinue Hydrocodone, as patient tolerant to this medication – suggest Oxycodone; (7) follow up Pain Care Evaluation clinic post all interventional therapy. (PX4).

The VA records reflect that Petitioner was seen on January 14, 2012 with reports of chronic back pain. Petitioner stated that she had back surgery on July 11, 2011 and had since undergone physical therapy as well as a reevaluation two weeks prior. A discussion was had regarding Petitioner's high medication narcotic agreement, and that she was in violation with the use of outside narcotics with the addition of narcotics provided by the Primary Care office. Petitioner stated that she was unaware of the violation. The records reflect that Petitioner was recommended a second opinion through Chiropractic Services at the VA Medical Center, and that it was suggested that she undergo a Pain Clinic Evaluation at the VA. Given that Petitioner had a fall in the past where her leg gave out, it was recommended that she be evaluated by Physical Therapy in Danville for the possibility of a cane being issued. The Assessment/Plan was noted to be (1) Chronic lower back pain, consultation to Danville Chiropractic Services as well as Dr. Wrestler for Pain Clinic; (2) hyperlipidemia; (3) history of a fall, consult physical therapy; (4) insomnia; (5) military sexual trauma, currently under the care of Mental Health services; (6) follow up in 6 months. (PX4).

The VA records reflect that Petitioner was seen by Dr. Hazelwood on what appears to be March 11, 2011, and that Petitioner presented for follow up of chronic low back pain with an MRI showing an annular tear between L5 and S1. Petitioner stated that the neurosurgeon wanted to do a trial of either cortisone injections or epidural injections, and that Petitioner still continued on Vicodin. The Impression was that of (1) Chronic low back pain with annular tear at L5-S1, obtain records from neurosurgeon's office. Petitioner also was seen on what appears to be November 29, 2010, at which time it was noted that Petitioner presented after having been seen in the ER for migraine headaches on the 27th of October. The records reflect that the main conversation on that date pertained to her low back pain. Petitioner was noted to have loss of disc height on an x-ray in 2009 at L2, and that she had not had any other scanning. Petitioner stated that her Hydrocodone for her headaches had worked for the back pain. The Impression was that of lumbar disc disease, unknown whether there was a herniated disc. Petitioner was given a prescription for Tramadol and set up for an MRI. (PX4).

Petitioner's Medical Bills Exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibit 5.

The Wage Statement for the April 26, 2010 alleged date of accident was entered into evidence at the time of arbitration as Respondent's Exhibit 1. The Wage Statement for the January 26, 2011 alleged date of accident was entered into evidence at the time of arbitration as Respondent's Exhibit 2.

The Workers' Compensation Employee's Notice of Injury Form for the alleged April 26, 2010 accident was entered into evidence at the time of arbitration as Respondent's Exhibit 3. The Form referenced a Date of Injury or Illness of April 26, 2010 at 11:30 a.m., and that the accident was reported to Petitioner's supervisor, David Jocson, on April 26, 2010 at 11:30 a.m. The Form indicated that Petitioner reported that she was bending over to close a file cabinet drawer when she felt a pulling in her low back and pain radiating down her legs. The Form further indicated that the witness to Petitioner's injury was Diane Hill. The Form was completed on April 29, 2010. (RX3).

The Workers' Compensation Employee's Notice of Injury Form for the alleged January 26, 2011 accident was entered into evidence at the time of arbitration as Respondent's Exhibit 4. The Form referenced a Date of Injury or Illness of January 26, 2011 at 11:00 a.m., and that the accident was reported to Petitioner's supervisor, David Jocson, on April 26, 2011 at 11:00 a.m. The Form indicated that Petitioner reported that she was kneeling down to file vouchers and when she stood up she felt a sharp pain in her low back with pain radiating down the left leg. The Form indicated there were no witnesses to Petitioner's accident. The Form was completed on January 27, 2011. (RX4).

The Tristar Medical Bill Report was entered into evidence at the time of arbitration as Respondent's Exhibit 5.

The Illinois State Police Timekeeping Codes were entered into evidence at the time of arbitration as Respondent's Exhibit 6.

The Illiana VA Medical Records were entered into evidence at the time of arbitration as Respondent's Exhibit 7. The records reflect that Petitioner called in on September 12, 2013, at which time she indicated she was "miserable" and that her pain medication was not working. The note indicated that when Petitioner was at Indianapolis they gave her steroids and Dilauded for relief which she knew she could not take long-term. The note indicated that Petitioner stated it was recommended that she be referred to physical therapy and Urology for incontinence. The note indicated that Petitioner stated that the Hydrocodone/Morphine were not working and requested a different medication. It was also noted that Petitioner was requesting a leave of absence from work due to difficulty with bending, squatting, and lifting. (RX7).

The Illiana VA records reflect that Petitioner also called in on September 9, 2013, at which time Petitioner stated that last week she was lifting and felt a pop in her back and had increasing pain. It was noted that Petitioner had been incontinent of bowel and bladder, that she had no focal weaknesses but did have left-sided radiculopathy. The records reflect that Petitioner was recommended to be evaluated at the local emergency department or Danville. (RX7).

The Illiana VA records reflect that Petitioner called in on September 6, 2013 at which time she indicated that her back pain was "out of control," that it started on Tuesday and that she did not remember any trauma to the area but she was vacuuming before her pain got worse. The records reflect that Petitioner also stated that since then she had been incontinent of bowel and bladder. The records reflect that Petitioner was given options of Urgent Care in Danville or to go locally with her private insurance. The records reflect that Petitioner chose to go to Memorial Medical Center. (RX7).

The Illiana VA records reflect that Petitioner was seen on December 14, 2009, at which time she reported low back pain that was constant in duration. The records reflect that Petitioner was seen on

November 2, 2009, at which time the Chief Complaint noted was that of chronic back pain for greater than 20 years. The records reflect that Petitioner reported that she developed back pain while serving in the military a little over 20 years, that she had injured her back, and that since then had had chronic pain. The records reflect that Petitioner reported that she wanted to take less Vicodin so that she did not feel as drowsy in her work environment. Petitioner reported that her pain was currently a 3-4/10 and could go up to 10/10, when she required an ambulance to take her to the ER as occurred a few days ago. Petitioner denied any numbness or tingling radiating down to her feet. The Assessment was that of chronic low back pain with history of L5 compression, current x-ray showing L2 vertebral body loss of height. A TENS unit was ordered, and Petitioner requested a trial of fee-based chiropractor visits. (RX7).

The medical records of Springfield Clinic were entered into evidence at the time of arbitration as Respondent's Exhibit 8. The "Office Procedure & Patient Introduction" dated March 25, 1992 noted that Petitioner's Present Complaints included severe pain in the lower back in area of fracture, started approximately two months ago. The records reflect that Petitioner underwent chiropractic care in March, April, May, June, September and October of 1992 and made various complaints of low back pain. The records reflect that Petitioner also underwent chiropractic care in April, May and June of 1994 and made various complaints of low back pain. (RX8).

The Springfield Clinic records reflect that Petitioner underwent chiropractic treatment with Dr. McKay in May and June of 2003 at which time she reported, among other things, moderate-to-severe lumbar pain. The records reflect that Petitioner also appears to have undergone chiropractic treatment in September and November 2008 for low back pain. The records reflect that Petitioner underwent chiropractic treatment for low back pain at various times through 2009 as well. (RX8).

The Springfield Clinic record dated November 7, 2012 noted that Petitioner fell off a ladder the day prior. The records reflect that Petitioner stated that she worked part-time at Target and full-time at the State Police. Petitioner stated that yesterday she was at Target and was on a ladder and fell, injuring her right wrist. Petitioner was assessed with a right distal radius fracture. (RX8).

The Springfield Clinic record dated November 30, 2012 noted that Petitioner had been having some low back pain and had had a new MRI scan. It was noted that Petitioner had a couple of episodes where her legs gave out on her. It was noted that Petitioner had good strength in both lower extremities and no significant radiating leg pain. It was further noted that Petitioner's MRI showed some bulging of the disc but no significant re-herniation. Petitioner was encouraged to take non-steroidals, work on her flexibility, and try her best to strengthen her core. It was noted that if Petitioner's symptoms worsened, she was to contact the office. (RX8).

The Springfield Clinic records reflect that Petitioner underwent EMG/NCV studies of the lower extremities by Dr. Gelber on November 12, 2013. It was noted that Petitioner in July 2011 had surgery at the L5-S1 level and now presented with complaints of pain in the back and a one-month history of pain radiating down the left leg. The Impression was noted to be a normal EMG/nerve conduction study of the lower extremities, that there was no electrodiagnostic evidence of acute or chronic lumbosacral radiculopathy on either side, that there was no evidence of peripheral neuropathy or of lower extremity nerve entrapments. (RX8).

The medical records of St. John's Hospital were entered into evidence at the time of arbitration as Respondent's Exhibit 9. The records reflect that Petitioner presented to the Emergency Room on November 5, 2013 at which time she indicated she was a restrained passenger in a vehicle driven by her son that struck the back of another vehicle at approximately 25-30 MPH. It was noted that Petitioner had a history of chronic back pain and presented complaining of neck and back pain. The

Diagnosis/Impression was noted to be neck pain, with an additional diagnosis noted of head and neck injury. (RX9).

The medical records of Koke Mill Medical Associates were entered into evidence at the time of arbitration as Respondent's Exhibit 10. The records reflect that Petitioner called in on September 20, 2005, at which time it was noted that Petitioner fell down four stairs the night prior and complained that her low back was tight. Petitioner called in on July 24, 2006 complaining of low back pain. Petitioner called in on October 9, 2006 complaining that her back was tight after painting a fence. Petitioner called in on February 1, 2007 complaining of back problems. (RX10).

Included within the Koke Mill Medical Associates records was the interpretive report for lumbar spine x-rays performed on April 17, 2009. The films were interpreted as revealing chronic changes but no acute finding; a history of low back pain was referenced. The records reflect that Petitioner was seen on August 4, 2009 regarding back pain, and that her bilateral buttocks and bilateral legs had worse pain with sitting. An acute flare-up was noted after painting. The Assessment was noted to be lumbar back pain with radicular leg symptoms. (RX 10).

The Koke Mill Medical Associates records reflect that Petitioner was seen on March 23, 2011 for worsening symptoms of back pain. It was noted that recent intervention included changing the dose of Vicodin to increase the dosage. The onset was noted to be six months ago and it was noted that Petitioner had a history of L5 fracture in 1999. The Assessment was that of Lumbago, and it was noted that Petitioner had back pain of unknown etiology and that Petitioner's pain control had been inadequate. The diagnostic plan was noted to be an EMG. Other planned treatment included work station modification. (RX10).

The Koke Mill Medical Associates records reflect that a Telenurse entry was made on April 3, 2011, at which time Petitioner stated that she fell asleep in the chair last night and because of her positioning, she work up this morning with severe pain in the low back. Petitioner stated that the pain when she was up was radiating down her left leg. (RX10).

The medical records of Memorial Medical Center were entered into evidence at the time of arbitration as Respondent's Exhibit 11. The records reflect that Petitioner was seen in Express Care on April 13, 2009 complaining of pain to the lower back and upper back with an onset of several days ago. Petitioner noted a history of "broken back" as a teen, and that she flared up once in awhile. Petitioner reported that the pain radiated down her right leg some, which was normal for her pain. (RX11).

The Memorial Medical Center records reflect that Petitioner was seen in the Emergency Department on September 28, 2009, at which time Petitioner reported that she bent over to pick something up and felt her back "give out" and that she had pain radiating into the left buttock. Petitioner reported prior occasional episodes. Lumbar spine x-rays were performed on that date which were interpreted as revealing no lumbar spine abnormality. (RX11).

The Memorial Medical Center records reflect that Petitioner was seen at Express Care on July 10, 2011, at which time Petitioner complained of falling that morning after which she had pain to the low back/tailbone. It was noted that Petitioner had fallen and landed on her buttocks on wooden steps at home. It was noted that Petitioner was scheduled to have an L5 discectomy the next day. (RX11).

The Memorial Medical Center records reflect that Petitioner was seen in the Emergency Department on February 3, 2014 at which time she presented with a "migraine" with an onset of 13 days ago. The "Psychiatric" section of the Physical Examination noted that Petitioner was agitated and demanding to be admitted, and it was noted that she was suspected of drug-seeking behavior. (RX11).

The IME report of Dr. Frank Petkovich was entered into evidence at the time of arbitration as Respondent's Exhibit 12. The report reflects that Petitioner was seen for an IME and impairment rating examination on May 12, 2015. The records reflect that Petitioner reported that on April 26, 2010, Petitioner was lifting some files out of a cabinet and felt and heard a "pop" in her lower back and had some pain in her lower back and left lower extremity. Petitioner reported that she was taken by ambulance to Memorial Medical Center, after which she was evaluated and released. Petitioner indicated that she subsequently was seen at the VA Hospital in Danville. Petitioner indicated that she was treated conservatively and had an MRI on November 24, 2010 which, per Dr. Petkovich, showed a lumbar disc protrusion towards the left at L5-S1. Petitioner indicated that she was having some back pain prior to April 26, 2010 because of her history of the L5 fracture in 1989. Petitioner indicated that she had treated conservatively after the incident of April 26, 2010 and made some improvement but had some persistent pain. (RX12).

The IME report indicated that Petitioner indicated that she sustained another injury at work on January 26, 2011 when she was lifting a box of files at work and developed recurring pain in her lower back. Petitioner indicated she was again taken to Memorial Medical Center, was evaluated and released, and had follow-up at the Danville VA Hospital. Petitioner indicated that during this time, she had some physical therapy. Petitioner indicated that she remained working much of this time, although she was off work for some period of because of lower back pain and pain into her left lower extremity. Petitioner indicated that she was referred by her primary care physician, Dr. Florence, to see Dr. Russell, a neurosurgeon. Petitioner reported that she ultimately had surgery for a lumbar laminotomy with microdiscectomy on the left at the L5-S1 level at Memorial Medical Center. Petitioner reported that following surgery she initially did well with resolution of her left lower extremity pain, but then had some recurring pain and had repeat lumbar epidural injections for pain control. Petitioner reported having last been seen by Dr. Russell in October of 2013 when she was released from his care. Petitioner indicated that she had continued under the care of Dr. Florence, and that she did have some persistent intermittent discomfort in her lower back along with some occasional pain into her left lower extremity, as well as some tingling along the lateral aspect of her left calf. Petitioner denied any pain into her right lower extremity and denied any bowel or bladder dysfunction. (RX12).

The IME report indicated that the physical examination performed revealed a well-healed lower lumbar scar form her prior surgery; that there was no evidence of inflammation; that range of motion of the lumbar spine was mildly limited with forward flexion at 80 degrees, extension 10 degrees, left and right bends each 10 degrees; that there was some mild tenderness to palpation in the right and left paraspinous lumbar areas; and that there was no muscle spasm in the right or left paraspinous lumbar areas. It was noted that there was no tenderness over the right or left sacroiliac joints; that there was no tenderness over the right or left sciatic notch areas; that the neurologic examination in both lower extremities showed patellar tendon reflexes to be 2+ and symmetrical; that the right Achilles tendon reflex was 2+ and the left Achilles tendon reflex was 1½ +. The report indicated that straight leg raising on the left at 80 degrees produced some mild radicular symptoms; that straight leg raising on the right at 90 degrees did not produce any radicular symptoms or hamstring pulling; and that range of motion of the right and left hips was full without discomfort. The report also delineated the various x-rays and MRI films that Dr. Petkovich reviewed and/or considered as part of the IME. The report in the Summary section indicated that Dr. Petkovich reviewed approximately 2000 pages of medical records. (RX12).

The IME report indicated that Dr. Petkovich opined that Petitioner sustained a muscular lumbar strain and a lumbar disc herniation on the left at the L5-S1 level as a result of the accidents of April 26, 2010 and January 26, 2011, and that Petitioner gave a history of the prior L5 fracture in 1989 while she was in the military, and that she had residual back pain after the injury in 1989. Dr. Petkovich indicated,

however, that Petitioner indicated that she had significantly worse pain and began having pain into her left lower extremity after the incidents at issue. (RX12).

The IME report indicated that Dr. Petkovich opined that Petitioner's current diagnosis was that of a lumbar disc herniation, left L5-S1, status post lumbar laminotomy with microdiscectomy. Dr. Petkovich indicated that the diagnosis was well-documented in the medical records, and that Petitioner had completely recovered from the accidents of April 26, 2010 and January 26, 2011. Dr. Petkovich indicated that Petitioner had reached maximum medical improvement regarding her lumbar spine and the accidents at the last time that she was seen by Dr. Russell. (RX12).

The IME report indicated that Dr. Petkovich did not believe that Petitioner needed any further medical treatment as a result of the incidents, and he did not believe that Petitioner needed to be on any medications as a result of the incidents nor were any further diagnostic studies or spinal injections necessary for Petitioner as a result of the incidents. (RX12).

The IME report indicated that Dr. Petkovich opined that Petitioner could work at the regular job that she was doing prior to April 26, 2010 without any restrictions, and that he did not believe that any work restrictions were necessary for Petitioner as a result of the incidents of April 26, 2010 or January 26, 2011. Dr. Petkovich further opined that Petitioner had a 12% whole person impairment as a result of the injuries that she described at work, and that such impairment opinion had been made in conjunction with the AMA *Guides to the Evaluation of Permanent Impairment*, Sixth Edition. (RX12).

The Petkovich Orthopedic and Spine Care, LLC history form was included with the IME report. When asked "What started your problem or pain?" Petitioner indicated "lifting files out of cabinet. Felt strain in low back. Fell to floor & experienced pain radiating down left leg." (RX12).

CONCLUSIONS OF LAW

In regard to disputed issues (C) and (F) for both 11 WC 39600 and 11 WC 40039, given the common evidence and facts relative to both issues, the Arbitrator addresses them jointly.

The Arbitrator finds Petitioner to be an incredulous witness and accordingly places no evidentiary weight on her testimony as it pertains to either alleged accident. After observing her demeanor and testimony at Arbitration, the Arbitrator finds Petitioner's testimony to be inconsistent with the medical records and accident reports entered into evidence at the time of arbitration, and finds Petitioner to have been consistently evasive on cross-examination questioning by Respondent's counsel. While Petitioner testified freely as to the circumstances surrounding the accidents of April 26, 2010 and January 27, 2011 at the time of arbitration – including specific dimensions of the files she was purportedly lifting at the time of each of her alleged accidents, Petitioner could neither recall nor remember the answers to the vast majority of questions posed to her on cross-examination, particularly those related to the frequency with which she treated for the pre-existing condition of her lumbar spine.

The Arbitrator finds that Petitioner's veracity is called into question by the objective records in evidence. For example, Petitioner testified on cross-examination that she did not previously have pain down to her knee the way that she did after the accident. (T.33-34). The medical records of Koke Mill Medical Associates, however, reflect that Petitioner was seen on August 4, 2009 regarding her back pain, at which time Petitioner indicated that her bilateral buttocks and bilateral legs had worse pain with sitting. The Assessment was noted to be lumbar back pain with radicular leg symptoms. (RX10). Furthermore, the April 13, 2009 Express Care records of Memorial Medical Center document that Petitioner reported that the pain radiated down her right leg some, which was normal for her pain. (RX11).

The Arbitrator notes that Petitioner testified at the time of arbitration that with the second injury of January 26, 2011 she started experiencing incontinence when she was sleeping. (T.27). The medical records of Memorial Medical Center, however, reflect that Petitioner was seen on October 23, 2013 at the Emergency Room, at which time she reported bladder/bowel incontinence since September 2, 2013. (PX1). Additionally, Petitioner testified at the time of arbitration that she no longer did any landscaping work. (T.27). The medical records of Springfield Clinic, however, reflect that Petitioner was seen on May 27, 2014 presenting with complaints of gradual onset of moderate left lower back pain, radiating to the left buttock and left thigh starting May 24, 2014. It was noted that Petitioner had been working in the yard mowing and had some increased pain. (PX3).

Furthermore, Petitioner testified at the time of arbitration that she has a roommate who does her housekeeping, and that she is unable to vacuum her house anymore because of the twisting sensation. (T.25). The physical therapy notes within the Springfield Clinic records, however, reflect that on December 12, 2011 Petitioner stated that she had a take a Vicodin the day prior but attributed it to cleaning her carpets on Saturday, stating that motion always bothered her. (PX2). Furthermore, the Illiana VA records reflect that Petitioner called in on September 6, 2013, at which time she indicated that her back pain was "out of control" and had started on Tuesday, and that she did not remember any trauma to the area but she was vacuuming when her pain got worse. (RX7). Additionally, Petitioner testified that she remembered being in a car accident in 2013, but that it did not cause any low back pain. (T.47). The medical records of St. John's Hospital for the date of service of November 5, 2013, however, noted that Petitioner indicated that she was a restrained passenger in a vehicle being driven by her son that struck the back of another vehicle at approximately 25-30 mph. It was noted that Petitioner had a history of chronic back pain and presented complaining of neck and back pain. (RX9).

Furthermore, the Arbitrator finds to be significant in this case that the first mention made in any of the medical records of Petitioner having been purportedly lifting any files at the time of either alleged accident was that as noted in the history provided to Dr. Petkovich at the time of the IME on May 12, 2015. At that time, Petitioner reported to Dr. Petkovich that on April 26, 2010 she was lifting some files out of a cabinet and felt and heard a "pop" in her lower back and had some pain in her lower back and left lower extremity. (RX12). With respect to the second accident of January 26, 2011, Dr. Petkovich noted that Petitioner reported that she was lifting a box of files at work and developed recurring pain in her lower back. (RX12). Petitioner also answered the question on the history form included with the IME report "What started your problem or pain?" with "lifting files out of cabinet." (RX12). The Arbitrator notes that these accident histories provided by Petitioner to Dr. Petkovich, however, were dissimilar from those documented in the post-accident medical records and accident reports.

For example, the Arbitrator notes that the first post-accident medical record at Memorial Medical Center pertaining to the April 26, 2010 accident noted that Petitioner arrived per EMS after bending over at work and could not get up from muscle spasms, that she had chronic back problems, and that she bent down at work and developed severe lower back pain and spasm. (PX1). Additionally, the first post-accident medical record at Memorial Medical Center pertaining to the January 26, 2011 accident noted that Petitioner was at work and bent over, and her back locked up when getting up. It was noted that she was recently seen on January 15, 2011 for the exact same exacerbation, and that she had a neurosurgeon consultation scheduled for March 1, 2011 with Dr. Russell. It was noted that this was a chronic issue that had occurred since Petitioner was 17 years old, and that it had been getting worse over the past year. (PX1).

Furthermore, the Arbitrator notes that on the Workers' Compensation Employee's Notice of Injury Form for the accident of April 26, 2010, Petitioner indicated that she was bending over to close a file cabinet drawer when she felt a pulling in her low back and pain radiating down her legs. (RX3). On

the Workers' Compensation Employee's Notice of Injury Form for the accident of January 26, 2011, Petitioner indicated that she was kneeling down to file vouchers and when she stood up she felt a sharp pain in her low back with pain radiating down the left leg. (RX4). The Arbitrator notes that these accident histories are all inconsistent with Petitioner's testimony at the time of arbitration. As such, the Arbitrator finds Petitioner to be an incredulous witness and accordingly places no evidentiary weight on her testimony.

As a result of the multitude of discrepancies between Petitioner's testimony and the objective medical records and accident reports entered into evidence at the time of arbitration, the Arbitrator finds that Petitioner's testimony at the time of arbitration was incredulous and places no evidentiary weight on her testimony. The Arbitrator finds Petitioner's testimony was not candid or forthcoming, and points to the multiple inconsistencies in her testimony as exemplifications of same. Furthermore, the Arbitrator is troubled by the reference in the February 10, 2012 VA medical record Addenda which noted that the cervical compression was negative for neck pain but it elicited pain in the lumbar spine which suggested a lack of organic basis for the lower back complaint; the notation in the January 14, 2012 VA medical record that noted that Petitioner was in violation of her medication narcotic agreement with the use of outside narcotics with the addition of narcotics provided by the Primary Care office; and the Emergency Department note of February 3, 2014 at Memorial Medical Center, which noted that Petitioner was suspected of drug-seeking behavior. (PX4; PX4; RX11).

As a result of the foregoing, the Arbitrator finds that Petitioner did not sustain an accident that arose out of and in the course of her employment with Respondent on either April 26, 2010 or January 26, 2011. All benefits are denied. The Arbitrator finds that the remaining issues of causation, medical bills, temporary total disability benefits and permanent disability benefits are moot, and the Arbitrator accordingly makes no conclusions as to those issues.

	)	☒ 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

Marla Ingram,

Petitioner,

vs.

NO: 13 WC 01107

16IWCC0629

Illinois Department of Agriculture,

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, permanent partial disability, medical, 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 FURTHER ORDERED BY THE COMMISSION that the Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury.

No bond or summons required for State of Illinois cases.

DATED: SEP 3 0 2016

MB/mam
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Mario Basurto

David L. Gore

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

INGRAM, MARLA
Employee/Petitioner

Case# **13WC001107**

16IWCC0629

IL DEPT OF AGRICULTURE
Employer/Respondent

On 1/21/2016, 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 0.37% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2211 MILLS, STEVEN C
206 S SIXTH ST
SPRINGFIELD, IL 62701

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

1368 ASSISTANT ATTORNEY GENERAL
CHRISTINA SMITH
500 S SECOND ST
SPRINGFIELD, IL 62706

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

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 21 2016

16IWCC0629

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

Marla Ingram
Employee/Petitioner

v.

Illinois Department of Agriculture
Employer/Respondent

Case # 13 WC 01107

Consolidated cases: n/a

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Springfield, on November 24, 2015. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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. [ ] 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 March 25, 2011, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $71,591.00; the average weekly wage was $1,377.00.

On the date of accident, Petitioner was 54 years of age, married with 0 dependent child(ren).

Petitioner has received all reasonable and necessary medical services.

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

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

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

ORDER

Based upon the Arbitrator's Conclusions of Law attached hereto, claim for compensation is denied.

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

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

William R. Gallagher, Arbitrator

January 6, 2016
Date

JAN 2 1 2016

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 for Respondent. The Application alleged a date of accident (manifestation) of March 25, 2011, and that Petitioner sustained repetitive trauma through typewriter/computer usage and that she sustained injuries to her right hand, arm, shoulders and neck (Arbitrator's Exhibit 2). Respondent disputed liability on the basis of accident and causal relationship (Arbitrator's Exhibit 1).

Petitioner has been employed by Respondent for over 37 years and, for the last 17 years, she has worked in the graphic design department. Petitioner is primarily responsible for the preparation and layout of various documents, schedules, parking passes, books, rules of participation, etc. for the State and DuQuoin State Fairs. The time immediately preceding the State Fairs is the busiest for Petitioner and she generally works overtime during that period of time.

Petitioner testified that she worked seven to seven and one-half hours per day and that she worked on the computer for virtually that entire time. Petitioner stated that she is left hand dominant, but that she holds and operates the mouse with her right hand. Petitioner used both of her hands to type on the keyboard.

Petitioner stated that in late 2010 she began to have symptoms of aching/numbness in her right hand. During that time, Petitioner was typing various documents pertaining to the Fairs. Petitioner initially sought medical treatment from Dr. Mark Hansen, her family physician, who referred her to Dr. David Gelber for EMG/nerve conduction studies. Dr. Gelber performed the test on March 25, 2011 (the date of manifestation alleged in the Application) which were positive for mild right carpal tunnel syndrome (Petitioner's Exhibit 1).

Petitioner continued to work but began wearing a splint at night and a glove while at work. Over time, Petitioner's right upper extremity symptoms worsened and she returned to Dr. Hansen who again referred her to Dr. Gelber for EMG/nerve conduction studies. Dr. Gelber saw Petitioner on May 29, 2012, and performed the studies which were positive for mild right carpal tunnel syndrome (Petitioner's Exhibit 1).

Petitioner was seen by Dr. Chris Wottowa on July 16, 2012. When seen by Dr. Wottowa, Petitioner advised that she typed at work and that for the preceding two to three years, she had numbness/tingling as well as pain in the third, fourth and fifth fingers of her right hand (Petitioner's Exhibit 1).

Petitioner was subsequently seen by Dr. Mark Greatting, an orthopedic surgeon, on October 10, 2012. At that time, Petitioner informed Dr. Greatting that she had a two year history of numbness/tingling in her right hand which had increased over time especially when using a mouse or keyboard at work. Dr. Greatting recommended that Petitioner have right carpal tunnel surgery (Petitioner's Exhibit 1).

Dr. Greatting performed surgery on December 4, 2012, and the procedure consisted of a right carpal tunnel release. Following surgery, Petitioner developed an infection at the surgical incision site and was given antibiotics. When seen by Dr. Greatting on January 3, 2013, Petitioner's right hand was still tender; however, the numbness/tingling had resolved (Petitioner's Exhibit 1).

At the direction of Respondent, Petitioner was examined by Dr. Patrick Stewart, a hand surgeon, on August 21, 2013. In connection with his examination of Petitioner, Dr. Stewart reviewed medical records provided to him by Respondent. Dr. Stewart also reviewed what he described as a "generalized job description" of Petitioner's work duties. The job description stated that Petitioner spent approximately 20% of her time planning, organizing and drafting telecommunication rules/regulations; 20% of her time planning, organizing and drafting forms; 15% of her time investigating and monitoring printed materials; 10% of her time using software to maintain files/forms; 10% of her time reviewing analysis on telephone operations and billing; 10% of her time as the agency liaison for telecommunications with the State Police and CMS; and 10% of her time on work orders and printed materials. Dr. Stewart reviewed this job description with Petitioner at the time of his evaluation and she informed him that the description had not been updated for quite some time. Further, she informed Dr. Stewart that in preparation for the State Fair, from January through August, Petitioner did approximately 80% of her work on the computer. Petitioner also advised Dr. Stewart that her workstation had an adjustable tray that the keyboard sits on and a mouse that sat on a mouse pad (Respondent's Exhibit 2; Deposition Exhibit 2).

Dr. Stewart opined that Petitioner was at MMI and that she had already returned to normal activities. In regard to causality, Dr. Stewart opined that Petitioner's work activities were repetitive; however, he noted that they did not require a requisite amount of force to perform and that Petitioner's workstation could be modified to what was comfortable for her. He opined that Petitioner's work was not an aggravating or contributing factor to the development of carpal tunnel syndrome (Respondent's Exhibit 2; Deposition Exhibit 2).

Dr. Greatting's deposition was taken on June 24, 2014, and was received into evidence at trial. In regard to his diagnosis and treatment of Petitioner, Dr. Greatting's testimony was consistent with his medical records. In regard to causality, Dr. Greatting stated that "...based on her history, that her work activities were aggravating her symptoms. That's based entirely on her history that she provided." (Petitioner's Exhibit 3; p 14).

On cross-examination, Dr. Greatting agreed that he did not have any information regarding Petitioner's workspace; he did not know how much Petitioner typed everyday; he did not know how many years Petitioner had been typing; and he did not know how Petitioner held her wrist when typing. He also agreed that Petitioner had other risk factors for the development of carpal tunnel syndrome, specifically, being female, in her 50s and being obese (Petitioner's Exhibit 3; pp 21-22).

Dr. Stewart's deposition was taken on April 14, 2015, and his deposition testimony was received into evidence at trial. Dr. Stewart testified that he had reviewed the description of Petitioner's job

duties and discussed it with Petitioner and determined that Petitioner spent approximately 80% of her time doing data entry. In regard to causality, Dr. Stewart opined the while Petitioner performed repetitive work, that it did not require sufficient force to cause or aggravate the carpal tunnel syndrome condition. He also noted that Petitioner had an adjustable workstation and that she had the ability to keep her hands in a neutral position when she was performing data entry. He also noted that Petitioner had other risk factors for the development of carpal tunnel syndrome, specifically, being a woman, postmenopausal and having a BMI over 30 (Respondent's Exhibit 2; pp 16-21).

At trial, Petitioner testified that the numbness/tingling had resolved after the surgery. Petitioner still complained of some aching in her right hand especially after working nine hours or more. Petitioner still had some complaints of weakness in the hand. Further, even though Petitioner is left hand dominant, she stated that she now uses her left hand more than what she did previously.

Conclusions of Law

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

The Arbitrator concludes that Petitioner did not sustain a repetitive, injury arising out of and in the course of her employment for Respondent that manifested itself on March 25, 2011, and that her current condition of ill-being is not related to her work activities.

In support of this conclusion the Arbitrator notes the following:

Petitioner's testimony regarding her work activities and the onset of her symptoms was credible and unrebutted.

Petitioner's treating physician, Dr. Greatting, opined, based entirely on the history Petitioner provided to him, that Petitioner's work activities aggravated her hand symptoms. Dr. Greatting lacked specific information as to Petitioner's workspace, how much typing Petitioner did, how long Petitioner had been typing and the position her hands were and when she typed. Further, on cross-examination, Dr. Greatting agreed that Petitioner had other risk factors for the development of carpal tunnel syndrome, specifically, being female, in her 50s and being obese.

Respondent's Section 12 examiner, Dr. Stewart, reviewed a description of Petitioner's job duties provided to him by Respondent and discussed them with Petitioner at the time of his evaluation. He also obtained information from Petitioner in regard to the configuration of her workstation. Accordingly, Dr. Stewart had a more comprehensive and thorough understanding of Petitioner's work activities and work space than Dr. Greatting. Further, consistent with Dr. Greatting, Dr. Stewart also noted that Petitioner had other risk factors for the development of carpal tunnel syndrome, specifically, being a woman, postmenopausal and having a BMI over 30.

Based on the preceding, the Arbitrator finds the opinion of Dr. Stewart be more persuasive than that of Dr. Greatting.

In regard to disputed issue (L) the Arbitrator makes no conclusion of law as this issue is rendered moot because of the Arbitrator's conclusion of law in disputed issues (C) and (F).

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

Sonia Garcia,

Petitioner,

vs. NO: 12 WC 32700

Hotel Staffing Solutions,

16IWCC0630

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, temporary total disability, causal connection, permanent partial disability, medical 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 3, 2016 is hereby affirmed and adopted.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $1.00. 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: SEP 30 2016

MB/mam
o:9/22/16
43

Mario Basurto

David L. Gore

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GARCIA, SONIA
Employee/Petitioner

Case# **12WC032700**

16IWCC0630

HOTEL STAFFING SOLUTIONS
Employer/Respondent

On 2/3/2016, 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 0.46% 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, JAMES P LAW OFFICES
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CHICAGO, IL 60602

4944 KOREY RICHARDSON LLC
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CHICAGO, IL 60603

16IWCC0630

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

Sonia Garcia
Employee/Petitioner

v.

Hotel Staffing Solutions
Employer/Respondent

Case # **12** WC **32700**

Consolidated cases: ______

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Deborah L. Simpson**, Arbitrator of the Commission, in the city of **Chicago**, on **December 2, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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 22, 2012**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**N/ A**; the average weekly wage was $**235.99**.

On the date of accident, Petitioner was **35** 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, $**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

Compensation is hereby denied because Petitioner failed to prove an accident occurred that arose out of or in the course of her employment.

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

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

Deborah L. Simpson

Signature of Arbitrator

February 1, 2016
Date

FEB 3 - 2016

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Sonia Garcia,	)	
Petitioner,	)	
vs.	)	**No. 12 WC 32700**
Hotel Staffing Solutions,	)	
Respondent.	)	

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

The parties agree that on August 22, 2012, the Petitioner and the Respondent were operating under the Illinois Worker's Compensation or Occupational Diseases Act and that their relationship was one of employee and employer. They agree that Petitioner gave the Respondent notice of the accident which is the subject matter of this dispute within the time limits stated in the Act. They further agree that the Petitioner's average weekly wage, calculated pursuant to Section 10 of the Act, was $235.99.

At issue in this hearing is as follows: (1) On that date did the Petitioner sustain an accidental injury that arose out of and in the course of the employment; (2) Is the Petitioner's current condition of ill-being causally connected to this injury or exposure; (3) Is the Respondent liable for the unpaid medical bills listed in the attachment to Arbitrators's exhibit #1, the stipulation sheet (4) Is the Petitioner entitled to TTD from August 23, 2012 through January 5, 2013; and (5) the nature and extent of the injury.

The Petitioner does not speak English, her native language is Spanish. She testified with the assistance of Noel Cortez, a certified interpreter, qualified to translate Spanish to English and English to Spanish. Mr. Cortez testified he is certified as an interpreter and has been employed in that capacity for many years. He has been qualified and permitted to serve as an interpreter in before the IWCC on a regular basis for more than 10 years. After being duly qualified and accepted by both parties as an interpreter Mr. Cortez served as an interpreter for the Petitioner.

STATEMENT OF FACTS

Respondent is a temporary staffing agency that supplies cleaning staff to Hotels in Chicago and the surrounding suburbs. Employees can either drive themselves directly to their assigned location, take public transportation or use a van provided by Respondent to transport

them to their assigned location. Use of the shuttle service was not required and was for the benefit of employees to assist them in getting to their job assignment. If an employee had their own transportation they could go directly to their job assignment. Employees who chose to take the company shuttle were in not compensated for the mileage or travel time while using the company shuttle.

On August 22, 2012, Petitioner was employed by Hotel Staffing Solutions as a housekeeper. There were two types of housekeeping employees, one group worked at the same facility everyday, the other group was assigned to different hotels on different days. The Petitioner was in the latter group, receiving a different assignment each day she worked. Petitioner testified that she worked at one hotel per day, she was never required to travel from one job location to another, but that hotel would change daily. At each hotel, her task was to clean rooms, make the bed, clean bathrooms, clean furniture, and vacuum the floors.

Maria Martinez was called to testify by the Respondent. She stated that she is a dispatcher for Respondent. She testified that she called Petitioner the day prior to the accident to offer her an assignment at Key Lime Cove on August 22, 2012. Ms. Martinez testified that Petitioner was not required to come to the office prior to going to her assignment at Key Lime Cove. Ms. Martinez testified that Petitioner came to the office so that she could take Respondent's van to the job assignment.

Petitioner testified that, because she did not have her own transportation, she went to Hotel Staffing Solution's office so that she could take the company provided shuttle to a particular job assignment. Petitioner testified that prior to going to an assignment, she would go to Respondent's office to obtain a "ticket" which contained the address of the hotel she was assigned to and the hours she would be working. Upon receiving her ticket, Petitioner would be taken to her work location, with vehicle and driver provided by the Respondent. Petitioner was not sure if she was paid for the time spent at the Hotel Staffing Solutions office, or in the vehicle on the way to her work site. This vehicle would carry up to five or six employees to their work sites. The same vehicle picked up the workers at the end of their shifts and returned them to Hotel Staffing Solutions. Petitioner testified that there were days when she would show up at Respondent's place of business and they would not have any work for her that day.

Ms. Martinez testified that Key Lime Cove did not require temporary employees to provide any documentation or paperwork prior to beginning their assignment. Ms. Martinez further testified that for the hotels that did require documentation for temporary employees prior to the start of their assignment, such documentation would be sent to the hotel via email or fax.

Petitioner testified that on the morning of August 22, 2012, she arrived at Respondent's office, picked up her ticket assigning her to Key Lime Cove and as she was hurrying to the transport van she fell, sustaining an injury to her left arm. At the time of the fall, Petitioner was on a sidewalk en route to the vehicle in the parking lot. She testified that the sidewalk was

adjacent to the parking lot where the van was parked waiting for the employees. According to the Petitioner the sidewalk was "kind of ugly" with rocks jutting out in the area. Petitioner testified that she did not know how she fell. She stated that she felt an immediate onset of pain in her left arm. Petitioner was helped up by Ms. Martinez, who came out of the office to assist her. The vehicle then left to take the employees to their work assignments, and returned approximately two hours later to take the Petitioner to Alexian Brothers Medical Center.

According to Ms. Martinez's testimony, Petitioner told her that she had tripped.

The history taken at Alexian Brothers states that Petitioner had left elbow pain after a fall to the ground at work. (PX 1) X-rays confirmed a left transcondylar fracture of the distal humerus, and a possible radial head fracture as well. She was casted, and given work restrictions of one-handed duty. Petitioner was referred to Dr. Biafora at Hand Surgery Associates for an orthopedic consultation. (PX 1)

Petitioner was seen the next day, August 23, 2012, by Dr. Prasant Atluri at Hand Surgery Associates. (PX 2) Dr. Atluri noted no prior history of injury to the left arm, he diagnosed a complex elbow fracture with involvement of the distal humerus and proximal radius. Dr. Atluri immediately took the Petitioner off work and recommended a CT scan in order to clarify surgical options. (PX 2) Dr. Atluri reviewed the CT scan on August 28, 2012, and noted a complex intra-articular distal humerus fracture with comminution involving the capitellum, which was displaced. He recommended an open reduction and internal fixation, to be performed as early as Friday, August 31. (PX 2)

Petitioner met with Dr. Atluri on August 30, 2012, and agreed with the surgical recommendation. Surgery proceeded on August 31, 2012 with Dr. Atluri and Dr. Biafora. Intraoperatively, Dr. Atluri noted a comminuted intra-articular radial head fracture, distal humerus fracture, and various ligament damage. The distal humerus was reduced and stabilized with screws. The radial head fracture was likewise reduced, though hardware was not used, as the fracture fragments were too small. The lateral epicondyle was then reduced and stabilized with a screw. (PX 2)

Petitioner had an initial follow-up on September 4, 2012. Id. Dr. Atluri noted she was doing well. He explained that the radial head fracture could not be reconstructed, and that a radial head replacement surgery may be required in the future. He referred her to physical therapy, which began on September 6, 2012. After a few visits of therapy at Hand Surgery Associates, Petitioner transferred her therapy to New Life Medical Center on September 11, 2012. (PX 6)

At her October 2, 2012 follow up, Dr. Atluri noted continued improvement, and returned the Petitioner to one-handed duty. (PX 2) Petitioner testified that she attempted to return to work post-operatively, and spoke with Hugo at Hotel Staffing Solutions. She testified that "they didn't give me back my work."

At a follow up appointment on December 11, 2012, Dr. Atluri noted continued improvement of range of motion. (PX 2) He noted healing of the fractures. Petitioner was returned to light duty with 2 pound work restrictions.

Petitioner saw Dr. Atluri for the last time on January 8, 2013. At that time, Dr. Atluri noted worsening symptoms with Petitioner's increased activity. He noted continued deformity at the proximal radius. Dr. Atluri recommended a resection and possible replacement of the radial head, and Petitioner consented to that surgical procedure. (PX 2) Petitioner testified that the recommended surgery was never performed due to lack of insurance authorization. At the time, Petitioner did not have her own health insurance.

Petitioner did post-operative therapy with New Life from September 11, 2012 until February 16, 2013. (PX 6) The therapy involved various activities including electronic manipulation. She was also given exercises and equipment to use at home. Per the Petitioner, the therapy was "a little" helpful.

Petitioner was not given work within her restrictions at Hotel Staffing Solutions, and eventually found new employment in January 2013 in a company that sorts mail. At present, her left arm continues to hurt in cold weather. She is unable to carry heavy items, clean, or vacuum with her left arm. She takes over-the-counter pain medication for her left arm. Petitioner denied any prior accidents or injuries involving the left arm.

Bill Gonzalez was called by the Respondent to testify. He testified that he was the Senior Safety Director for Most Valuable Personnel (MVP.) Hotel Staffing Solutions was, at the time, a subsidiary of MVP. His job duties included developing and implementing safety programs, as well as managing workers' compensation claims.

He explained the business model of Hotel Staffing Solutions – namely that the company would provide temporary employees to various hotels in the area. Employees were free to take their own vehicles to job sites, or could take a shuttle provided by the Respondent. The shuttle would be located at the Hotel Staffing Solutions office, specifically in the parking lot of a public strip mall. The lot was not under the control of Respondent. He agreed that employees were required to be in the parking lot in performance of their job duties if they were going to use the services of the shuttle. Employees were not compensated for time spent at the office or in the shuttle.

Mr. Gonzalez was notified of the incident, specifically that Petitioner was "rushing" to get to the shuttle bus and tripped and fell on the sidewalk outside the office. After becoming aware of the August 22, 2012 incident involving the Petitioner, Mr. Gonzalez inspected the area outside the Hotel Staffing Solutions office on August 23 or 24. He testified that there were no defects or cracks in the sidewalk. He prepared a memorandum that was entered into evidence as Respondent's Exhibit 1. Respondent's 1 is consistent, generally, with the testimony of the Petitioner and Mr. Gonzalez. (RX 1)

On cross-examination, Mr. Gonzalez admitted that it would reflect poorly on the Respondent for their employees to be late to their shifts. He testified that Hotel Staffing Solutions had never received a complaint of an employee being late to a shift at a hotel.

CONCLUSIONS OF LAW

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

The burden is on the party seeking the award to prove by a preponderance of credible evidence the elements of the claim, particularly the prerequisites that the injury complained of arose out of and in the course of the employment. *Hannibal, Inc. v. Industrial Commission,* 38 Ill.2d 473, 231 N.E.2d 409, 410 (1967)

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

In determining the level of permanent partial disability, for injuries that occur on or after September 1, 2011, the Commission shall base its determination on the following factors: (i) the reported level of impairment pursuant to subsection (a); (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; (v) evidence of disability corroborated by the treating medical records. No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order. (820 ILCS 305/8.1b)

In support of the decision with regard to the issue did an accident arise out of and in the course of Petitioner's employment with Respondent, the Arbitrator makes the following conclusions of law:

The Arbitrator finds that Petitioner failed to prove that her accident arose out of and in the course of her employment with Respondent. Therefore, Petitioner's demand for benefits is hereby denied.

A Workers Compensation Claimant bears the burden of proving that an accident arose out of his/her employment. *Builders Square, Inc. v. Industrial Commission,* 339 Ill.App.3d 1006, 1010 (3rd Dist. 2003). The purpose of the Workers' Compensation Act is to protect employees against risks and hazards which are peculiar to the nature of the work they are employed to do. *Orsini v. Indus. Comm'n*, 117 Ill. 2d 38, 44 (1987). An injury is compensable under the Act only if it "arises out of" and "in the course of" the employment. *Ill.Rev.Stat.*1985, ch. 48, par. 138.2.

The phrase "in the course of" refers to the time, place and circumstances under which the accident occurred. *Orsini,* at 44. The words "arising out of" refer to the origin or cause of the accident and presuppose a causal connection between the employment and the accidental injury. *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill.2d 52, 57(1989). Both elements must be present at the time of the accidental injury in order to justify compensation. *Orsini*, at 45.

The general rule is that an injury that occurs while a claimant is going to and coming from his or her employment does not arise out of or in the course of the employment and is not compensable. *Commonwealth Edison Co. v. Industrial Commission*, 86 Ill.2d 534, 537 (1981). The purpose behind the rule is that an employee's trip to and from work is the product of his own decision as to where he lives, to which the employer has no interest. *Sjostrom v. Sproule*, 33 Ill.2d 40, 43 (1965). One exception to this general rule is that of the "traveling employee." "A traveling employee is one who is required to travel away from her employer's premises to perform her job." *Mlynarczyk v. Illinois Workers' Compensation Commission*, 999 N.E.2d 711, 717 (3rd Dist. 2013).

In *Venture-Newberg-Perini, Stone & Webster v. Illinois Workers' Compensation Commission*, 376 Ill.Dec. 823, 825-26 (2013), the petitioner, Ronald Daugherty, was a pipefitter who lived in Springfield. Daugherty couldn't find work in Springfield, so he took a job with Venture in Cordova, Illinois, some 200 miles away. *Id.* at 826. Daugherty testified that Venture wanted workers to be within an hour drive so that they could be available whenever they were needed, but Venture did not direct workers on where to stay, what route to take to work, nor were the workers reimbursed for travel expenses or travel time. *Id.* Additionally, Daugherty was a temporary employee who would be assigned from time to time to work at various fixed job sites, and at the end of his assignment he would be terminated and expected to seek a new position within the company at another job site. *Id.* Daugherty had worked for Venture previously at four different job sites. *Id.* While working at the Cordova job site, Daugherty and a coworker were staying at a local motel. *Id.* While riding in the co-workers' car to the job site one morning, Daugherty was injured in a car accident. *Id.* Whether Daugherty was a "travelling employee" was the question before the Supreme Court. The Court ultimately concluded that Daugherty was not a "travelling employee" and, thus, concluded that Daugherty's injuries were not compensable. *Id.* at 830. The Court relied on the following facts to reach this conclusion:

1) Daugherty was not a permanent employee.

2) Daugherty was not working for Venture on a long term, exclusive basis.
3) Nothing in Daugherty's contract required him to travel out of his union's territory to take the position at Venture.
4) Daugherty made a personal decision that the benefits of the pay outweighed the personal cost of traveling.
5) Daugherty was hired to work at a specific location and was not directed by Venture to travel away from this work site to another location.
6) Venture did not reimburse Daugherty for his travel expenses, nor did it assist Daugherty in making his travel arrangements.

Id. at 829-830. Additionally, the Court noted that policy concerns dictated that Daugherty's claim be found not to be compensable. The Court reasoned that should they find for Daugherty then an unfair result would ensue, stating that "while an employee who chooses to relocate closer to a temporary job site can receive benefits if injured on the way to work, an employee who permanently resides close to the job site is not entitled to benefits if injured on the way to work." *Id.* at 830.

In *Mlynarczyk*[1], claimant was a permanent employee of a cleaning service whose duties involved cleaning various churches, homes, and offices. 999 N.E.2d at 713. Claimant was paid by the job and often worked at more than one job site in a given day. *Id.* Claimant's husband also worked with Claimant and she and her husband carpooled from job site to job site in a minivan given to them by their employer. *Id.* The employer paid for gasoline as well as insurance and licensing fees. *Id.* On the day of Claimant's accident, Claimant and her husband were at a jobsite and the work finished earlier than expected as there had been cancellations. *Id.* at 714. That day the employer notified Claimant that she could return to work later that evening to work a job at a different location. *Id.* Claimant returned home in the minivan and she ate lunch with her husband. *Id.* 90 minutes later, Claimant was walking back to the minivan and slipped on ice, injuring herself on a public sidewalk adjacent to her driveway. *Id.* The third district in this matter concluded that Claimant was a "travelling employee," therefore, her accident near her home was compensable. *Id.* at 717. The court reasoned that, "claimant did not work at a fixed jobsite. Rather, her duties required her to travel to various locations throughout the Chicagoland area." *Id.*

The facts of the case sub judice are analogous to those found in *Venture-Newberg*. Like the Claimant in *Venture-Newberg*, Petitioner was a temporary employee who was not working for Respondent on a long-term or exclusive basis; was hired to work at a specific location and was not directed by Respondent to travel away from this location to work at other locations; and was not reimbursed for travel expenses, nor was she paid for her time while travelling.

[1] It should be noted that at several instances in this decision, the appellate court relies on the below appellate court's decision in *Venture-Newberg*, which the Supreme Court expressly overturned.

Additionally, Petitioner made a personal decision to use the company shuttle rather than travel to her fixed jobsite on her own.

The facts of the *Mlynarczyk* case are distinguishable from the matter currently before the Arbitrator. The Claimant in *Mlynarczyk* was a permanent employee who was required to travel to and from several jobsites on any given day. This was not the case with Petitioner, as she was not a permanent employee and she was assigned to one specific hotel at a time. Once Petitioner reached her job assignment for the day she remained there until the completion of her shift.

In rendering this decision, the Arbitrator also takes into consideration the policy concerns expressed by the Court in *Venture-Newberg*. For, if Petitioner's accident were found to be compensable, the Arbitrator would essentially be saying that an employee who voluntarily chooses to take the company shuttle has more protection under the Act than do employees who choose to drive themselves directly to the jobsite. Such a conclusion would be to suborn an injustice, in violation of the public policy underpinnings of the Act.

Based on the preceding case law, Petitioner was not a "traveling employee" under the Act and therefore her claim is found to be not compensable.

Even if the Arbitrator had been inclined to find that Petitioner was a "traveling employee" under the Act, the Arbitrator still concludes that Petitioner's claim is still not compensable.

In *Rose Parker v. Illinois Department of Human Services*, 05 ILWC 42012 (2006), the Rose Parker was an employment resource specialist for Illinois Department of Human Services, as an employment resources specialist, her job duties included assisting disabled customers locate employment and helping train employers, which meant that she sometimes traveled away from respondent's offices to meet with other employers. When Parker made trips to the other employers, Parker's employer would reimburse her for her mileage.

On the day of her accident, Parker was working in the Respondent's main office, though she testified of plans to leave the office later that day to visit off-site employers. At some point during the day, but prior to traveling to visit off-site employers, she left her office to retrieve documents from her vehicle. She described stepping from the sidewalk along the building over a curb to reach her vehicle when she fell and injured her right hand. Her vehicle was parked in a lot that was available to Respondent's employees, as well as to employees of other businesses in the building and visitors to the building.

The Arbitrator in *Parker* ruled[2] that the accident did not arise out of the course of employment and was therefore not compensable. This was based on the conclusion that while Parker, at times traveled as part of her job, and had planned to travel on the day of her accident, she was not traveling at the time of her injury and, thus, her accident was not evaluated under the traveling employee doctrine. In addition, there was no evidence of any particular risk or defect in the parking lot that Petitioner faced as being related to her employment, especially since the employer did not own or control the parking area or have it exclusively for the use of its employees.

In the instant matter, even if the Arbitrator had concluded that Petitioner traveled as part of her job, Petitioner was not actually traveling at the time of her accident. Instead, like *Parker*, Petitioner was on the sidewalk adjacent to the parking lot at the time of her accident.[3] The Arbitrator in *Parker* found that "[d]ecisions applying [the traveling employee] doctrine involve cases where the injuries occurred from accidents while the employee was actually traveling away from the office such as driving back to a [sic] office from visits to other sites as part of the job, or while temporarily staying out of town while performing duties of the job." Thus, the present matter is not evaluated under the "traveling employee" doctrine.

The Arbitrator in *Parker* determined that because Parker was not a traveling employee, her case was to be evaluated as any other employee's claim to determine whether she was injured as a result of a risk or hazard that was peculiar to her employment duties. *Orsini v Industrial Comm'n*, 117 Ill.2d 38 (1987). The Arbitrator in *Parker* determined that where Parker fell in a parking lot that was not owned or maintained by her employer or even used exclusively by her employer, she failed to prove that she was exposed to a risk related to her employment and greater than the risk to the general public. In his decision, the Arbitrator specifically stated that, "falling while stepping from a sidewalk to a driveway or over a curb by itself is not any extraordinary risk related to the Petitioner's job activities."

The facts in the case sub judice, are directly on point with those in *Parker*. Petitioner fell on the sidewalk adjacent to a parking lot that was not owned or maintained by Respondent or even used exclusively by Respondent. Petitioner presented no evidence of any particular hazard in the parking lot associated with her injury. In fact, there was testimonial and photographic evidence presented that there were no defects present in the area where Petitioner fell.

Having determined that the Petitioner failed to prove that her accident arose out of and in the course of her employment with Respondent, Petitioner's claim for benefits is hereby denied.

---

[2] And the Commission adopted.

[3] A parking lot that was not owned by Respondent.

In support of the Arbitrator's decision with regard to the remaining issues (2) Whether Petitioner's present condition of ill-being is causally related to the injury, (3) Is the Respondent liable for the unpaid medical bills listed in the attachment to Arbitrators's exhibit #1, the stipulation sheet; (4) Is the Petitioner entitled to TTD from August 23, 2012 through January 5, 2013; and (5) the nature and extent of the injury, the Arbitrator makes the following conclusions of law:

In light of the determination Petitioner failed to establish her fall and injury arose out of and in the course of her employment with Respondent, the remaining issues of Respondent's liability for Section 8 medical benefits and the nature and extent of the injury are moot, and not reached by this Arbitrator. Accordingly, benefits are denied.

ORDER OF THE ARBITRATOR

The Petitioner failed to prove a compensable accident within the meaning of the Act. Benefits requested pursuant to Section 8 are therefore denied.

Deborah L. Simpson

Signature of Arbitrator

February 1, 2016
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 DUPAGE	)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
			☐ PTD/Fatal denied
		☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Christiana Williams,

Petitioner,

vs. NO: 15 WC 19886

Edward Hospital, **16IWCC0631**

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 2, 2016 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 $20,500.00. 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: SEP 30 2016

MB/mam
o:9/22/16
43

Mario Basurto

David L. Gore

Stephen Mathis

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

WILLIAMS, CHRISTIANA
Employee/Petitioner

Case# **15WC019886**

16IWCC0631

EDWARD HOSPITAL
Employer/Respondent

On 3/2/2016, 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 0.48% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4442 LAW OFFICE OF TIMOTHY E TAKASH
111 W WASHINGTON ST
SUITE 1500
CHICAGO, IL 60602

2965 KEEFE CAMPBELL BIERY & ASSOC
SEAN C BROGAN
118 N CLINTON ST SUITE 300
CHICAGO, IL 60661

STATE OF ILLINOIS)
)SS.
COUNTY OF DuPage)

16IWCC0631

- [ ] 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)

Christiana Williams
Employee/Petitioner

Case # **15** WC **19886**

v.

Consolidated cases: ___

Edward Hospital
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 **Gerald Granada**, Arbitrator of the Commission, in the city of **Wheaton**, on **January 25, 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. [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. [ ] Were the 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 ___

FINDINGS

On the date of accident, **April 13, 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 $**25,610.83**; the average weekly wage was $**492.52**.

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

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

Respondent shall be given a credit of $**10,032.28** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**0**.

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $328.35/week for 62 weeks, from April 14, 2014 through November 7, 2014, and then from June 7, 2015 through January 25, 2016 as provided in Section 8(b) of the Act. Respondent shall be given a credit for all temporary total disability benefits that have been paid thus far.

Respondent shall authorize and pay for any and all related prospective medical treatment as recommended by Petitioner's treating medical providers, including additional injections, physical therapy and a functional capacity evaluation, subject to the fee schedule as provided in Section 8(a) of the Act..

The petition for penalties and attorneys' fees is denied.

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

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

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

Signature of Arbitrator

3/1/16
Date

MAR 2 - 2016

16IWCC0631

FINDINGS OF FACT

This case involves a petitioner claiming injury to her low back stemming from an undisputed incident on April 13, 2014. The disputed issues in this case include 1) causation, 2) average weekly wage, 3) TTD, and 4) prospective medical care.

Christiana Williams ("Petitioner") worked for Edward Hospital ("Respondent") as a certified nursing assistant (CNA). Trial Transcript (Tr.) 12. Her job was to care for patients, including washing, feeding, lifting, and turning patients. Tr. 13. She testified she never had any low back problems until she was injured at work on April 13, 2014. Tr. 14. On that date, April 13, 2014, Petitioner testified she and a nurse were lifting and turning a heavy patient when she heard a click and a pop and felt pain in her back. Tr. 15-17.

When seen in Edward Hospital Emergency Department on April 13, 2014, Petitioner stated she experienced sudden left low back, "crampy" type pain while she was moving a heavy patient. She initially denied any lower extremity symptoms. On exam, she had full range of motion of her lumbar spine with complaints of tenderness over the left lower lumbar musculature; however, as she was being discharged, she started complaining of radiating pain into the left groin. A CT of the abdomen and pelvis was completed to rule out kidney stones. The CT showed a shallow ventral hernia and a calcification that was presumed benign. The doctor diagnosed a lumbar strain, prescribed medications, and instructed Petitioner to follow up with her primary care physician and/or corporate health. Petitioner Exhibit (PX) #1.

On April 14, 2014, Petitioner presented to Dr. Williamson-Link of Edward Hospital Corporate Health. She stated she developed low back and buttock pain after moving and transferring a patient on April 13, 2014. She denied any prior back injuries. The doctor diagnosed severe back, left buttock, and left leg pain and recommended Petitioner be transferred to the emergency room for further evaluation and better pain management. She was taken off work. PX #1.

On April 14, 2014, Petitioner presented to Edward Hospital Emergency Department complaining of left low back pain radiating to the left buttock. She stated her symptoms started the previous night while helping move a patient who weighed approximately 300 pounds. She further stated she was bending over and lifting when she felt immediate left low back pain. She was given pain medications intravenously. The doctor diagnosed a lumbar strain and muscle spasms and noted her neurologic exam was normal. She was instructed to fill her pain prescriptions and follow up with corporate health. PX #1.

On April 16, 2014, Petitioner returned to Dr. Williamson-Link. She continued to complain of low back pain radiating to the left buttock area. The doctor recommended off-work restrictions and continued pain medications. PX #1.

On April 21, 2014, Petitioner followed up with Dr. Williamson-Link. She reported improvement but continued pain. The doctor recommended off-work restrictions, MRIs of the low back and left hip, and continued pain medications. PX #1.

On April 28, 2014, Petitioner returned to Dr. Williamson-Link. Her pain complaints continued. The doctor noted MRI authorization was contingent on orthopedic approval. Her work restrictions were continued. PX #1.

16IWCC0631

On May 1, 2014, Petitioner presented to Dr. Steven Mather of M&M Orthopaedics. She stated she was lifting a patient weighing about 300 pounds on April 13, 2014 when she experienced immediate back pain that progressively got worse. On exam, she complained of tenderness to palpation over the left L4-5 and L5-S1 areas. She had limited range of motion due to pain but without any radiation, and she complained of low back pain with straight leg raising. Her neurological exam was normal. X-rays of the low back showed normal disc height at all levels and some mild arthropathy at L4-5. The doctor diagnosed acute low back syndrome and recommended an MRI of the low back as he suspected a L4-5 disc herniation. She was prescribed a Medrol Dosepak and her Norco prescription was refilled. Her off-work restrictions were continued. PX #2.

On May 8, 2014, an MRI of Petitioner's low back was completed at Midwest Open MRI. The radiologist assessed a 2 mm disc bulge at L4-5 with no spinal, lateral recess, or foraminal stenosis. The radiologist also assessed a 2 mm disc bulge at L5-S1 with a small annual tear but without any stenosis. PX #2.

On May 19, 2014, Petitioner returned to Dr. Mather. She complained of continued low back pain. She stated she could not sit or stand for too long and had begun experiencing intermittent numbness and tingling in her legs. The doctor noted the MRI scan was normal and that she could have some disc degeneration but there was certainly no nerve root compression or herniations. The doctor recommended lumbar epidural steroid injections, physical therapy, and off-work restrictions. PX #2.

On June 16, 2014, Petitioner followed up with Dr. Mather. She reported some improvement but continued pain. The doctor continued her off-work restrictions until July 7, 2014 or when she finished her injections. PX #2.

On June 30, 2014, Petitioner was examined by Dr. Manganelli of DuPage Medical Group. The doctor noted Petitioner had left low back and gluteal pain with bilateral lower extremity parathesias in spite of a benign MRI. A lumbar epidural steroid injection (ESI) was administered at L4-5. PX #2.

On July 14, 2014, Petitioner returned to Dr. Mather. She reported only 2-3 days of relief following her lumbar ESI. A functional capacity evaluation (FCE) was recommended and her off-work restrictions were continued. PX #2.

Petitioner underwent additional lumbar ESIs at L4-5 on July 21 and August 11, 2014. PX #2.

On October 13, 2014, Petitioner presented to Dr. Zelby for an independent medical examination. She stated she was turning a patient on April 13, 2014 after which she felt tightness in the left buttock and a pop/click in her left hip and groin. On exam, she complained of tenderness to palpation of the left gluteal region, even with non-physiological light touch, and straight leg testing and Patrick's maneuver were normal. Petitioner also complained of pain with simulation testing, a second positive Waddell finding. The doctor assessed mild lumbar spondylosis and a lumbar strain as Petitioner's spine and neurologic exams were normal and her MRI showed only mild degenerative changes without any acute or post-traumatic abnormalities. The doctor opined that the lumbar epidural steroid injections were unreasonable/unnecessary considering Petitioner had no condition of the spine that was treatable with such measures. Dr. Zelby further opined that Petitioner's reported symptoms, both their persistence and severity, were inconsistent with objective medical findings. Last, the doctor noted an FCE was not needed as Petitioner would have reached maximum medical improvement (MMI) and could have resumed her full duties by mid-July 2014. Respondent Exhibit (RX) #1.

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Petitioner testified she returned to work in November 2014, and the parties stipulated that she was paid TTD from April 14, 2014 through November 7, 2014. Tr. 8, 37; Arbitrator Exhibit #1. She testified she worked as a CNA, albeit in a different department, throughout November 2014, but she did not seek any medical treatment for her low back in the month of November. Tr. 38-39. She further testified she continued working throughout December 2014 as well as January, February, March, April, and May 2015, but she did not seek any medical treatment for her low back over those months. Tr. 39-40. She also testified she did not injure or reinjure her low back at work after she resumed working in November 2014. Tr. 35, 40.

Initially, Petitioner testified her back pain started becoming gradually worse three months after returning to work in November 2014. Tr. 28. Then, she testified her back pain started approximately eight weeks after returning to work in November 2014. Tr. 40-41. Finally, she testified that she was experiencing pain as soon as she returned to work in November 2014. Tr. 42. She confirmed that June 6, 2015 was the last day she worked for Respondent. Tr. 42

On June 4, 2015, Petitioner presented to her primary care physician, Dr. Gigi Ip. She reported she had injured her back at work in April 2014, had three steroid injections, and was off work seven months. She additionally reported her symptoms had returned two weeks prior. The doctor diagnosed lumbar degenerative disc disease with radiculopathy and prescribed a Medrol Dosepak. Dr. Ip recommended Petitioner off work for the period of June 7-10, 2015 and she imposed restrictions of no bending or heavy lifting effective June 11, 2015. PX #1.

On August 19, 2015, Petitioner presented to Hinsdale Orthopedics where she was seen by Dr. Michael Zindrick. She complained of low back pain radiating into her bilateral lower extremities. She reported she injured her back at work on April 15, 2014, felt better after physical therapy and injections, went back to work in November 2014, and her pain returned. She denied an acute injury. On exam, she complained of pain with range of motion. X-rays of the lumbar spine showed degenerative changes with osteophyte formation but good disc space height throughout. The doctor's reviewed an MRI of the lumbar spine completed on July 7, 2015 MRI and discerned L4-5 facet arthropathy with bilateral foraminal encroachment, greater on the right as well as L5-S1 minimal disc bulge with an annular fissure. The doctor assessed low back pain with radiculopathy caused by an annular tear at L5-S1. Lumbar ESIs at L4-5 and L5-S1 were recommended as were sedentary work restrictions effective August 20, 2015. PX #3.

On November 25, 2015, Petitioner returned to Dr. Zindrick. She complained of continuing pain. On exam, she moved in an antalgic fashion and had positive seated straight leg tests. The doctor assessed persistent back pain and radiculopathy. Her work restrictions were continued and the doctor noted Petitioner would return for a caudal ESI when she had somebody to drive her. The doctor refilled her Norco prescription. PX #3.

Petitioner testified she worked a babysitting job two days per week, nine hours each day, for one month after she last worked for Respondent in June 2015. Tr. 42-44. She testified she was paid $22 per hour. Tr. 43

Respondent offered a 12-page "Payment Detail Listing" as an exhibit without objection from Petitioner. The document purports to be a summary of Petitioner's earnings over the 52-week period preceding April 13, 2014. The document indicates Petitioner earned $25,610.83 in regular wages, various

16IWCC0631

differentials, and paid time off as well as $584.59 in overtime over the 52-week period preceding April 13, 2014. RX #2.

CONCLUSIONS OF LAW

1. With regard to the issue of causation, the Arbitrator finds that the Petitioner has met her burden of proof. In support of this finding, the Arbitrator relies on the Petitioner's unrebutted testimony and the medical evidence. While there is no dispute that Petitioner sustained an injury to her back while working for the Respondent on April 13, 2014, the main question underlying this case is whether the Petitioner's current condition of ill-being is related to the undisputed accident. The Petitioner credibly testified that she continued to receive conservative medical treatment for her back since the accident date. And although she was able to return to work for Respondent in another position from November, 2014 through June, 2015, she credibly testified that her back symptoms did not completely go away. Despite the Respondent's IME, Dr. Zelby opining that the Petitioner should have been at MMI as of July, 2014, Petitioner's pain appears to have progressively worsened upon her return to work for the Respondent, to the point where she returned to her treating physician, Dr. Ip and then followed up with Dr. Zindrick. Petitioner's complaints of pain in her back are documented and supported by the treating medical records, which show Petitioner was not released back to full duty and that further medical treatment has been recommended in the form of injections, physical therapy and an FCE. There was no evidence presented showing any break in the chain of causation from the Petitioner's original accident to present. As such, the Arbitrator finds persuasive the opinions of the Petitioner's treating physicians that Petitioner has not reached MMI from her non-disputed accident. Accordingly, the Arbitrator concludes that the Petitioner's current condition of ill-being is causally related to her undisputed April 13, 2014 work accident.

2. Based on the Arbitrator's findings with respect to the issue of causation, the Arbitrator further finds that the Petitioner is entitled to TTD from April 14, 2014 through November 7, 2014; and from June 7, 2015 through January 25, 2016. Respondent shall receive a credit for any and all TTD or other forms of disability benefit is has paid thus far for the periods in question. In further support of this finding, the Arbitrator relies on the medical evidence from Petitioner's treating physicians showing that the Petitioner was taken off work with restrictions as of June 7, 2015 and has not been released to return to work since that date.

3. Based on the Arbitrator's findings with respect to the issue of causation, the Arbitrator further finds that the Petitioner's request for prospective medical care as recommended by her treating physicians was reasonable, related and necessary in the treatment of her work-related back condition. This treatment would include additional injections, physical therapy and an FCE. Accordingly, Respondent shall authorize and pay for said medical treatment, subject to the Fee Schedule.

4. With regard to the issue of Petitioner's earnings, the Arbitrator finds Petitioner earned $25,610.83 in regular wages, various differentials, and paid time off, as well as $584.59 in overtime over the 52-week period preceding April 13, 2014. Further, as there was no evidence regarding whether or not Petitioner's overtime was mandatory, the Arbitrator, using the traditional method of calculating the average weekly wage (gross earnings less overtime divided by weeks worked in the 52-week period preceding the alleged date of loss), finds Petitioner's average weekly was $492.52.

16IWCC0631

5. Regarding the issue of penalties and attorneys' fees, the Arbitrator finds penalties and attorneys' fees are not warranted in this case. In support of this finding, the Arbitrator makes note of the Respondent's reliance on the opinions of its IME, Dr. Zelby in questioning the issues in dispute. Respondent's reliance on its expert's opinions to support its defense on the issues in dispute was reasonable, and the Respondent's refusal to pay benefits was not vexatious or unreasonable. Accordingly, the petition for penalties and attorneys' fees is denied.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Daniel Donaldson,

Petitioner,

vs.

NO: 15 WC 22003

16IWCC0632

Central Grocers, Inc. D/B/A Centralla Foods And Sentry Casualty Co.,

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, temporary total disability, causal connection, medical, 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 January 28, 2016 is hereby affirmed and adopted.

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

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

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

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

DATED: SEP 30 2016

MB/mam
o:9/22/16
43

Mario Basurto

David L. Gore

Stephen Mathis

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

DONALDSON, DANIEL
Employee/Petitioner

Case# **15WC022003**

16IWCC0632

CENTRAL GROCERS INC D/B/A CENTRALLA FOODS AND SENTRY CASUALTY CO
Employer/Respondent

On 1/28/2016, 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 0.41% 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:

1876 PAUL W GRAUER & ASSOCIATES
EDWARD A CZAPLA
1300 E WOODFIELD RD SUITE 203
SCHAUMBURG, IL 60173

3998 ROSARIO CIBELLA LTD
MARK P MATRANGA
116 N CHICAGO ST SUITE 600
JOLIET, IL 60432

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

STATE OF ILLINOIS)
)
COUNTY OF COOK)

16IWCC0632

ILLINOIS WORKERS' COMPENSATION COMMISSION

19(b) ARBITRATION DECISION

DANIEL DONALDSON
Employee/Petitioner

Case #15 WC 22003

v.

CENTRAL GROCERS, INC. D/B/A CENTRALLA
FOODS AND SENTRY CASUALTY CO.,
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Robert Williams, arbitrator of the Workers' Compensation Commission, in the city of Chicago, on November 25 and December 18, 2015. After reviewing all of the evidence presented, the arbitrator hereby makes findings on the disputed issues, and attaches those findings to this document.

ISSUES:

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

E. ☐ Was timely notice of the accident given to the respondent?

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

G. ☐ What were the petitioner's earnings?

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

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

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

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

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

Robert E. Williams
Signature of Arbitrator

January 27, 2016
Date

JAN 2 8 2016

Dr. Bush-Joseph examined the petitioner on February 27th. He opined that the hip MRI showed evidence of moderate to severe preexisting osteoarthritic wear. The doctor noted that the petitioner walked with a moderate limp and required both hands to rise from a chair. He found a 15-degree external rotation contracture of the left foot, a 10-degree flexion contracture of the left hip in the supine position, a negative 15 degrees of internal rotation and a negative 20 degrees of external rotation. The doctor opined that x-rays of the petitioner's hip revealed a marked pistol grip deformity with end stage bone-on-bone change of the superolateral portion of the acetabulum of the left hip, cystic changes and a complete loss of the anterior and lateral joint spaces. The doctor opined that x-rays and an MRI of the petitioner's left knee were normal, the examination was normal and the range of motion was full with no evidence of crepitation or instability. His diagnosis was an acute exacerbation of a preexisting degenerative arthritis of the petitioner's left hip. He further opined that a total hip replacement was warranted.

The petitioner saw Dr. Muzammil, his personal physician, on June 10th and reported that his left hip pain was more aggravated the last six months. The petitioner was evaluated by Dr. Karlsson for a Section 12 examination on June 12th.

FINDING REGARDING WHETHER THE PETITIONER'S ACCIDENT AROSE OUT OF AND IN THE COURSE OF HIS EMPLOYMENT WITH THE RESPONDENT:

Based upon the testimony and the evidence submitted, the petitioner proved that he sustained an accident on January 6, 2015, arising out of and in the course of his employment with the respondents.

joint, that there was no doubt that the MRI findings were not related to the January 6, 2015, incident and both revealed no acute changes. The MRI did not have any signs of edema of a recent collapse or change, no bony edema, no fracture lines, or any acute or recent damage, only chronic changes. The opinions of Dr. Karlsson are cogent and convincing and are supported by persuasive medical basis, a detailed physical examination and a review of diagnostic tests. The opinion of Dr. Bush-Joseph of an acute exacerbation of his pre-existing hip condition is not consistent with the evidence, is not supported by any medical basis and is conjecture. His opinion is not given any weight. The petitioner failed to prove that he sustained more than a sprain/strain of his left hip and that his pre-existing hip condition was permanently or even temporarily exacerbated by the incident on January 6, 2015.

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

The petitioner was given work restrictions on January 12, 2015. On February 27, 2015, Dr. Bush-Joseph's examination of the petitioner's left knee was normal. The petitioner is entitled to temporary total disability benefits from January 12, 2015, through February 27, 2015. The respondents shall pay the petitioner temporary total disability benefits of $685.99/week for 6-5/7 weeks, from January 12, 2015, through February 27, 2015, as provided in Section 8(b) of the Act, because the injuries sustained caused the disabling condition of the petitioner.

FINDING REGARDING PROSPECTIVE MEDICAL:

The petitioner failed to prove that the left hip replacement recommended by Dr. Bush-Joseph is reasonable medical care necessary to relieve the effects of the work

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

Andrew Hufnagl,

Petitioner,

vs. NO. 14 WC 15052

Village of Alsip,

Respondent.

16IWCC0633

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 8, 2016 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: SEP 30 2016
SJM/sj
o-9/22/2016
44

Stephen J. Mathis

David L. Gore

Mario Basurto

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HUFNAGL, ANDREW
Employee/Petitioner

Case# **14WC015052**

VILLAGE OF ALSIP
Employer/Respondent

16IWCC0633

On 2/8/2016, 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 0.46% 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:

0728 LAW OFFICES OF THOMAS W DUDA
CRAIG MILLMAN
330 W COLFAX ST
PALATINE, IL 60067

0507 RUSIN & MACIOROWSKI LTD
JEFFREY RUSIN
10 S RIVERSIDE PLZ SUITE 1530
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS. **16IWCC0633**
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Andrew Hufnagl
Employee/Petitioner

Case # 14 WC 15052

v.

Village of Alsip
Employer/Respondent

Consolidated cases: D/N/A

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Molly C. Mason, Arbitrator of the Commission, in the city of Chicago, on 1/19/16. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☐ What were Petitioner's earnings?

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

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

J. ☒ Were the 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 the claimed accident, 2/27/14, 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 not sustain an accident that arose out of and in the course of employment. The Arbitrator views the remaining disputed issues as moot and makes no findings as to those issues.

The parties stipulated Petitioner provided Respondent with timely notice of his claimed accident. Arb Exh 1.

In the year preceding the injury, Petitioner earned $146,640.00; the average weekly wage was $2,820.00.

On the date of accident, Petitioner was 40 years of age, married, with 2 children under 18.

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 $21,336.60 under Section 8(j) of the Act.

ORDER

Accident

For the reasons set forth in the attached decision, the Arbitrator finds that Petitioner failed to prove he sustained accidental injuries that arose out of and in the course of his employment. The Arbitrator views the remaining disputed issues as moot and makes no findings as to those issues.

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.

Molly C. Mason

Signature of Arbitrator

2/8/16
Date

FEB 8 - 2016

Andrew Hufnagl v. Village of Alsip
14 WC 15052

Arbitrator's Summary of Disputed Issues

The primary disputed issues are accident and causation, with Petitioner claiming his right-sided hernia, diagnosed on March 27, 2014, stemmed from lifting-related paramedic duties he performed a month earlier.

Arbitrator's Findings of Fact

Petitioner testified he has worked as a firefighter/paramedic for Respondent for 18 ½ years. He has held the rank of lieutenant for almost 10 years. Since the fall of 2003, he has held a second job as a fire science/EMS coordinator, at Moraine Valley Community College. He described this job as administrative and non-physical in nature.

Petitioner testified he first underwent paramedic training in 1992. At that point, he attended a four-month course. After successfully completing this course, he underwent additional training at Advocate for one year. He holds a paramedic license and regularly attends continuing education courses.

Petitioner testified his job duties for Respondent vary widely from routine "well being" checks and lock-outs to medical emergencies and fires. He has responded to a number of different calls during his career.

Petitioner testified he began experiencing sporadic dull aching in his left lower quadrant in early 2014. He "blew off" these symptoms at that point and did not seek care. In February 2014, he started experiencing severe acute pain in his right lower quadrant while having sex with his wife.

Petitioner testified his work schedule consisted of 24 hours "on" followed by 48 hours "off." On February 26, 2014, he started a 24-hour shift at 4 AM. He made various calls throughout February 26th and into the early morning hours of February 27th. Four of those calls were of a paramedic nature. Two of the four calls involved the same individual, an obese man who was well known to the department. Petitioner testified that, at about midnight on February 26th, he and three other paramedics went to this man's home on Kildare after the man reported being unable to get into bed. Petitioner testified the man weighed 300 to 350 pounds. He and the three other paramedics had to struggle to lift the man off the floor and get him into bed. [Records produced by Respondent in response to Petitioner's counsel's FOIA request include a partially redacted report showing that Petitioner responded to a call shortly after midnight on February 27, 2014 with that call involving providing assistance to an invalid. PX 4.] About four hours later, at 4 AM on February 27th, they responded to a second call at the same home, after the man called in and reported shortness of breath. They helped the man get into a "stair chair" and down stairs, via a home lift, and then transferred him to an ambulance.

Petitioner described a "stair chair" as weighing about 35 pounds. It is narrow and can be maneuvered more easily in stairwells than a conventional chair.

Petitioner testified he also responded to a fire call during his February 26-27, 2014 shift. Before responding to that call, he was required to don about 50 pounds of required equipment within 90 seconds, per department regulations.

Under cross-examination, Petitioner acknowledged he did not experience any symptoms during or immediately after his February 26-27, 2014 shift. He had no difficulty performing his regular job duties after that shift.

Petitioner testified he experienced right lower quadrant pain while having sex with his wife on the evening of February 27, 2014. His 40th birthday fell on that date. He and his wife joked about the symptoms being related to turning 40.

Petitioner testified he experienced another episode of "alarming pain" several days later, again while having sex with his wife.

Petitioner testified he did not have a primary care physician during this time period. On March 7, 2014, he saw an occupational physician, Dr. Moisan, for a pre-scheduled examination for work purposes. Per department regulations, he was required to undergo such an examination on an annual basis once he turned 40. Petitioner testified he told Dr. Moisan about both the dull left-sided and acute right-sided symptoms he had been experiencing. The doctor then examined him. Under cross-examination, Petitioner expressed the belief that Dr. Moisan "missed" a right-sided hernia during this examination. Petitioner testified that Dr. Moisan released him to full duty.

PX 3 consists of certified records from Dr. Moisan. The Arbitrator notes that PX 3 contains only 23 pages of records, including some duplicates, despite the fact that the certification page refers to 82 attached pages. Some of the 23 pages, including a history form, are dated March 7, 2014 but none set forth any abdominal/groin examination findings. The history form reflects that Petitioner complained of abdominal pain but denied any difficulty with job performance or any illness/injury requiring medical attention since the last examination. The 23 pages include the results of vision/hearing testing and blood work performed on March 7, 2014 but they do not include the doctor's history or examination findings of that date. Petitioner returned to Dr. Moisan on March 18, 2013, with Petitioner voicing no complaints on a history form, but no examination findings are included in the exhibit.

Under cross-examination, Petitioner acknowledged he did not report any injury to Dr. Moisan. He indicated that, when he saw Dr. Moisan, he did not know the cause of his symptoms.

Petitioner testified that Dr. Moisan referred him to Dr. Vasdekas, a general surgeon. Petitioner testified he saw Dr. Vasdekas on March 27, 2014. A handwritten history bearing that

date reflects that Petitioner was being seen for "evaluation of a possible hernia, left lower abdomen." It also reflects that Petitioner complained of intermittent left abdomen pain of six months' duration, "excruciating pain at the base of [the] penis before and after sex," with that pain starting "approx. one month ago" and a change in bowel habits. The history contains no mention of work activities or a work-related incident.

On examination, Dr. Vasdekas noted a right inguinal hernia. He recommended that Petitioner undergo a CT scan and a colonoscopy for his left sided-symptoms and then undergo a surgical repair of the hernia. He wrote out a note describing the etiology of the left-sided abdominal pain as "unclear." He wrote out a second note prescribing a right inguinal hernia repair. He did not comment on the etiology of the hernia. PX 5a. RX 2.

Under cross-examination, Petitioner acknowledged he did not tell Dr. Vasdekas about the lifting-related activities he performed on February 26th and 27th. Dr. Vasdekas told him his hernia was "definitely due to heavy lifting." Petitioner denied performing heavy lifting at any time other than when working for Respondent. He is not adept at home repairs and does not work on his car.

Petitioner testified that, on March 28, 2014, the day after he learned he would need a hernia repair, he prepared two documents, including a Form 45 and a "to/from" memo addressed to his supervisor, Chief Styczynski. Petitioner testified he was required to complete both forms at that time since he was the shift commander. On the Form 45 (PX 1), he indicated he sustained accidents at 00:24 and 04:11 on February 27, 2014 while lifting/moving a large, heavy patient. He described his injury as "abdominal discomfort that has caused pain." He indicated he had been diagnosed with a hernia. He acknowledged the hernia was "not immediately felt or noticed" after the lifting. PX 1. In the memo, he indicated he had been experiencing occasional abdominal pain in late February or early March and mentioned this pain to Dr. Moisan at his annual physical on March 7, 2014. He also described his subsequent visit to Dr. Vasdekas and the doctor's surgical recommendation. He went on to state:

> "I cannot point to a specific incident or circumstances that led to the pain/discomfort. I do not recall having severe pain during or after a call. After thinking about the incidents that I responded to, one address stood as a potential cause for the hernia. In the very early hours of February 27, 2014 (00:24), we responded to [address omitted by Arbitrator] for a lift assist. Upon arrival a very large, heavy patient was on his bedroom floor. He was unable to get into his bed. The crew lifted the patient up, held him up, until his bed could be brought over to him. The patient was dead weight and offered no assistance. The crew could not physically carry the patient to the bed, so the bed was brought to the patient. the crew had used a lot of physical effort to assist this citizen.

On this first incident, I was on the patient's left side helping to lift him up and off the floor.

Later the same morning (04:11 hrs.), the same patient wanted to be transported to the hospital. The crew took the patient out of his bed, placed him in a stair chair and removed him from the residence. The residence is too small for a stretcher to fit into the front door and a backboard will not make it out the front door. The patient, as before, was not much help. The crew had to physically exert themselves trying to remove the patient from the residence.

On the second incident, I assisted the patient from the bed and I was the person who was manipulating him throughout his home and down the residence's chair lift, in our stair chair.

I am not sure the hernia is directly related to the two incidents at _______ Kildare. However, those two incidents are the only calls that I can remember having to exert so much energy and effort. Additionally, the pain/discomfort did become noticeable shortly after those two calls for assistance."

PX 2.

Petitioner testified he gave PX 1 and PX 2 to Chief Styczynski on March 28, 2014. The chief left to make a call. On his return, he directed Petitioner to go home.

Petitioner underwent the recommended abdomen/pelvis CT scan on April 1, 2014. The scan was essentially negative. PX 6. RX 2.

Petitioner testified that, on April 2, 2014, he received a call from Christine Dapper of the Public Risk Fund. Dapper secured his permission to record their conversation. She asked him a series of questions which he answered. Petitioner described his testimony as consistent with the information he provided to Dapper. [Neither party offered any recorded statement into evidence.]

Petitioner underwent the recommended colonoscopy on April 7, 2014. PX 7. RX 2.

On April 10, 2014, Dr. Vasdekas released Petitioner to resume light duty, with no lifting over ten pounds. PX 5A.

PX 3 contains a handwritten note dated April 28, 2014, apparently authored by Dr. Moisan and bearing Petitioner's name, stating: "it is possible that lifting caused or contributed to his inguinal hernia."

Dr. Vasdekas performed a right inguinal hernia repair at Silver Cross Hospital on April 30, 2014. PX 8. RX 2. The "history and physical records" section of the hospital records describes Petitioner's chief complaint as "right inguinal hernia." This section also states: "patient states work related incident." PX 8, p. 3 of 99. In his operative report, Dr. Vasdekas diagnosed a "right inguinal hernia" and described "evident floor weakness." He did not comment on etiology. PX 8, pp. 28-29.

On May 15, 2014, Dr. Vasdekas described Petitioner as "progressing well." He advised Petitioner to begin increasing his activity level. RX 2.

On June 17, 2014, Dr. Vasdekas noted that Petitioner was starting to increase his activity level and was still experiencing some discomfort. The doctor noted no abnormalities on examination. He directed Petitioner to follow up in one month. RX 2.

On July 8, 2014, Dr. Vasdekas noted that Petitioner complained of sharp, right-sided lower groin pain of one week's duration. The doctor noted no abnormalities on examination. He advised Petitioner to apply ice to the affected area and return in two weeks. RX 2.

On July 22, 2014, Dr. Vasdekas described Petitioner as "doing well" and voicing no complaints. He released Petitioner to full duty as of July 27, 2014. RX 2.

Petitioner testified he returned to Dr. Moisan thereafter, with the doctor approving his return to work. Petitioner testified he resumed full duty on August 7, 2014, after taking a pre-scheduled vacation.

At Respondent's request, Petitioner saw Dr. Palacci for purposes of a Section 12 examination on February 24, 2015. In her report of that date, Dr. Palacci indicated she reviewed various records, including the operative report and records from Drs. Moisan and Vasdekas. She recorded the following history:

> "[Petitioner] states that on February 27, 2014, he experienced a sharp 9 out of 10 pain in the right groin with a burning sensation radiating into the right scrotum during sexual intercourse. He denied seeing or feeling an inguinal bulge. He experienced occasional left lower quadrant pain in the past. He denied any work injuries or trauma. He denied any nausea or vomiting. He denied any inguinal pain while lifting at work prior to and after this incident."

Dr. Palacci noted that Petitioner denied any current complaints and reported being able to perform all work and non-work activities. On examination, she noted a well-healed scar of the right groin with no evidence of bulge or hernia. She described the hernia repair as successful.

Dr. Palacci addressed causation as follows:

> "[Petitioner] is a 40-year-old firefighter employed by the Village of Alsip who reported sharp right groin pain on February 27, 2014 during sexual intercourse. He denied any work accidents or injuries. He was subsequently diagnosed with a right inguinal hernia and underwent a hernia repair on April 13, 2014, performed by Dr. Vasdekas . . .
>
> Based on review of the medical records, history and physical exam, Mr. Hufnagl has a diagnosis of a right inguinal hernia, which was successfully repaired. In my opinion, given to a reasonable degree of medical certainty, [Petitioner] did not sustain a work accident, as he developed pain while at home and denied any specific work trauma or injury. He has even denied any inguinal or abdominal pain during work hours. In addition, none of the treating records of Dr. Moisan or Dr. Vasdekas ever document a work-related incident."

Dr. Palacci further explained that "direct hernias," such as Petitioner's, "are acquired and caused by weakening of the abdominal muscles over time with weakness in the floor of the inguinal canal. This weakness can be due to inherent connective tissue abnormalities in many cases, although some may occur due to deficiencies in the abdominal musculature resulting from chronic overstretching or injury or possibly drug effects."

Referencing the AMA 6th Edition Guides, and citing the absence of any palpable defect at the surgical site, Dr. Palacci classified Petitioner's condition as "Class 0." She indicated this class "does not require further adjustment" and accordingly rated Petitioner's impairment as 0%, indicating this "is typical for a successful hernia repair." Palacci Dep Exh 2.

Petitioner testified he used his group insurance to pay his medical expenses.

Petitioner denied having hobbies of a physical nature. He is required to stay in good shape and works out at the fire station. He continues to perform his regular duties for Respondent. He occasionally notes dull aching on the right side of his abdomen. This aching is new. He attributes it to the mesh used during the hernia repair. When Dr. Palacci asked him if he had an accident he said no because he conceives of an accident as a motor vehicle collision or other sudden event. He also denied any traumas when he saw Dr. Palacci. He thinks of a trauma as a gunshot wound, stabbing or other injury requiring a visit to a trauma center.

Under cross-examination, Petitioner acknowledged he did not report any injury or accident to Respondent between his February 26-27, 2014 shift and March 28, 2014. During that time, he did not think his symptoms were work-related. It was only after Dr. Vasdekas diagnosed a hernia that he concluded the symptoms stemmed from his job with Respondent. It was at that point that he looked back at his log books to determine which calls had involved strenuous lifting. He acknowledged it falls to him, since he is a shift commander, to tell employees to report work injuries promptly. He believes Dr. Moisan "missed" the hernia on March 7, 2014. In his view, it would be "preposterous" to think that sexual activity caused the hernia. But for his previously scheduled vacation, he would have resumed full duty on July 28, 2014. Other than the occasional right-sided aching, he has no other physical problems attributable to the hernia. He is not scheduled to follow up with any physician in connection with the hernia.

On redirect, Petitioner testified that a "jump bag" weighed 42 pounds as of his February 26-27, 2014 shift. His daughters are currently 3 and 12 years old. His 3-year-old weighed between 10 and 15 pounds as of his February 26-27, 2014 shift. He did not lose any time from his second job at Moraine Valley. He obtained Respondent's okay to continue performing this job. Dr. Vasdekas released him to resume full duty as of July 27, 2014. [RX 2.] He took a pre-planned vacation thereafter, through August 6, 2014.

Under re-cross, Petitioner acknowledged that neither Dr. Moisan nor Dr. Vasdekas drew a link between his hernia and any particular call he made while working for Respondent.

No witnesses testified on behalf of Respondent at the hearing.

Respondent offered into evidence Dr. Palacci's evidence deposition of August 25, 2015. The doctor, an osteopath, testified she obtained board certification in internal medicine in 2005. RX 1 at 6. She was last involved in direct patient care in December 2013. As of the deposition, her practice consisted of performing Social Security disability evaluations. RX 1 at 6-7. She devotes about one-third of her practice to medical-legal work. RX 1 at 7.

Dr. Palacci testified she reviewed records from Dr. Moisan, Dr. Vasdekas, Silver Cross Hospital and Palos Community Hospital in connection with her examination of Petitioner. RX 1 at 8-9. The records reflected a diagnosis of a hernia. RX 1 at 9. Dr. Moisan's note of March 7, 2014 does not contain any history of an injury. RX 1 at 9-10. Dr. Vasdekas's initial note of March 27, 2014 also contains no history of an injury. RX 1 at 10. In his operative report of April 30, 2014, Dr. Vasdekas noted a "direct inguinal hernia with evidence of floor weakness." RX 1 at 11.

Dr. Palacci testified that none of the records she reviewed indicated that the hernia stemmed from a work-related accident. RX 1 at 12.

Dr. Palacci testified that, on February 24, 2015, Petitioner provided a history of 9/10 pain in his right groin with a burning sensation radiating into his right scrotum during sexual

intercourse. Petitioner denied feeling or seeing any inguinal bulge at that time. Petitioner denied any work injuries or trauma. Petitioner "even stated that he didn't have any inguinal pain even while lifting at work" prior to or after this incident. RX 1 at 13. Petitioner denied any nausea or vomiting associated with his groin pain. Such symptoms might give rise to concern for complications associated with hernias. Symptoms associated with hernias can range from a dull, pulling sensation to sharp pain. Sometimes the pain can radiate into the scrotum. RX 1 at 14. The pain can worsen by the end of a day, especially for people who do a lot of standing or perform labor. RX 1 at 14.

Dr. Palacci found it significant that Petitioner denied experiencing inguinal pain while working on February 27, 2014. She assumes that, by denying any trauma, Petitioner was including heavy lifting in his definition of "trauma." RX 1 at 14-15.

Dr. Palacci testified that Petitioner denied any complaints at the time of the examination. He had resumed full duty as a firefighter. RX 1 at 16.

Dr. Palacci testified there are several risk factors for hernias. The only identifiable risk factor in Petitioner's case is that he is a male Caucasian. RX 1 at 16-17.

Dr. Palacci opined that Petitioner did indeed have a right inguinal hernia and that the hernia repair was successful. She found no evidence that the hernia resulted from the work activities Petitioner performed on February 27, 2014. She found Petitioner to have reached maximum medical improvement. RX 1 at 18.

Dr. Palacci testified that the operative report described Petitioner as having a "direct inguinal hernia." This diagnosis, along with the "operative findings of a weakened inguinal canal floor," told her that Petitioner "probably had some kind of inherent connective tissue abnormalities that caused weakening of the fibromuscular tissue in the abdominal wall." RX 1 at 19.

Dr. Palacci testified she performed an impairment rating after examining Petitioner. She relied on the sixth edition of the AMA Guides in so doing. The diagnosis of a "right inguinal hernia that was successfully repaired" placed Petitioner in "class zero." By definition, a "class zero is zero percent impairment." RX 1 at 26, 28. She found Petitioner's "functional history grade modifier" to be zero because Petitioner had no complaints. However, she did not need to consider this because Petitioner's diagnosis placed him in class zero. RX 1 at 26.

Under cross-examination, Dr. Palacci testified she reviewed a cover letter from Respondent's attorney in addition to medical records. She used the cover letter only as a general guideline. RX 1 at 29-30. She completed her report within a few days of examining Petitioner. RX 1 at 30. She did not retain her notes. She has admitting privileges at St. Joseph Hospital. RX 1 at 31. She last treated patients in December 2013. RX 1 at 32. She devotes two thirds of her current practice to Social Security disability evaluations and one third to medical legal work. RX 1 at 32. About 60 to 80 percent of the medical legal work comes from insurers

or respondent attorneys. RX 1 at 33. She is not sure whether Dr. Vasdekas communicated with Dr. Moisan. RX 1 at 35. She is also not sure about the etiology of Petitioner's left-sided complaints. The CT scan showed no evidence of a left-sided hernia. RX 1 at 38. Petitioner told her he began experiencing pain at the base of the penis while having sex on February 27, 2014. She put this in her report. Dr. Vasdekas's initial note reflects a one-month history of this pain. RX 1 at 39. Her report does not reflect that she reviewed any recorded statement given by Petitioner to a claim representative. RX 1 at 41-42. As a firefighter, Petitioner would perform lifting. RX 1 at 46. She did not ask Petitioner about his specific duties. RX 1 at 47. Whether a hernia is related to firefighting duties depends on the scenario and risk factors. RX 1 at 47. Dr. Vasdekas was looking for a left-sided condition initially, based on Petitioner's complaints, but ended up finding a right-sided hernia. RX 1 at 48-49. Not everyone who has an inguinal hernia notices the hernia immediately. RX 1 at 49-50. A hernia could possibly stem from strenuous activity such as lifting. RX 1 at 52. Most hernias result from congenital defects. RX 1 at 55. She is not aware of the specific work activities Petitioner engaged in during the month before his hernia was diagnosed. RX 1 at 56-57. It is possible that Petitioner's work activities could have caused a defect leading to the need for hernia surgery but "there are still a lot of unknowns." Petitioner was "evaluated for GI issues" and maybe had some other gastrointestinal complaints that could have increased his intra-abdominoanal pressure. RX 1 at 57. The work activities cannot be eliminated as a cause but Petitioner denied any inguinal pain during those activities. Abdominal pain is different from inguinal pain. The abdominal pain Petitioner was experiencing was on the opposite side of the hernia. RX 1 at 58-59. She has performed maybe thirty examinations of firefighters claiming hernias. RX 1 at 61. She would not disagree with the period of time that Petitioner was kept off work following the mesh hernia repair. RX 1 at 62. She cannot say with absolute certainty that the hernia was unrelated to Petitioner's work activities. RX 1 at 64. A person who undergoes a mesh repair faces a possible risk that the mesh will separate, causing a recurrence. RX 1 at 64.

On redirect, Dr. Palacci testified she definitely asked Petitioner how he injured himself, with Petitioner indicating he experienced a sharp pain during sexual intercourse on the night of February 27th. RX 1 at 68. She specifically asked him if he experienced any work injuries or traumas. When he said no, there was no need for her to press further. RX 1 at 69.

Under re-cross, Dr. Palacci testified it would have been typical for Petitioner to move large individuals, using stair chairs and stretchers, and maybe fight fires. Petitioner probably would not identify such activities as traumas since he routinely performed them. RX 1 at 71. She did not review the Form 45 or the accident report in connection with her examination. RX 1 at 73.

On further redirect, Dr. Palacci testified that, in light of Petitioner's history and the contemporaneous records, the Form 45 and accident report do not prompt her to change her opinions. RX 1 at 76.

Arbitrator's Credibility Assessment

Petitioner's lieutenant status and lengthy tenure with Respondent weigh in his favor, credibility-wise.

The Arbitrator does, however, question Petitioner's attempt to link his right-sided hernia, diagnosed on March 27, 2014, with lifting activities he performed during a shift a month earlier. Petitioner testified he (alone and as part of a team) had to lift and carry an obese individual at two points during that shift. Petitioner freely acknowledged, however, that he did not experience any symptoms while or shortly after performing those activities. He became symptomatic on the night of February 27, 2014, while having sex with his wife on his 40th birthday. He next experienced the symptoms, which he described as "alarming pain," a few days later, again during sex. He insisted that it was the work-related lifting of February 26-27, 2014 rather than the sexual activity that caused his symptoms yet, when he related the symptoms to Dr. Vasdekas on March 27, 2014, he linked them to sex. The doctor's note of that date contains no mention of work, let alone the calls Petitioner made on February 26-27, 2014. Petitioner testified that Dr. Vasdekas told him his hernia stemmed from heavy lifting but this is not documented in the doctor's initial note. Rather, it appears to the Arbitrator that it was Petitioner, rather than any physician, who decided to target the lifting he performed on February 26th and 27th as a cause after learning of the need for surgery that would clearly result in some lost time.

Petitioner testified he provided a recorded statement to a representative of the Public Risk Fund on April 2, 2014. Respondent did not offer a transcript of this statement into evidence. The Arbitrator would typically question this but notes that, even if the transcript reflected Petitioner told the representative he experienced symptoms while or shortly after performing lifting on February 26-27, 2014, that would conflict with his sworn testimony.

Arbitrator's Conclusions of Law

<u>Did Petitioner sustain an accident on February 27, 2014 arising out of and in the course of his employment?</u>

Initially, the Arbitrator considers the effect of Section 6(d)(f) of the Act. This section provides, in relevant part, as follows:

> "Any condition or impairment of health of an employee employed as a firefighter, emergency medical technician (EMT), or paramedic which results directly or indirectly from any bloodborne pathogen, lung or respiratory disease or condition, heart or vascular disease or condition, hypertension, tuberculosis, or cancer resulting in any disability (temporary, permanent, total or partial) to the employee shall be rebuttably presumed to arise out of and in the course of the employee's firefighting, EMT or paramedic employment and, further, shall be rebuttably presumed to be causally connected to the hazards

> or exposures of the employment. This presumption shall also apply to any hernia or hearing loss suffered by an employee employed as a firefighter, EMT or paramedic. However, this presumption shall not apply to any employee who has been employed as a firefighter, EMT or paramedic for less than 5 years at the time he or she files an Application for Adjustment of Claim concerning the condition or impairment with the Illinois Workers' Compensation Commission."

This section has an obvious application to the instant case. Petitioner alleges a hernia and had worked as a firefighter/paramedic for more than 5 years as of the date he filed his Application. The question for the Arbitrator to resolve is whether the presumption in favor of compensability was successfully rebutted.

The Arbitrator, having found that Petitioner was less than credible as to certain issues, and having considered the timeline and all of the evidence, finds that the statutory presumption was rebutted in this case. In so finding, the Arbitrator relies on the following: 1) Petitioner's candid admission that he did not experience any symptoms while or immediately after performing the tasks he retrospectively targeted as the cause of his hernia; 2) Petitioner's apparent failure to offer into evidence all of Dr. Moisan's certified records; 3) the fact that Dr. Vasdekas's initial history contains no mention of work, let alone a specific work activity, as the cause of Petitioner's complaints; 4) the opinions expressed by Respondent's examiner, Dr. Palacci.

The Arbitrator has also compared this case with another firefighter hernia case recently decided by the Commission, Timothy Capua v. Lisle-Woodridge Fire Protection District, 2015 Ill. Wrk. Comp. LEXIS 170 (March 9, 2015). The facts of both cases are very similar, with one significant exception.

In Capua, as in the instant case, the claimant was symptomatic for a period before being diagnosed with a hernia and did not report any injury to his employer until after he was diagnosed and referred to a surgeon. The claimant, like Petitioner, did not link his abdominal symptoms to work, let alone any specific work activity, when first evaluated by a physician.

In Capua, the arbitrator found that the claimant failed to establish accident and causation. The Commission (Tyrrell, Brennan and Lamborn) reversed, citing the "rebuttable presumption" language of Section 6 and the claimant's testimony that "he felt a pain in his abdomen after pulling [a] 35-foot ladder out of about 5 inches of mud" while fighting a fire. The Commission characterized this testimony as credible, further noting that the claimant described his pre-existing abdominal swelling as increasing significantly after he extricated the ladder from the mud. It is that credible testimony and sequence of events that are missing from the instant case.

The Arbitrator also considers the analysis and result in Curtis Simpson v. City of Peoria, 2015 Ill.Wrk.Comp. LEXIS 37, a case decided by the Commission approximately a year ago. While Simpson involves a firefighter claiming a myocardial infarction rather than a hernia, it is instructive because, as in the instant case, the symptoms manifested after a non-work activity. In Simpson, the claimant experienced chest pain at home, after cleaning his garage and moving some items. He was diagnosed with a heart attack shortly thereafter. The arbitrator found the case compensable and awarded permanency benefits. [The arbitrator's decision is not available online.] The Commission (Basurto, Mathis and Gore) reversed. Initially, the Commission cited the "rebuttable presumption" language of Section 6(f) along with decisions in which the appellate courts analyzed presumptions arising outside the realm of workers' compensation. The Commission relied on Franciscan Sisters Health Care Corp. v. Dean, 95 Ill.2d 452 (1983) for the proposition that "if a strong presumption arises, the weight of the evidence brought it in to rebut it must be great." The Commission went on to say that because the presumption created by Section 6(f) is statutory, "it requires stronger evidence to overcome." The Commission found that the employer successfully rebutted the presumption "by providing strong evidence through its experts' opinions, along with Petitioner's own health history, work history and Petitioner's own testimony to show there were other causes of Petitioner's cardiovascular problems and his condition is not related to his employment as a firefighter."

The Commission's analysis did not end there. Again citing Franciscan Sisters, the Commission went on to address the question of whether the claimant "met his burden of proving by a preponderance of the evidence that his heart attack was related to his employment." In other words, the Commission felt compelled to analyze the evidence as it would in an ordinary case in which no presumption applied. The Commission concluded that the claimant did not meet this burden since the activity giving rise to the symptoms was "personal in nature." The Commission assigned greater weight to the opinions of the claimant's expert than to those of the claimant's.

The Arbitrator, following the Commission's lead in Simpson, takes her analysis beyond the confines of Section 6(f) and finds that Petitioner failed to prove, by a preponderance of the evidence, that his hernia stemmed from any work activities performed during his February 26-27 shift. A classic "chain of events" analysis is inapplicable since Petitioner denied experiencing symptoms while or immediately after performing those activities. The treatment records do not contain mention of those activities. Instead, they coincide with Petitioner's sworn testimony that he experienced the symptoms during sexual activity. Petitioner did not offer any medical opinion, to a degree of reasonable certainty, that the activities he performed on February 26-27, 2014 were a cause of his hernia. Dr. Moisan merely opined that it was possible that non-specific lifting could have caused or contributed to the hernia. Similarly, Dr. Palacci conceded merely that it was possible Petitioner's work activities could have contributed to the development of the hernia.

The Arbitrator, having found that Petitioner failed to prove a compensable work accident, views the remaining disputed issues as moot and makes no findings as to those issues. Compensation is denied.

STATE OF ILLINOIS	)	
	) SS.	
COUNTY OF COOK	)	

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Noel Rosario

Petitioner,

vs. NO. 15 WC 18349

Iron Mountain

16IWCC0634

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19b having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses, penalties and fees, temporary disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. 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 January 6, 2016 is hereby affirmed and adopted.

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

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

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

No bond is required for 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: SEP 30 2016
SJM/sj
o-9/22/2016
44

Stephen J. Mathis

David L. Gore

Mario Basurto

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

ROSARIO, NOEL
Employee/Petitioner

Case# **15WC018349**

IRON MOUNTAIN
Employer/Respondent

16IWCC0634

On 1/6/2016, 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 0.50% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

3098 MICHAEL D NICHOLSON LTD
7111 W HIGGINS
CHICAGO, IL 606056

0560 WIEDNER & McAULIFFE LTD
MARY C SABATINO
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

16IWCC0634

- [ ] 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)

NOEL ROSARIO,
Employee/Petitioner

v.

IRON MOUNTAIN,
Employer/Respondent

Case # 15 WC 18349

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 **MARIA S. BOCANEGRA**, Arbitrator of the Commission, in the city of **Chicago**, on **November 5, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

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

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

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

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

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

G. [ ] What were Petitioner's earnings?

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

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

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

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

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

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

N. [ ] Is Respondent due any credit?

O. [ ] Other ____

FINDINGS

On the date of accident, **12-10-13**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$23,660.00**; the average weekly wage was **$455.00**.

On the date of accident, Petitioner was **26** years of age, ***married*** with **0** dependent children.

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

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$0**. Respondent is entitled to a credit for any medical pays paid by group under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical services for the ***chest contusion*** 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.

Respondent is ***not liable*** to Petitioner for temporary total disability.

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

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

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

Signature of Arbitrator

1-6-2016
Date

ICArbDec19(b)

JAN 6 - 2016

FINDINGS OF FACT

Noel Rosario ("Petitioner") testified that on December 10, 2013 he was 35 years old and an 11-year full time employee of Iron Mountain ("Respondent"). He said he worked as a transportation coordinator whose duties included preparing routes for drivers, preparing shredding cans and getting vehicles warmed up in the backyard. He testified the shred cans are used to shred paper and that he uses both hands and arms to complete this and had done so for years.

On December 10, 2013, Petitioner testified the temperature outside was subzero and he went out to warm up a work truck. While starting the truck, he fell down 12 to 13 feet from the top of the truck to the concrete pavement below landing on his right side injuring his chest, fracturing his ribs and injuring his right shoulder. He testified he lay on the floor for 3-4 minutes after the fall and that he could not get up from the parking lot surface. A co-worker helped him up and he was out of breath and winded. After he got up he reported to Robert Lee that he was not feeling well and that he was hurt on the right side. He testified he indicated to Lee what occurred.

Petitioner went to the Concentra that same day where he reported the accident and his injuries including the right shoulder. He recalled being driven by a driver to Concentra. He noticed he was having pain on the right side, right shoulder and ribs on right side. He said he was only treated for his diagnosed chest injuries and was not diagnosed for his right shoulder injury. Exam showed pain with reaching to only to 45 degrees. At that time, Petitioner was returned to work modified duty of no overhead work, maximum 10lb. lifting restriction. Petitioner testified he reported shoulder pain to both Concentra and to his supervisor during this time. On cross, he denied stating he injured his left side. He agreed he did not receive any right shoulder diagnosis. On re-direct, he said he indicated to Concentra of pain to right shoulder. Petitioner stated he returned to work 2 days later on light duty and was able to do clerical work but was still having pain on right shoulder and right side of body.

Records show that therapy continued with Concentra through January. At the initial evaluation on December 11, 2013, therapists mentioned contusion of the chest wall and Petitioner was treated for a diagnosis of same. Petitioner was tested for range of motion of the bilateral shoulders. On December 12, 2013, Petitioner received therapy for contusion of the chest wall. From December 16, 2013 through December 23, 2013, Petitioner received therapy for contusion of the chest wall. It was noted that on December 23, 2013, Petitioner felt better for left chest wall. Petitioner testified he did not recall saying that, he did not recall saying he cleaned out his basement and did not recall saying he had pain sleeping on left side. On January 13, 2014, Petitioner was discharged from therapy with Concentra. At trial, Petitioner conceded he did not receive any treatment with Concentra for the right shoulder.

Petitioner testified that after physical therapy ended, he told his supervisor he was still having shoulder pain. On September 10, 2014, Petitioner returned to Dr. Shah who noted recurrent right shoulder pain. On December 29, 2014, Petitioner followed up with Dr. Shah and right shoulder pain was noted. On January 7, 2015, Petitioner returned to Dr. Shah, who noted Petitioner was "suffering from chronic right shoulder pain no improvement after cortisone shot that he had last year." The doctor noted a history of a "couple injuries to the right shoulder most recent last year when he fell off a truck and had a hairline rib fracture and shoulder contusion." Petitioner testified that during this time, he continued to complain of right shoulder pain to his supervisor. Of note, prior to Petitioner's work accident, on March 12, 2013, Dr. Shah noted "chronic right shoulder pain for last few years, increased with bowling." Petitioner's right shoulder was injected and an MRI was ordered. On cross, Petitioner stated he did not recall injections.

On February 9, 2015, Petitioner went to Chicago Orthopedic Clinic where he saw Dr. Ellis Nam. Petitioner related he fell off a truck and landed on his right side a year ago. The doctor noted Petitioner played a lot of baseball and bowing since he was a child. Two prior injections were noted. Dr. Nam impingement and an MRI of the right shoulder revealed a SLAP tear of the superior glenoid labrum and a 4 mm partial thickness undersurface tear of the distal supraspinatus tendon.

On August 18, 2015, Petitioner underwent and Dr. Nam performed a right shoulder arthroscopy. Post operative diagnosis indicated a right shoulder slap tear, impingement syndrome and a partial rotator cuff tear. Petitioner was off work August 17, 2015 to September 1, 2015 and received no temporary total disability. After September 1, 2015, Petitioner returned to work for Respondent in a light duty capacity in a sling.

The Petitioner continues at present to receive physical therapy and has incurred some $57,681.05 in unpaid medical bills for his medical treatment. Currently, Petitioner is still taking Norco when he goes to physical therapy but not everyday. He is still in rehab at AthletiCo.

Today, he notices lack of hand and shoulder strength. He has sustained any subsequent injuries to the right arm, had not injured himself in that area prior to the accident. On redirect he said if he had prior shoulder pain he would have told his doctor. He said he previously had a groin injury at work and had a prior back injury at work but never had any prior shoulder or arm injury at work.

CONCLUSIONS OF LAW

Arbitrator's Credibility Assessment

Petitioner was the only individual to testify at trial. The Arbitrator finds that Petitioner was credible in relating the mechanism of injury and the specifics surrounding his accident but was not as credible in proving his right shoulder condition was the result of that work accident, as more fully set forth below.

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

After a careful review of Petitioner's testimony as well as all available evidence submitted at trial, the Arbitrator concludes that Petitioner has failed to prove by a preponderance of the evidence that his current condition of ill-being as it relates to the right shoulder is causally related to his undisputed work accident of December 10, 2013.

In so finding Petitioner's right shoulder condition is not causally related to the accident, the Arbitrator relies primarily on the credibility assessment of the Petitioner and on Petitioner's medical treatment records, which fail to corroborate and confirm Petitioner's trial testimony that he attempted to related his shoulder injury to his medical providers. The Arbitrator does conclude, based on a chain of events theory, that Petitioner's ***chest contusion is causally related*** to the work accident based upon the corresponding medical records.

Regarding the right shoulder, in reviewing the initial treatment records from Concentra dated December 10, 2013, Dr. George Bridgeforth noted Petitioner complained "about his shoulder which was injured on 12/10/2013" after Petitioner described to the doctor slipping and falling off of a work truck, injuring the left side. While the statement tends to be supportive of Petitioner's description of the accident it is not supportive of Petitioner's testimony that his right shoulder was injured. Petitioner conceded at trial he did not receive

treatment for or any diagnosis for the right shoulder. Concentra records only show treatment for a left-sided chest injury and only show complaints to the left side.

At trial, there was discussion had whether Petitioner complained of left sided pain. Petitioner specifically denied this, stating he did not recall identifying the left side but did recall stating he injured his shoulder. The Arbitrator finds Petitioner not credible in this regard. The entirety of Concentra medical and physical therapy records repeatedly mention and document treatment to the left side and Petitioner's testimony that he does not recall this is simply not supported. As it relates to the Concentra records, there is no evidence Petitioner complained of, received treatment for or was otherwise diagnosed with any right arm and/or shoulder injury.

Petitioner submitted medical records from his primary healthcare physician, Dr. Shah, into evidence. Px2. While Petitioner's trial testimony that he complained to Dr. Shah of right shoulder pain is in the medical record, the reasons noted did not concern any work accident. First, Dr. Shah noted *chronic* right shoulder pain with duration of a *few years, increased with bowling*. (Emphasis Added). This note *pre-dates* Petitioner's work accident. Second, when Petitioner did complain to Dr. Shah of right shoulder pain nearly 10 months after the work accident, Dr. Shah did not identify any injury or fall and instead noted recurrent right shoulder pain. At trial, Petitioner attempted to relate his right shoulder complaints made to Dr. Shah to the work accident but failed to adequately address Dr. Shah's notations, as mentioned above. When confronted on cross-examination with other possible causes or scenarios, Petitioner failed to acknowledge any of Dr. Shah's notations and/or simply denied any such statements and/or simply forgot the history noted. Petitioner failed to carry his burden in this regard. In addition, subsequent records of Dr. Shah dated 12/29/14 do not mention a work accident. On January 7, 2015, Dr. Shah did note a "history of a couple injuries to right shoulder most recent *last year* when he fell off a truck and had *hairline rib fracture* and shoulder contusion." (Emphasis Added). Dr. Shah's notation is based on an inaccurate history as the Arbitrator is unable locate any evidence of a hairline rib fracture and the fall Dr. Shah mentions would have occurred in 2014 rather than Petitioner's 2013 claimed work accident.

Finally, Petitioner submitted the records of Dr. Nam into evidence. On February 9, 2015, more than one year after the work accident, Dr. Nam noted progressively worse right shoulder pain for two years and that Petitioner fell off a work truck landing on the right side a year ago. Based on this history, Petitioner had shoulder pain as far back as 2013 and fell in 2014, not 2013. Dr. Nam also noted 2 prior injections. The only injection administered to the right shoulder in evidence was performed by Dr. Shah in March 2014, which would mean the other injection identified by Dr. Nam is unaccounted for and unexplained. At trial, Petitioner denied injections. Given the multiple discrepancies already noted, the notations by Drs. Shah and Nam of a work fall are insufficient to carry Petitioner's burden on the issue of accident.

Based on the foregoing, the Arbitrator concludes Petitioner failed to prove 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 does conclude, based on a chain of events theory, that Petitioner's ***chest contusion is causally related*** to the work accident based upon the corresponding medical records.

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

Having found in favor of Respondent on the issue of causal connection between Petitioner's right shoulder and work accident, the Arbitrator does conclude that any and all treatment related to the chest contusion is related and that all such treatment thereto has been reasonable and necessary. Respondent shall pay reasonable and necessary medical services for the ***chest contusion*** as provided in Sections 8(a) and 8.2 of the Act. Px1. 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.

ISSUE (L) What temporary benefits are in dispute?

Having found in favor of Respondent on the issue of causal connection between Petitioner's right shoulder and work accident, the Arbitrator notes that Petitioner lost no time as a result of his causally related chest contusion. Ax1, Px1. Petitioner's claim for TTD is as to his missed time from work following his unrelated right shoulder surgery. Ax1. Accordingly, Respondent is ***not liable*** to Petitioner for temporary total disability.

Signature of Arbitrator

1-6-2016
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

Richard Wold,

Petitioner,

vs. NO. 07 WC 39690

Sun Towing Inc. and Dan Rutherford,
State Treasurer as Ex-Officio Custodian of the IWBF,

16IWCC0635

Respondents.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 26, 2016 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that the Illinois State Treasurer as *ex-officio* custodian of the Injured Workers' Benefit Fund was named as a co-Respondent in this matter. The Treasurer was represented by the Illinois Attorney General. This award is hereby entered against the Fund to the extent permitted and allowed under §4(d) of the Act, in the event of the failure of Respondent-Employer to pay the benefits due and owing the Petitioner. Respondent-Employer shall reimburse the Injured Workers' Benefit Fund for any compensation obligations of Respondent-Employer that are paid to the Petitioner from the Injured Workers' Benefit Fund.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent Sun Towing 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.

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: SEP 30 2016
SJM/sj
o-9/22/2016
44

Stephen J. Mathis

David L. Gore

Mario Basurto

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WOLD, RICHARD E Case# **07WC039690**
Employee/Petitioner

SUN TOWING INC AND DAN RUTHERFORD STATE TREASURER AND EX-OFFICIO OF THE IWBF **16IWCC0635**
Employer/Respondent

On 1/26/2016, 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 0.41% 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:

0006 LEO ALT
221 N LASALLE ST
CHICAGO, IL 60601

0975 RIFFNER BARBER ROWDEN & SCOTT
SCOTT BARBER
1834 WALDEN OFFICE SQ #500
SCHAUMBURG, IL 60173

5273 ASSISTANT ATTORNEY GENERAL
MEGAN MURPHY
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

STATE OF ILLINOIS)

)SS.

COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Richard E. Wold
Employee/Petitioner

Case # 07 WC 039690

v.

Sun Towing, Inc. and Dan Rutherford, State Treasurer and Ex-offico Custodian of the IWBF
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Jeffrey Huebsch**, Arbitrator of the Commission, in the city of **Chicago**, on **April 2, 2015 and October 14, 2015.** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

Richard E. Wold v. Sun Towing, Inc., et al, 07 WC 039690

FINDINGS

On **July 28, 2007**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$10,400.00**; the average weekly wage was **$200.00**.

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

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

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

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

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

ORDER

Respondent shall pay reasonable and necessary **medical services of $18,477.86, as provided in Sections 8(a) and 8.2 of the Act.**

Petitioner's claim for TTD benefits is denied.

The Illinois State Treasurer as *ex-officio* custodian of the Injured Workers' Benefit Fund was named as co-Respondent in this matter. The Treasurer was represented by the Illinois Attorney General's Office. Award is hereby entered against the Fund to the extent permitted and allowed under Section 4 (d) of the Act, in the event of the failure of Respondent-employer, Sun Towing, Inc., to pay the benefits due and owing the Petitioner. Respondent-Employer shall reimburse the Injured Workers' Benefit Fund for any compensation obligations of Respondent-Employer that are paid to the Petitioner from the Injured Workers' benefit Fund.

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

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

Signature of Arbitrator — January 22, 2016 (Date)

JAN 2 6 2016

Richard E. Wold v. Sun Towing, Inc., et al, 07 WC 039690

PROCEDURAL BACKGROUND

Petitioner filed an Application for Adjustment of Claim herein against Sun Towing, Inc., alleging that he sustained accidental injuries on 7/28/07 on September 5, 2007. An Amended Application for Adjustment of Claim, naming the State Treasurer, as ex-officio custodian of the IWBF and others was filed on June 8, 2011.

Proofs were taken in this case on April 2, 2015 and October 14, 2015, with Petitioner proceeding against Sun Towing, Inc. and the State Treasurer, as ex-officio custodian of the IWBF.

Petitioner's oral motion to amend the Amended Application by deleting certain named respondents was granted on April 2, 2015. The Amended Amended Application was admitted as Arbitrator's Exhibit 2 on April 2, 2015.

FINDINGS OF FACT

Petitioner worked for Sun Towing, Inc. ("Sun") as licensed tow truck driver. He filled out an application with Sun and also with the Illinois Commerce Commission. Sun paid a few for Petitioner to get his license. Petitioner's boss at Sun was John Collier, who was a friend. Sun owned the tow truck and supplied the tools that Petitioner used on the job. Sun set Petitioner's work hours of 8:00pm to 8:00am, with 2 days off. There was a Sun Towing sign on the truck, with Sun's address, phone number and ICC and DOT numbers. Sun did the repairs on the truck and furnished Petitioner with a fuel card for the truck. Sun's business was towing, primarily removing improperly parked vehicles from private lots and charging a fee. Collier provided Petitioner with instructions on which lots to patrol and Sun gave Petitioner a Nextel walkie-talkie so that he could receive tow instructions. Sun paid Petitioner by check, 30% of each tow (usually $30.00). Petitioner was not given a W-2 by Sun and taxes were not withheld from the payments that were made to Petitioner. Petitioner was discouraged from working for anyone else when he worked for Sun. Petitioner was told by Sun that he wasn't needed anymore in August of 2007 and the relationship with Sun Terminated.

Sun had a company cat that lived at its facility. Petitioner and members of the public would interact with the cat during the day. The cat was very friendly. Petitioner's job duties did not include interacting with or caring for the cat.

On July 28, 2007, Petitioner was working for Sun. He had made a tow and was filling out required paperwork at the desk at Sun. The cat jumped on Petitioner's lap and Petitioner "brushed" it. The cat bit Petitioner on his left hand. Petitioner did not recall the cat biting anyone before. Petitioner washed his hand and continued to perform his work for Sun.

Jeffrey Morency testified on behalf of Petitioner. Morency was friends with Petitioner and would occasionally go on ridealongs with Petitioner when he towed for Sun. Morency was present with Petitioner at Sun's office when the cat bit Petitioner. He did not see the cat bite Petitioner, but did hear the cat yelp and saw the bite mark on Petitioner's hand. Petitioner told Morency that the cat had bitten him.

When Petitioner woke up the next day, his hand was swollen "like a boxing glove." Petitioner worked the next day and eventually sought medical treatment at Little Company of Mary Hospital on July 31, 2007. Petitioner was first seen in the emergency room and spent several hours there. Eventually, Petitioner left AMA on August 1, as an I&D procedure was being contemplated. Petitioner returned to Little Company of Mary and was admitted from August 1, 2007 at 22:10 through August 4, 2007. He had a follow up visit for a bandage change,

as well. The eventual diagnosis was cat bite cellulitis of the left hand and Petitioner did undergo an I&D on August 3, 2007. Various pain medications and antibiotics were given during the admit. (PetEx. 4 & 5)

Petitioner obviously wasn't the best historian at Little Company of Mary, telling various providers that the bite was from a friend's cat, mechanic shop cat, shop cat, occurring 7/28, yesterday, approximately 2 days ago and 4 days prior to 8/1. Petitioner also said that he was laid off and unemployed. (PetEx. 4 & 5)

Petitioner had discussions with John Collier when he was in the hospital.

Petitioner denied being bit by his pet ferret. Petitioner denied that he was laid off by Sun at the time of the injury.

Petitioner testified that he was off work "probably 6 days" as a result of the injury. His hand is now okay, fine. At trial, Petitioner advised that he was not seeking PPD. Petitioner tendered Exhibit Number 3, which was unpaid bills from Little Company of Mary.

Petitioner's Exhibit 1 was a statement from the IWCC that Sun did not have workers' compensation insurance. Petitioner's Exhibit 2 was a no insurance statement from NCCI for the date of accident.

CONCLUSIONS OF LAW

The Arbitrator adopts the above Findings of Fact in support of the Conclusions of Law set forth below. Petitioner's testimony is found to be credible. Petitioner was bit by Sun's company cat on July 28, 2007 while he was sitting in Sun's office doing paperwork regarding a tow.

WITH RESPECT TO ISSUE (A), WAS THE RESPONDENT OPERATING UNDER AND SUBJECT TO THE ILLINOIS WORKERS' COMPENSATION OR OCCUPATIONAL DISEASES ACT, THE ARBITRATOR FINDS AS FOLLOWS:

The IWCC has jurisdiction over this claim because the accident occurred in Illinois.

Sun is subject to the coverage under §3(15) of the Act.

WITH RESPECT TO ISSUE (B), WAS THERE AN EMPLOYEE-EMPLOYER RELATIONSHIP, THE ARBITRATOR FINDS AS FOLLOWS:

There was an employee-employer relationship between Petitioner and Sun. Sun provided the tools and the tow truck and directed Petitioner where to patrol and where to pick up tows.

Richard E. Wold v. Sun Towing, Inc., et al, 07 WC 039690

WITH RESPECT TO ISSUE (C), DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF THE PETITIONER'S EMPLOYMENT BY THE RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner sustained accidental injuries which arose out of and in the course of his employment by Sun. Petitioner was in Sun's office, filling out required paperwork, when the company cat jumped on his lap and later bit him. The risk of injury by a company cat is a risk incidental to Petitioner's employment by Sun and, therefore the injury arose out of the employment. Petitioner was at work, filling out required paperwork, accordingly, the injury was in the course of Petitioner's employment by Sun.

WITH RESPECT TO ISSUE (D), WHAT WAS THE DATE OF THE ACCIDENT, THE ARBITRATOR FINDS AS FOLLOWS:

The date of accident was July 28, 2007. The slight inconsistencies in dates given by Petitioner to various providers at Little Company of Mary are of no consequence. The Arbitrator believes Petitioner's testimony that the injury occurred on July 28, 2007.

WITH RESPECT TO ISSUE (E), WAS TIMELY NOTICE OF THE ACCIDENT GIVEN TO THE RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

Notice is proven by Petitioner's unrebutted testimony that he told agents of Sun in August of 2007 that he was in the hospital because the company cat bit him.

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

The Arbitrator finds that there is a causal connection between the injury of July 28, 2007 and the cat bite cellulitis condition that Petitioner received treatment for from July 31, 2007 through August of 2007 at Little Company of Mary Hospital, based upon Petitioner's testimony and the medical records.

WITH RESPECT TO ISSUE (G), WHAT WERE THE PETITIONER'S EARNINGS, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner would be entitled to only the minimum compensation rate of $200.00/week, based upon the proofs in this case.

WITH RESPECT TO ISSUES (H), WHAT WAS THE PETITIONER'S AGE AT THE TIME OF THE ACCIDENT, AND (I), WHAT WAS THE PETITIONER'S MARITAL STATUS AT THE TIME OF THE ACCIDENT, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner was 49 years old and single with no dependant children on the date of injury.

Richard E. Wold v. Sun Towing, Inc., et al, 07 WC 039690

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 Arbitrator finds that the medical services provided to Petitioner at Little Company of Mary Hospital were reasonable and necessary and causally related to the injury. The bills were submitted as Petitioner's Exhibit 3 and they total $18,477.86. The bills are awarded in the amount of $18,477.86, pursuant to §§ 8(a) and 8.2 of the Act.

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:

Petitioner failed to prove that he was entitled to any TTD benefits. His testimony that he "probably" missed 6 days from work is not persuasive. While he was admitted at Little Company of Mary from 22:10 on 8/1/2007 through 8/4/2007, no off work slips were tendered and there was no evidence of exactly which, if any, working days Petitioner was excused from work.

WITH RESPECT TO ISSUE (O), LIABILITY OF THE IWBF, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner has proven that he sustained accidental injuries which arose out of and in the course of his employment by Respondent/Employer, Sun, on July 28, 2007. Sun was not insured for workers' compensation injuries on July 28, 2007. To the extent that Sun fails to pay the awarded medical expenses herein, liability should attach to the IWBF, in accordance with §4(d) of the Act. Petitioner's claim against the IWBF is not time barred because the Application naming Sun was timely filed.

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

Toney Griffin,

Petitioner,

vs. NO. 15 WC 23189

Compass Group/Levy Restaurant-Wrigley, **16IWCC0636**

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19b having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, prospective medical, causal connection, notice, permanent disability, and temporary disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 28, 2016 is hereby affirmed and adopted.

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

No bond is required for 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: SEP 3 0 2016
SJM/sj
o-9/22/2016
44

Stephen J. Mathis

David L. Gore

Mario Basurto

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

GRIFFIN, TONEY
Employee/Petitioner

Case# **15WC023189**

COMPASS GROUP/LEVY RESTAURANT-WRIGLEY
Employer/Respondent

16IWCC0636

On 1/28/2016, 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 0.41% 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:

2234 CHEPOV & SCOTT LLC
AARON GOLE
5440 N CUMBERLAND SUITE 150
CHICAGO, IL 60656

0210 GANAN & SHAPIRO PC
ELAINE T NEWQUIST
210 W ILLINOIS ST
CHICAGO, IL 60654

16IWCC0636

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)

Toney Griffin
Employee/Petitioner

Case # **15WC 23189**

v.

Consolidated cases: ______

Compass Group/Levy Restaurant-Wrigley
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Kurt Carlson** , Arbitrator of the Commission, in the city of **Chicago**, on **October 14, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☐ What were Petitioner's earnings?

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

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

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

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

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

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

N. ☐ Is Respondent due any credit?

O. ☐ Other ______

FINDINGS

On the date of accident, **6/14/2015**, 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 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 **$5,363.28**; the average weekly wage was $103.14.

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

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

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

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

ORDER

The Arbitrator finds the Petitioner has failed to prove an accidental injury sustained in the course and scope of his employment with Respondent on June 14, 2015, did not provide timely notice, and has failed to prove causal connection. The Arbitrator therefore finds Petitioner has failed to prove himself entitled to any benefits in this matter. Claim for all compensation is denied.

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

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

Signature of Arbitrator

1.28.16
Date

ICArbDec19(b)

JAN 2 8 2016

Toney Griffin v. Levy Restaurant 16IWCC0636
15 WC 23189

Statement of Facts

Petitioner was employed with Respondent at Wrigley Field, working all Cubs' home games. He was assigned to the right field commissary, where venders obtain the beer, hot dogs, peanuts and other items for sale in the stands. Petitioner's duties involved obtaining cases of beer and boxes of ice cream from the coolers, other stock from dry storage, stacking the boxes and helping load product into the venders' tubs. Petitioner described a case of beer as weighing about 21 lbs. His shift began three hours before game time and ended about one half hour after the end of each game, after he had wipted the floor, stacked the boxes and left them for the grounds crew to take to the compactor. Petitioner testified there were about 25 people in his department, with three team leaders in a supervisory capacity.

Petitioner testified he worked the same job at Wrigley for 20 years. He admitted he knew to report any work accident to the supervisor or stand manager right away, in his case to s Joann. If she was unavailable he could report an accident to the security guard, Tony Martinez or to Mary Ann, who he could call at any time.

Petitioner testified on June 14, 2015 he was working with a co worker Shanni, a "little girl," and that with her he needed to move four kegs of beer to get to the cases of beer. Petitioner testified the kegs each weigh about 65 to 70 lbs. He testified he had never moved beer kegs at any time in his 20 years of employment for Respondent. When asked if he could have asked for help to move the beer kegs, he testified "they was no one unavailable." He testified he had to move each keg over about five or six inches.

Petitioner described two kegs were stacked on top of two other kegs. He lifted the first keg and set it on a pallet. He lifted a second keg and slid it over. He lifted and moved a third keg. He then lifted the fourth keg, and claimed while doing so he slipped in the same direction as he moving the keg in.

At trial Petitioner demonstrated the activity for the Arbitrator, standing, bending, demonstrating lifting a keg from floor level, twisting and setting it down. The Arbitrator noted Petitioner moved freely and demonstrated no observable difficulty or pain while standing, bending at the waist, extending his arms down, standing back upright, twisting, and then bending while in a twisted position to show how he set down the beer keg. Petitioner testified he felt a "little pain" in his right lower back at the time, he yelled out "whoa," and Shanni asked him if he was okay. Petitioner testified he told her he had pulled a muscle. She asked him if he wanted her to go get Joann, and Petitioner said "no."

On direct exam, Petitioner testified he did not immediately report the incident, finished moving the beer kegs, and then told his supervisor, Joann. Petitioner testified he continued working but could not perform his duties as he had before, and that he needed help with the beer. By the end of his shift he testified he was starting to hurt. He went home and soaked in a hot tub.

On cross exam Petitioner testified after moving the kegs he finished taking the soda out of the cooler, lifting the boxes up, stacking them on a dolly, "steady lifting and steady bending," then when there were seven cases on the dolly pushing it into the beer cooler where he picked up and stacked "a lot" of cases of beer, "over 80 cases." Petitioner testified each case weighs 15 – 16 lbs. and he would sometimes lift two cases at a time. He testified he did this for about 45 minutes.

Petitioner testified he then talked to Joann, around the time the first pitch of the game was thrown, and that he specifically told her he had pulled a muscle moving a keg of beer. Petitioner denied that this conversation first took place on June 22, 2015.

Petitioner admitted there are multiple medical facilities on site at Wrigley, but that he did not request or seek medical attention at any of them.

He testified he worked his full shift on June 14, getting out of work around 10:15 p.m.

Petitioner testified he reported to work for the next home game, June 15, 2015, but was sent home as it was raining. He reported for work for the next home game against Cleveland and worked, June 16, 2015, but had a co worker help with the beer. He testified it was Shanni. Petitioner testified he told Joann that he needed help and she made sure he had the help he needed.

Petitioner testified that at the next home game June 22, 2015 against the Dodgers, he reported the injury to his "big supervisor," Mary Ann. Petitioner thought it was about five days after the incident. Petitioner testified he showed her where he had hurt his back lifting the beer kegs in the cooler. Petitioner now testified he had not reported it to anyone before this. Petitioner also denied sustaining any injuries outside of work or at home in the interim.

Petitioner testified Mary Ann sent him to human resources where he met with a Theresa, and that he filled out some forms for her and was sent to Concentra. Petitioner denied this did not occur until June 24, 2015, but admitted he was first seen at Concentra on the same date he filled out the forms. When shown accident forms which he filled out and dated

June 24, 2015, Petitioner again insisted this all occurred on June 22. He had no explanation as to why he showed on payroll has having worked full days on June 22 and 23. He then admitted the same day he went to Concentra was the day he talked to Theresa and filled out the accident forms. When asked exactly what he had told Theresa, he testified he told her that on the date of accident he went home, took a bath, put on his pajamas, reached down to put on his slippers and "that's when the pain just took off." He denied telling Theresa the pain didn't start until he was at home doing laundry on June 20, 2015. He admitted he wrote on his accident form "I didn't feel pain until late Saturday night on June 21, 2015."

Petitioner was sent to Concentra on June 24, 2015. He reported to them he had injured his low back ten days earlier *lifting boxes of beers,* minimal soreness at the time *but four nights ago was bending when the pain worsened and now the pain is severe.* He was diagnosed with a lumbar strain, and was referred to their physical therapy department. (Pet.Ex.#1) Petitioner testified he had pain and couldn't walk. Petitioner was given crutches and was directed to return back to work. Petitioner testified he took a cab back to work and tried to see Theresa about a "form they sent me in the mail." Petitioner denied talking to Crystal but testified he talked to Jennifer. He gave her a sealed envelope and left. He testified he did not know Respondent was giving him light duty. He then testified he knew he was supposed to report back to work the next day because Jennifer told him to report to work the next day as he would be working in the office.

Petitioner did not report to work June 25, 2015. He sought care at Loyola on that date, reporting low back and right hip and buttock pain like a pulled muscle, after lifting a full sized beer keg at work June 14, 2015. He was noted to be able to ambulate and was observed lying on a cart in no distress. X-rays showed loss of vertebral height at L5 but no acute injury, mild lumbar spondylosis with a few small osteophytes, and a small ossicle but an otherwise normal right hip. He was diagnosed with a muscular strain and was directed to work with no lifting over 5 lbs. for four days, after which he should be re-evaluated by the company physician for any further restrictions. (Pet.Ex.#2) Petitioner testified he did not return back to work for Respondent because he couldn't walk and was still in a lot of pain.

Petitioner testified he was still hurting and returned to the emergency room at Loyola July 2. He testified he couldn't walk, was having pain in his back, leg and whole right side. He testified the emergency room was crowded and he couldn't get waited on. Loyola's medical records do document he was seen on this date. No change was made in his work capabilities. (Pet.Ex.#2)

July 3, 2015 was the next home game. Petitioner called off work, stating he was still sore.

July 4, 2015 was the next home game. Petitioner did not appear for work. Petitioner did seek emergency room care again at Loyola where he noted continued complaints. He was noted to have been given Norco and Flexeril at his last visit but advised he was only taking them sporadically. He was supposed to follow up with the company doctor the preceding Friday but claimed he could not get there. It was stressed that Petitioner needed to follow up with the company doctor for further care. (Pet.Ex.#2)

The next home game was July 5, 2015. Petitioner called off "due to illness." On July 5, 2015 Respondent wrote Petitioner about the light duty job offer, the dates he could have worked light duty but had failed to, that he needed to report to work for light duty on next home games July 6 and 7, and that if he made no further contact in seven days that he would be terminated. (Resp.Ex.#4) Petitioner admitted he received this letter, which was messengered to him on July 5, and that he knew Respondent was offering him light duty with scheduled dates for work.

Petitioner testified he returned to Concentra on July 6, 2015. He testified he had had trouble getting to Concentra but denied missing any prior appointments due to transportation. On re-direct Petitioner then testified he missed appointments at Concentra due to pain and transportation issues. Petitioner testified the doctor asked him whether he had had a MRI. Concentra's records for this date make no mention of a MRI discussion, but do note Petitioner had failed to appear for scheduled physical therapy, was not taking prescription medications but was self treating with over the counter medication. He denied seeking any care elsewhere, and made no mention of seeking care at Loyola. It was stressed that he needed to keep scheduled appointments and he was again referred for physical therapy. (Pet.Ex.#1)

Petitioner did not call or show for work as scheduled on July 6, 2015. He did not call or show for work on July 7, 2015. (Resp.Ex.#2)

He returned to Concentra on July 8 and testified he was given therapy to do at home but couldn't do it as he was having difficulty standing. The Concentra records show he actually had physical therapy at their location on that date. Petitioner did return and have a second session of physical therapy at Concentra on July 10. (Pet.Ex.#1)

He returned to Concentra July 13. He denied telling them he was feeling better. He testified he went there that day for therapy. He said he was told to take a seat, and then told he was "dismissed." He again denied telling them he was feeling better or could return back to work, but said the doctor wouldn't listen to him. The Concentra records for this visit record that Petitioner reported he was feeling better with no pain, that his symptoms had resolved with only occasional pain in his low back. He had full range of motion in his hips. He had no deformity, tenderness, normal strength, normal lordosis,

full range of motion, and a negative straight leg raise bilaterally. He was cleared to full duty and discharged from care. (Pet.Ex.#1)

Petitioner testified he did not report back to Respondent and was not in contact with them at this point in time.

Petitioner retained an attorney and signed the Application for Adjustment of Claim on July 24, 2015. That same day he sought care with Dr. Sokolowski. He testified this was on referral from his cousin. Where asked on the intake form to list family/others involved in coordination of medical care, to whom information might be released, Petitioner listed his attorney. Petitioner advised the doctor of back and right hip, and testified he described his prior medical care. There is no showing he reported to the doctor he had reported he was fine and was having no pain by July 13, 2015 at Concentra, or that he had been discharged from care and released to full duty on that date. He told the doctor about therapy, but testified he received only limited care that was discontinued with only slight improvement accomplished. He testified the doctor took the time to examine him thoroughly, which he denied had occurred at Concentra. The doctor recommended a MRI and continued therapy, which Petitioner testified he does at home as he has no insurance. He testified he tried to go back to Loyola but wasn't accepted. Petitioner testified his pain improved with the medication and therapy done at home, but testified he was still at a 9/10 when seen by Dr. Sokolowski again September 15, 2015, and then testified he couldn't do the home therapy as he was in too much pain.

Petitioner signed for a second letter from Respondent dated July 29, 2015, which noted the dates he had failed to show for work June 25, July 3 – 8, July 10 – 12, that Respondent had been notified of the full duty release July 13, 2015, but that Petitioner had failed to show for work July 24 – 29, and that he was therefore terminated. (Resp.Ex.#5) Petitioner admitted signing for the letter but denied reading it. He testified he did not know he was terminated.

He denied any accidents or strenuous activities at home. He initially denied any prior workers' compensation cases, then admitted to a prior one against Doors Products.

The Arbitrator notes Petitioner resides at 1012 North Waller in Chicago, and that when seen at Concentra it was at a facility at 1030 West Chicago, in Chicago. When Petitioner sought medical care at Loyola's emergency room on three occasions he travelled to Maywood.

Theresa Schiller testified she is employed with Respondent as the general manager of concessions. She described Petitioner's duties as grabbing cases of product like beer or peanuts, and loading it into the venders' tubs. Petitioner would remove beer cases from

the cooler, 48 or 96 cases per pallet. Cases of mixed beer are lifted and loaded into the tubs for the venders. This activity continues until the middle of the sixth inning. Theresa described the work as physical. The beer cases weigh about 30 lbs.

On cross exam Theresa testified she actually started her career with Respondent doing Petitioner's job. In the smaller commissaries like the one Petitioner worked at, there is a lot of lifting and moving of boxes. She described it as "hustling." She testified if someone was injured they wouldn't be able to do the lifting required.

Theresa described the reporting procedure for all work related accidents to be immediately, whether serious or not. Team members like Petitioner are advised of this during orientation at the start of each season, and it is reiterated during training sessions throughout the season. Education is also provided on proper lifting techniques. Joann would have been Petitioner's direct supervisor, with Mary Ann over her. Joann would be present in the commissary during the entirety of Petitioner's work shift, unless on break. Mary Ann and others can also be reached by phone, including nine section supervisors and more than ten managers. Minor injuries are treated at first aid on premise, with more serious injuries referred to the clinic or the emergency room. Theresa testified the purpose of the immediate reporting is both to document an injury for preventative measures and to make sure the injured worker receives proper medical care.

Theresa was first notified on June 24, 2015 that Petitioner was claiming an injury, by Mary Ann. She understood from Mary Ann that the alleged incident had occurred during the prior home stand. She had not been advised of any prior report of the incident, or that Petitioner had needed any help doing his job. When she met with Petitioner, he told her he had hurt his back moving beer kegs on June 14, 2015, but that "it just hurts now." She asked him if his back had hurt on June 14, and he said "no." She asked him if he had reported the incident, and he said "no." She asked him if he felt pain when he was moving the beer keg, and he said "no." She asked him why he thought the pain he was now experiencing was from moving the beer keg back on June 14, and he told her "that's the only thing he can think of." She asked him when he first felt pain and he said "the Sunday, you know, he felt it in his back." She asked him what he had been doing Sunday when he developed back pain and he said "laundry." Theresa understood that Petitioner was claiming to have injured his low back at work on June 14, 2015, but not to have experienced any pain until he was at home doing laundry on June 21, 2015.

Theresa acknowledged there might be beer kegs stored inside the beer coolers, but denied that Petitioner would have to ever move them. She herself has moved them and is able to.

Theresa testified after Petitioner was seen at Concentra he returned to drop off paperwork from them, and he said he was feeling a little bit better. She saw he had been cleared to

return to work with restrictions, and she told him they could offer him modified duty. She went to get the paperwork on that and when she returned he was gone.

Theresa contacted Joann and Shanni for statements, as part of her investigation of the claim. She asked both Joann and Shanni if Petitioner had reported any injury or if they were aware Petitioner had sustained any injury on June 14, 2015, and they both said "no." Joann's written statement provided that Petitioner had not told her about any injury until June 22, 2015. (Resp.Ex.#6). Shanni's written statement provided Petitioner had told her he first had pain on June 20, and provided nothing about having to assist Petitioner with his work duties after June 14.

Crystal MacLean testified she is the director of human resources for Respondent. She begins work four hours before game time and is there at least two hours afterward. She provides training for new and returning employees including accident reporting procedures. She stresses immediate reporting of accidents, to assess the injury and provide proper care, and stresses late reported accidents may be questioned as "you're saying it now happened here, but we don't know." She stated it is to protect the company and the injured worker.

She was first notified Petitioner was claiming a work injury on June 24, 2015, filled out paperwork that day, was sent to Concentra and then returned back to work. She recalled Theresa talking to him, and overhead Theresa advising him he had been cleared to light duty which was being offered to him, and when he should report back to work. Crystal testified she reiterated this information to Petitioner on June 24, 2015 after Theresa had explained it to him. She testified Petitioner failed to appear for work as scheduled on June 25, July 3, 4 and 5. On July 5, 2015 she authored a letter to Petitioner, messengered to him, which advised him of his missed days of work, that light duty continued to be available for him, and offering him work on the next scheduled home games. (Resp.Ex.#4) Petitioner did not report to work on the next six scheduled home games. She then authored a letter notifying him he was being terminated, on July 29, 2015, sent to Petitioner certified mail (Resp.Ex.#5)

Crystal reviewed the statements prepared by Joann and Shanni, and understood that Petitioner had not reported any work injury to Joann until June 22, 2015, and that he consistently told everyone he had not had any pain until while he was at home on June 20.

Joann Bates' written statement of June 25, 2015 provides she was first notified by Petitioner of a back injury on June 22, 2015, however, Petitioner failed to provide "any details or explanation of how, when or where this happened." (Resp.Ex.#6) Shanni Johnson's written statement of June 25, 2015 provides she did move beer kegs with

Petitioner, but that Petitioner did not tell her until June 22, 2015 that he had hurt himself, and that he didn't feel pain until June 20. (Resp.Ex.#8)

Conclusions of Law

Regarding 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 is claiming an injury to his low back while moving a beer keg on June 14, 2015, early in his work shift. He claimed to have expressed pain and to have told a co-worker, Shanni about it. She admitted she and Petitioner had been moving beer kegs but denied any knowledge of injury. She indicated Petitioner told her he did not have pain until June 20, in a conversation on June 22, 2015.

Petitioner claimed to have told his direct supervisor Joann about the injury on June 14, around the time the first pitch of the ball game was thrown. Joann advised she was not told about any injury by Petitioner until June 22, 2015, without any details as to how, when or where any injury had occurred. Petitioner did not request to fill out any accident forms, nor did he request medical care at that time.

Petitioner continued working full duty for the next home games June 16, 22 and 23. He reported to work on June 24. At trial he testified he had needed help doing his work on those days, provided by Shanni, and that Joann was aware of this. None of this was provided in the statements of Shanni or Joann. Theresa testified Petitioner would not have been able to do his full duties with a back injury.

Petitioner did report the work injury of June 14, 2015 on June 24, 2015, to Mary Ann. He thought the conversation took place on June 22, but admitted it was the same day he filled out the accident report and received care at Concentra, which was June 24. Petitioner testified he thought he had been injured about five days before he talked to Mary Ann, but also told Mary Ann he had not reported the injury to anyone else before speaking to her.

Petitioner met with Theresa on June 24, 2015 and filled out accident forms, one with Theresa and one on his own. At trial Petitioner testified he told Theresa the pain began the evening of June 14 after bent to put on his slippers. Theresa testified he told her he did not experience any pain until he was at home on June 20 or 21, after doing laundry. On his own prepared accident report Petitioner provided he "didn't feel pain until late Saturday night on June 21, 2015."

When first seen at Concentra on June 24, 2015, Petitioner reported he had injured his low back ten days earlier lifting boxes of beer, not moving a keg, but also advised that the pain worsened and became severe while bending four nights earlier, which would have been while Petitioner was at home on June 20, 2015. By the time he began treating with Dr. Sokolowki, after seeing an attorney on July 24, 2015, Petitioner now claimed an injury lifting beer kegs with immediate onset of pain.

An Arbitrator is charged with the responsibility of assessing witness credibility. Petitioner has asked the Arbitrator to find he sustained an injury to his back on June 14, 2015, developed low back pain right away or in the ensuing days without any intervening accident or incident outside of work, and that all of his subsequently needed medical care is related to that June 14, 2015 incident. Here, there are multiple inconsistencies in Petitioner's testimony of when he first had pain, who he told about it, what he was able to do, what treatment he received, why he didn't show up for appointments at Concentra, and/or why they documented he was fine, discharged from care and cleared to full duty after two physical therapy appointments he did manage to attend, as of July 13, 2015. Also unexplained is why Petitioner sought no medical care on premise or nearby for ten days, some of those days while at work at Wrigley, was unable to attend appointments at a nearby Chicago location for Concentra but then travelled all the way to Maywood for care on at least three other occasions.

The evidence suggests Petitioner may have been moving beer kegs on June 14, but that he continued working his full duties which included extensive lifting, bending, pulling, loading and unloading for the remainder of that shift and the next several shifts worked, that he did not develop pain, become unable to work, report any problem or seek or require medical care until after bending and/or doing laundry at home on June 20 – 21· 2015, that he was most honest in reporting such to Theresa and Concentra on June 24, 2015, but less so after he had been terminated and sought an attorney's counsel on July 24, 2015.

For the foregoing reasons the Arbitrator finds that Petitioner failed to prove an accidental injury on June 14, 2015. Claim for compensation is denied.

Regarding E) was timely notice of the accident given to Respondent, the Arbitrator notes the following:

Petitioner had been repeatedly educated on the importance of immediately reporting any accidental injury. He did not deny knowledge of that. He told Joann he was having pain but now "how, when or why" on June 22, 2015. He told Theresa he had lifted beer kegs but did not feel pain or need medical care until after doing laundry at home June 20 – 21, 2015. He told Respondent's clinic he developed low back pain after bending at home

June 20. He filled out an accident statement providing he did not have pain until June 20, 2015.

From these histories there was no basis for Respondent to understand Petitioner was relating his current inability to work full duty or his need for medical care to any work related injury, rather, to something that had developed at home. Claim for compensation is denied on this basis, as well.

Regarding F) is Petitioner's present condition of ill being causally related to the injury, the Arbitrator finds the following:

Petitioner related his pain to lifting boxes of beers at work to Concentra on June 24, 2015, something not claimed at trial. He also told Concentra he developed severe pain after bending June 20, 2015. Concentra rendered no causation opinion relating Petitioner's low back strain and need for care to anything that occurred on June 14, 2015.

Dr. Sokolowski began treating Petitioner on July 24, 2015, with a history only of the June 14, 2015 lifting of kegs of beer at work, with a report of immediate pain, without a history Petitioner continued working full duty, developed pain only while at home doing laundry or bending on June 20 – 21, 2015, even after that reported he was fine, with no symptoms and cleared back to full duty July 13, 2015, and only sought his care for alleged continued problems after failing to show back up for either light or full duty when cleared to, having been notified he was being terminated by Respondent, and after retaining an attorney. Dr. Sokolowski did not specifically set forth a causation opinion, and even were one to be inferred from his medical records, such is clearly defective in light of the missing/discrepant histories provided by Petitioner.

Claim for compensation is denied on this basis, as well.

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

Mainor Reyes

Petitioner,

vs. NO. 13 WC 25758

Kenall Manufacturing Co.,

16IWCC0637

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19b having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical expenses, prospective medical care, notice, and temporary disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed June 18, 2015 is hereby affirmed and adopted.

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

No bond is required for 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: SEP 30 2016
SJM/sj
o-9/22/2016
44

Stephen J. Mathis

David L. Gore

Mario Basurto

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

REYES, MAINOR
Employee/Petitioner

Case# **13WC025758**

KENALL MANUFACTURING CO
Employer/Respondent

16IWCC0637

On 6/18/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.10% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2553 LAW OFFICES JAMES P McHARGUE
BRENTON M SCHMITZ
123 W MADISON ST SUITE 1000
CHICAGO, IL 60602

2461 NYHAN BAMBRICK KINZIE & LOWRY
CHRISTINE M JAGODZINSKI
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF LAKE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

MAINOR REYES,
Employee/Petitioner

Case # **13 WC 25758**

v.

Consolidated cases:

KENALL MANUFACTURING CO.,
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **ROBERT FALCIONI**, Arbitrator of the Commission, in the city of **WAUKEGAN AND ROCKFORD**, on **April 22, 2015 and May 20, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

B. ☐ Was there an employee-employer relationship?

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

D. ☒ What was the date of the accident?

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

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

G. ☐ What were Petitioner's earnings?

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

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

J. ☒ Were the 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 30, 2013** , Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

In the year preceding the injury, Petitioner earned **$31,103.28**; the average weekly wage was **$598.14**.

On the date of accident, Petitioner was 44 years of age, ***married*** with 2 dependent children.

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

Respondent shall be given a credit of $0 for TTD, $0 for TPD, $0 for maintenance, and **$10,210.82** for other benefits, for a total credit of **$10,210.82**.

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

ORDER

Denial of benefits

No benefits are awarded. The Arbitrator finds that Petitioner failed to prove that he sustained an accident arising out of and in the course of his employment with Respondent on the date alleged. All other issues are moot.

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 16, 2015
Date

ICArbDec19(b)

JUN 1 8 2015

STATE OF ILLINOIS)
) ss. **16IWCC0637**
COUNTY OF LAKE)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Mainor Reyes

Petitioner,

v. Court No. **13 WC 25758**

Kenall Manufacturing, Inc.

Respondent.

FINDINGS OF FACT AND CONCLUSIONS OF LAW
MEMORANDUM OF ARBITRATOR'S DECISION

I. STATEMENT OF FACTS

Mainor Reyes testified that he has been employed at Kenall Manufacturing since October 28, 2002. As of July 2013, he was a machine operator. Mr. Reyes testified that Kenall Manufacturing fabricates lamps for jails, hospitals, and cities. Mr. Reyes testified that he mainly operates the VIPRO machine. He uses a computer and has to punch dials made out of steel or iron and feed the machine materials. He feeds the machine sheets that are usually 120" x 60" and weigh anywhere from 60 pounds to 150 pounds. Mr. Reyes testified that he usually operated one machine each shift depending upon whether a co-worker would show up.

During the first week of March 2013, around March 4, 2013, Mr. Reyes testified that he arrived at work. At the beginning of his shift, he checked his machine and the door of the machine. He tried to shut the door and it would not shut. He went to report this to his crew leader, who told him to tell a maintenance person. Mr. Reyes stated that his crew leader was Martha Quintero. He then spoke with Tom in Maintenance. Mr. Reyes testified that the machine door was damaged and he was taught that the door had to be locked. Even though the machine was not locked, Martha and Tom told him to operate the machine. Mr. Reyes noted that he had to use a lot of force to shut the door and felt something pop between his shoulder and neck. He felt this on the right side. At that time, he had operated the machine for 3-4 hours using a lot of force. In this 3-4 hour period, he opened and shut the door at least 25 to 30 times. He told his co-workers, Geraldo and Salvador that he injured his neck and right

shoulder. He testified that he also told Martha Quintero. Mr. Reyes testified that he did not seek any medical treatment and went back to work on March 5, 2013. He continued working until July 2013. During those months, Mr. Reyes noted that he felt right shoulder, neck and ear pain and thought he was losing his sense of hearing. He told his crew leader, Martha, about this every week and she provided Ibuprofen. He admitted that he performed all of his job duties without any restrictions.

On July 30, 2013, Mainor Reyes testified that he was running another similar machine with heavier material. He reported to his crew leader, Martha, that he felt back, neck, right shoulder and ear pain. Mr. Reyes stated that a report was completed and he spoke with Human Resources. He went to the Work Comp Clinic on that date. They checked his ear, x-rayed his shoulder and gave him a sling. Mr. Reyes testified that surgery was recommended.

The next day, he went for a follow-up visit and was referred to an orthopedic physician. On August 7, 2013, Mr. Reyes testified that he chose to seek treatment with Dr. Levi. He testified that Dr. Levi took him off work. He continued working until August 7, 2013.

Mr. Reyes stated that he began physical therapy at New Life or Centro Medico Nueva Vida. He had treatment at that facility until May 2014. This therapy consisted of electrical manipulation, patches on his neck to his forearm as well as arm exercises and neck movement. He also had massages. Mr. Reyes noted that this treatment was not helpful and he got worse. He was unable to move his neck and he now had pain along the top center of his back to his mid back and his right leg got numb.

In the fall of 2013, Mr. Reyes testified that he underwent CT scan and injections into his neck. The injections did not help. He was referred to Dr. Dixon. Dr. Dixon recommended surgery, which Mr. Reyes testified consisted of taking out his discs in his neck and replacing those with plastic ones. Mr. Reyes testified that he wanted to have this surgery. His pain is a 10 on a scale of 10. It was located up the side of his head and he had pain when he lifted his arm along the whole right side. The only medication he was taking at the time of trial was Advil. In the past, he stated that he used Menthol creams, a device with electrical patches, a towel that had adjustable temperatures for his back and elastic bands for his neck, arm and leg. Mr. Reyes acknowledged that he returned to work light duty at Kenall for two days at some point in October. He noted that he had to go for therapy on the second day and could not be working as his pain got worse. On direct examination, Mr. Reyes denied that he had medical treatment for his neck or right arm before 2013.

On cross-examination, Mr. Reyes testified that he mainly worked on the VIPRO and LASER machines. The VIPRO machines included the King A and the King B machines. Mr. Reyes stated that he did rotate machines. Mr. Reyes indicated that he thought he noticed problems with the King B machine on March 4, 2013. He spoke with

Martha and he noted that eventually the problem with the King B machine was fixed by the time he left work in August 2013. He then admitted that the machine was fixed the next time he worked on it a month and a half later, around April 2013. Mr. Reyes noted if there is a problem with any machine, he reports the problem to his crew leader or supervisor so they can report it to maintenance. Mr. Reyes noted that the amount of times he would be required to open the door of the King B machine would vary depending upon the job.

Mr. Reyes agreed that he did not ask to seek medical treatment in March 2013. He testified that Martha Quintero gave him Ibuprofen when he reported his pain. He stated that she gave him Ibuprofen on other occasions. He testified that he would ask for Ibuprofen from Martha from March 2013 through July 2013 once a week and then he eventually bought his own. He further admitted he did not have any medical treatment from March 2013 to July 2013.

Mr. Reyes admitted that the door on the King B Turret had shocks. Without the shocks, he estimated that the door weighed 60-70 pounds. He agreed that he was required to ask assistance to lift anything that weighed over 50 pounds. He stated that it was not possible for two people to open and close the door on the King B machine. Mr. Reyes testified that the shocks were not working at all on the King B machine in March 2013.

When asked about his testimony on direct examination where he said he never had prior treatment for his right shoulder or neck, Mr. Reyes admitted that that was true. He was then confronted with the medical records from 2005 at St. Therese Medical Center where he had treatment for his neck, right shoulder and ear. Mr. Reyes admitted that if there was proof, he guessed it was true that he had prior treatment.

On July 30, 2013, Mr. Reyes stated that he told Martha he had more pain. He denied having a new accident on that date. Mr. Reyes admitted that he was called into a disciplinary meeting on July 29, 2013. He noted that there were harassment complaints against him. He was in pain during the meeting, but noted that he did not report the pain at that time because they were talking about some other things at the meeting. He waited until July 30, 2013 at approximately 4:00 to 5:00 p.m. to tell Martha he was in pain.

Mr. Reyes agreed that he was examined Dr. Tomas Nemickas with regard to his right shoulder at the request of Respondent. He also testified that he was seen by Dr. Wellington Hsu on March 24, 2014 for his neck. He claimed Dr. Hsu did not examine him.

When he returned to work in November 2013, Mr. Reyes testified that he only worked 4.75 hours on November 12, 2013. He stated that he informed Isaac that he was feeling bad as Martha was not in her office and he could not tell her. He then left. On

November 13, 2013, he worked 8 hours. Mr. Reyes testified that he has not returned to work in any capacity since that time as his doctors have him off work.

When asked on cross-examination whether he attends English as a second language class at Lake County College, Mr. Reyes admitted that he does take that class. He attends class two times a week, with each class a lasting 3½ hours with a 15-20 minute break.

Mr. Reyes testified that he reported to Martha Quintero at various times that he was in a lot of pain, but his pain complaints were ignored. Mr. Reyes testified that he told Martha at least once a week that he felt bad.

When questioned about whether he had group insurance, Mr. Reyes noted that he did not have any insurance. He indicated that he also did not have a primary care doctor. Mr. Reyes stated that he has not applied for Public Aid or Obamacare. When asked about outside activities, Mr. Reyes noted that he used to play soccer 15-20 years ago. Mr. Reyes claimed that he did not ask for medical treatment from anyone else when Martha Quintero ignored his request. He claimed that there was a rule that prohibited him from going from one area of the company to another, so he did not want to make a complaint.

Respondent called Martha Quintero to testify. Martha stated that she has worked at Kenall Manufacturing for 19 years. She currently works as a Set-up Specialist in the metal department. Before she worked as a Setup Specialist, she worked in assembly. She noted that Kenall makes lamps for hospitals, jails, schools and for under bridges. Her job duties include monitoring the assembly line products, the housing, and the rest of the components that are assembled. In 2013, she worked the second shift in the metal department as a Second Shift Group Leader and she supervised employees.

Ms. Quintero noted that if somebody had a work injury with a cut or blood, she would send them directly to the clinic at Condell. If there was no blood, she would ask the employee how they felt and whether they wanted to go to the clinic. If they were sent to the clinic, she would complete more than one report including an incident report as well as an injury report. If they did not go to the clinic, she would just fill out an incident report. She would also e-mail her supervisor, Steve, and let him know if a person had claimed an injury during the second shift.

Ms. Quintero testified that she knew Mainor Reyes. She worked with him on the second shift. Mr. Reyes was a machine operator and he worked on various machines including the LASER, King A, King B, Queen and PEGA machines. Ms. Quintero stated that the machine operators worked different machines according to a schedule created by Steve Szybowicz. Mr. Szybowicz would assign each machine operator to a machine

and publish the schedule on a monthly basis. (RX 17). The schedule would usually have the operator working on a particular machine for a week.

On March 5, 2013, Mr. Reyes came to her office to tell her that the King B machine was not operating correctly. He reported pain in his right shoulder. Ms. Quintero testified that he did not report any pain involving his neck and he did not want to go to the clinic for treatment. She offered him Ibuprofen and he took it.

Ms. Quintero testified that she also looked into the issues with the King B machine. Mr. Reyes told her that the shocks which support the door were stiff and hard. She notified maintenance. She did try the door and it was difficult to move.

In order to investigate this further, Ms. Quintero noted that she contacted Jose Lopez and Salvador Sandoval, two other machine operators, to question whether they had noticed any problems with the machine as they operated the King B machine around the same time as Mr. Reyes. She also told Steve Szybowicz about the issue with the door the following day. She noted that Steve put in a work order and the problem with the shocks was fixed.

Ms. Quintero identified Respondent's Exhibit 12A as a picture of the King B machine and door which Mr. Reyes claimed was broken in March 2013. Ms. Quintero pointed out the shocks that assist with opening and closing the door as well as the locking mechanism. She noted that if the locking mechanism does not work, there are sensors which will not allow the machine to run. This is contrary to Mr. Reyes' testimony on direct-examination as he indicated that Martha and Tom told him to operate the machine even though the door would not lock.

Ms. Quintero noted that Mr. Reyes kept working during the rest of his shift on March 5, 2013 and performed his full work duties until July 30, 2013. After Mr. Reyes declined treatment on March 5, 2013, Ms. Quintero testified that she asked him the following day if he was okay. He denied any continued issues and told her he was fine.

Ms. Quintero identified an e-mail that she sent to Steve Szybowicz on April 12, 2013 documenting her investigation where she asked Jose Lopez and Salvador Sandoval about any issues they noted with the King B machine when they operated it in February 2013. (RX 8). She also informed Steve that despite his initial report of right arm and shoulder pain, Mr. Reyes declined treatment and had no further complaints. (RX 8).

Ms. Quintero testified that, on July 30, 2013, Mr. Reyes came to her and told her his ear was hurting. He told her it was a consequence of his shoulder injury from March. He did not report right shoulder problems to her on July 30, 2013 or any new injury. Ms. Quintero stated that she observed Mr. Reyes working every day during the second shift and she did not notice him exhibit any pain behaviors from March 2013 to July 2013.

On cross-examination, Ms. Quintero was asked about her job duties. She noted that she was responsible for work schedules, the functioning of the machines, and the safety and security of everyone. She did not physically operate the machines herself. Ms. Quintero identified Respondent's Exhibit 17 as the schedules completed by Steve Szybowicz on a monthly basis from February 2013 through August 2013. Ms. Quintero could not specifically describe the strength necessary to operate the King B machine in general. When asked how much strength would be needed to move the door in the King B machine when it was in good working order, Ms. Quintero noted that not much strength would be needed. She agreed that the door was hydraulic assisted. When asked about the schedule in February 2013, outlined in Respondent's Exhibit 17, Ms. Quintero agreed that the machine operators at that time were all men. She did not have an explanation as to why they were all men. At the time she was in the metal department, Ms. Quintero noted that there were no women working on the machines. She testified that there are now women working in the metal department, but she is not sure what jobs they perform. She was then asked on re-cross whether she would physically be able to operate the King B machine. Ms. Quintero testified that she would be able to physically operate that machine.

The Respondent called Steve Szybowicz to testify. Mr. Szybowicz testified that he is employed at Kenall Manufacturing. He is a track leader/supervisor and has worked in that capacity since March, 2012. His job duties include dealing with personnel issues, making sure materials are available and watching over the operations. He is responsible for all personnel in two departments. He also addresses attendance issues and makes sure that people work on the correct machines. He currently oversees approximately 30-35 people. In 2013, he oversaw about 40 people when the plant was located in Gurnee. He currently noted that there are only two shifts. In 2013, there were three shifts, consisting of a first shift, a second shift and a third shift. In January 2015, Kenall Manufacturing moved to Kenosha, Wisconsin. Mr. Szybowicz noted that there were two team leads who worked on the second and third shift in 2013 and he covered the first shift. The team lead on the second shift was Martha and the team lead during the third shift was Leonard. Mr. Szybowicz noted that he was familiar with the jobs performed at Kenall and he had operated similar types of machines at a prior job as well as some of the same machines used at Kenall.

Mr. Szybowicz testified that he took the pictures of the King B machine which were marked Respondent's Exhibits 12A, B, and C. He identified Exhibit 12A as a picture of the whole King B machine, including the door, the table and the shocks. The second picture was a picture of the door when it was lowered. (RX 12B). Mr. Szybowicz identified the third picture as a close up picture of the hydraulic shocks that assisted with opening and closing the door of the King B machine. (RX 12C). Mr. Szybowicz noted that if are issues with any of the machines, these issues would be addressed at Safety Pod meetings. In January 2013, Mr. Szybowicz testified that there was an issue raised about the shocks going bad on the King B machine. A work order was put in

place to check the shocks on the King B and King A machines. The shocks on the King B machine were replaced in February with shocks from Grainger. Although these shocks were good, they were not up to the machine specifications and new shocks were ordered. These shocks were eventually placed in the King B machine on March 15, 2013. Mr. Szybowicz noted that the door of the King B machine still operated, but it did not operate as smoothly until the second set of shocks were installed on March 15, 2013.

Mr. Szybowicz testified that Martha Quintero let him know on March 6, 2013 that there was an issue with the shocks on the King B machine again. This is the same date he put in the work order. (RX 11). He also checked the door and noted that there was more resistance. He estimated that the weight of the door was 30-35 pounds with the shocks. He admitted that the door may have been about 20 pounds heavier with the shocks that were in place on March 6, 2013 and before the installation of the second set of shocks on March 15, 2013. Mr. Szybowicz testified that he took off the door and weighed it without any assistive shocks and the door alone weighed 100 pounds.

Mr. Szybowicz stated that Martha told him Mr. Reyes was claiming pain in his right shoulder as a result of the difficulty opening the door on the King B machine around March 5, 2013. He agreed that Mr. Reyes did not have any medical treatment from March 2013 until he complained of ear pain on July 30, 2013.

In terms of lifting, Mr. Szybowicz testified that employees are required to ask for assistance to lift anything that weighs more than 50 pounds. In terms of opening and closing the door of the King B machine, Mr. Szybowicz noted that this could occur as little as 10 times in one shift or as many as 25 times. It would depend on the length of the runs. If the operator had longer pieces, the operator would not need to open the door as much.

Mr. Szybowicz testified that he was aware of disciplinary issues with Mr. Reyes. In May 2013, he had to discuss an issue with Mr. Reyes as he was not working from the top down. The operators were required to work on jobs from the top down in the computer, but Mr. Reyes was selecting easier jobs and skipping jobs. Mr. Szybowicz also indicated that Mr. Reyes was also brought into a disciplinary meeting to investigate another worker's claim that Mainor Reyes was sexually harassing him. This meeting occurred on July 29, 2013.

Mr. Szybowicz noted that he did not notice Mr. Reyes exhibit any pain behaviors when he saw him at work from March 2013 through July 30, 2013. He testified that Mr. Reyes performed his full duties during that time.

On cross-examination, Mr. Szybowicz was questioned about the machines at Kenall. He testified that the King A and King B machines were essentially the same, although the King A machine used thicker and heavier materials. The Queen machine

was a smaller machine that used smaller sheets. The PEGA was the smallest of the four turrets.

Respondent called Adrienne Cramer to testify. Ms. Cramer testified that she has worked at Kenall Manufacturing since November 1999. She started as a Human Resources manager and she then became the director of Human Resources in 2013. Her job duties include strategic planning, benefits administration, workers' compensation, event planning, employee relations and administrative duties.

Ms. Cramer testified that Mainor Reyes is an employee of Kenall. He worked as a primary setup operator. She was aware that he did have a claimed work injury in March, 2013. She noted that he initially reported right shoulder pain to his group leader, Martha. As Mr. Reyes did not seek medical treatment for five months, she stated that she was not aware of these complaints until July 30, 2013, when he complained of ear pain from the March incident and requested medical treatment.

Ms. Cramer testified that she did question the validity of his complaints on July 30, 2013 as Mr. Reyes had been called into a disciplinary meeting on July 29, 2013. At that time, a temporary employee, Aldryn, had alleged harassment complaints against Mr. Reyes. He claimed that Mr. Reyes was hugging him, saying inappropriate things to him and making obscene gestures. Mr. Reyes would not stop doing this and he told Aldryn he would tell Steve and Martha that Aldryn was not doing his job if he reported him. Mr. Reyes also told Aldryn that he wanted to fight him.

Ms. Cramer noted that Mr. Reyes did work light duty from July 31, 2013 through August 6, 2013. She offered him light duty work on multiple occasions as evidenced by letters that she sent to Mr. Reyes and his acceptance of transitional duty. (RX 13, 14, 15, 16). She testified that she also spoke with him in October 2013, November 2013 as well as in April 2014. She noted that he did not return to work after working 1½ days in November 2013. She did indicate that she saw him on video at the Kenall plant in Gurnee. She did not recall when this was, but he was visiting employees and bringing food. This occurred when he was not working.

Although Mr. Reyes testified on cross-examination that he did not have a primary care doctor, Ms. Cramer testified that he had HMO insurance and he was required to list a primary care doctor on that insurance. Ms. Cramer noted that he did in fact list a primary care doctor on his group insurance application. She admitted on cross-examination that she was not aware if he had treatment with a primary care doctor.

She acknowledged that Human Resources would not necessarily be aware of the original claimed right shoulder pain in March 2013 as Mr. Reyes did not have treatment. She did become aware of the original incident once he requested treatment on July 30, 2013 and indicated that his ear pain was related to the March incident.

On July 30, 2013, Mainor Reyes presented to Advocate Occupational Health Gurnee Center. (PX1). He claimed that he was lifting a heavy door and hurt his right shoulder and neck four months ago. He stated that his pain has become worse and he had ear pain. He indicated that this occurred on April 12, 2013. His primary problem was pain located in the right shoulder. Upon examination of his right shoulder, his range of motion was limited. Tenderness to palpation was not apparent. He exhibited full strength with rotation against resistance and internal rotation against resistance. The x-ray report revealed swelling in his shoulder and a sliver chip fracture to the edge of the glenoid. Light duty work restrictions were issued of no above shoulder work, no lifting more than 10 pounds and he was instructed to immobilize his right arm completely. He was referred to an orthopedic surgeon.

On August 1, 2013, Mr. Reyes presented to Dr. Gregory Caronis. (PX1). He stated that he hurt his shoulder at the end of March. He was unable to describe the exact mechanism of how he hurt his shoulder. Dr. Caronis noted that he lifted something heavy at work and had pain in his shoulder. He explained that he did not seek medical attention until July 30, 2013. He noted that the pain was in the posterior aspect of his shoulder with numbness radiating down his arm toward his hand. Upon examination, he was tender along the paraspinal muscles of his neck. On the right, Speed's and O'Brien's tests were positive. He also exhibited a positive impingement sign on the right. Dr. Caronis recommended a MRI arthrogram. Dr. Caronis restricted him to one-handed work only.

On August 7, 2013, Mr. Reyes underwent MRI studies at Edgebrook Open MRI. (PX2). The results revealed an intact rotator cuff with some evidence of rotator cuff tendonitis. There were no fractures or dislocations noted in the glenohumeral joint. X-rays of his right shoulder on that date also failed to demonstrate any significant bony or soft tissue abnormalities. The study was unremarkable.

On August 7, 2013, Mr. Reyes also presented to Illinois Orthopedic Network. Dr. Gabriel Levi examined him on that date. (PX2). He related a history of an injury on July 30, 2013. He stated he was closing a machine door that weighs 100 pounds when he felt a pop in his right shoulder. He had an MRI done on that date, but Dr. Levi did not have the ability to view it on the computer as the disk was not functioning. Dr. Levi noted that he had a possible rotator cuff tear. He authorized him off work. He prescribed physical therapy. Dr. Levi later issued an addendum indicating that he was able to visualize what appeared to be a rotator cuff tear of the supraspinatus, which was full thickness in his opinion. He did not have the radiologist report.

On August 9, 2013, Mr. Reyes presented to New Life Medical Center (PX1). He completed a workers' compensation form indicating that he reported his injury on July 30, 2013. He was working on a machine which required him to open and shut a door that weighs 80-100 pounds due to the springs being broken from the door. He reported

pain and continued to work and then was taken to the hospital. Mr. Reyes noted that he saw Dr. Malek for this condition. He noted that his pain occurred suddenly on July 30, 2013. In the initial exam report, Mr. Reyes stated that he reported his accident to Martha Quintero in March or April, but received no advice. As time passed, the pain in his shoulder became worse. Two months later, he reported it to Martha Quintero, but he claimed that she did not help him or offer additional advice. His pain was unbearable on July 30, 2013 and he reported it to Martha Quintero again. He continued to have sharp pain in his right shoulder, right arm, right forearm, right hand with numbness to the finger, neck, upper back, right ear, headaches, irritability, tiredness, anxiety, and tension. He denied previous injury to his right shoulder, neck, upper back, right ear or right temporal areas. Chiropractor Aldrin Carrion diagnosed him with right shoulder pain with radiation, neck pain with right arm pain and right hand numbness and tingling, right ear pain and difficulty hearing, headaches, tension and irritability as well as tiredness, and anxiety. His shoulder range of motion was now 20 degrees with internal rotation, 22 degrees with external rotation, 67 degrees with shoulder flexion, 15 degrees with shoulder extension, and 35 degrees with shoulder abduction due to severe pain in his shoulder. Chiropractic treatment was recommended for his right shoulder. Mr. Reyes continued to seek treatment at New Life Medical attending 9 visits throughout the month of August in addition to his initial evaluation.

As of September 9, 2013, Mr. Reyes informed Chiropractor Carrion that he was able to move his right shoulder with less pain. (PX1). The chiropractor noted improved range of motion, but did not document any objective improvement. Mr. Reyes attended a total of 9 visits in September, 2013 with Chiropractor Aldrin.

On September 18, 2013, Dr. Levi examined him again (PX2). Dr. Levi noted that he presented for an initial evaluation of his right shoulder pain, even though he had been seen previously. He stated that he was injured two months earlier. Dr. Levi noted that he reviewed the MRI report of the right shoulder. It was negative for a rotator cuff tear as well as for any fracture or dislocation. Dr. Levi did not have a good concrete diagnosis other than pain. He recommended a CT scan of the right shoulder to rule out the glenoid fracture. He prescribed Gabapentin, Norco and Terocin.

On October 14, 2013, Mr. Reyes presented to Dr. Tomas Nemickas at Illinois Bone and Joint Institute. (RX 2). Dr. Nemickas noted that he claimed an original injury while lifting a table with his right arm on March 5, 2013 while working on the King B turret. He continued to work his regular duties. He then claimed pain in his right ear on July 30, 2013. Mr. Reyes denied prior history of neck, shoulder, and arm pain. He stated that on July 25, 2013, he was working on a machine that he states was "defective" and he had to slam the handle forward "repetitive" times over the course of four hours. He then redeveloped neck, shoulder and arm pain. (RX2). His medications included Advil. Dr. Nemickas noted a significant amount of symptom magnification with apprehension and guarding. He exhibited a positive Spurling's sign that was reproducible with distraction testing and a negative Lhermitte's. His cervical range of

motion was full although he did exhibit guarding. His right shoulder range of motion was 160 degrees with forward flexion, abduction to 160 degrees, internal rotation to T6, external rotation to 60 degrees at neutral and 90 degrees at 90 degrees. His functional strength was 3+/5, although there was no focal evidence of motor deficit. Provocative biceps, SLAP and labral testing was negative. X-rays were obtained. Three views of his right shoulder revealed a small inferomedial cortical rim avulsion-type fragment from the lip of the glenoid with no fracture dislocation noted or appreciated. Five views of the cervical spine were obtained which revealed spurring, marked facet arthropathy and cervical spondylosis from C5-T1. Dr. Nemickas noted that he had probable cervicalgia with right upper extremity radicular pain. Dr. Nemickas noted that, assuming he did have a subsequent exacerbation and recurrence of pain in July, 2013, his diagnosis is cervicalgia with right upper extremity radicular pain. There did not appear to be functional evidence of right shoulder internal derangement, but he wanted to review the actual MRI films. Dr. Nemickas noted that his condition was related to the claimed work injury assuming the facts supported the mechanism in March, 2013 with a reoccurrence following the claimed episode in July, 2013. Dr. Nemickas recommended that Mr. Reyes return to work without using his right upper extremity.

Mr. Reyes continued to attend treatment with Chiropractor Carrion. (PX 1). In October, 2013, he attended 9 visits. At a visit on October 28, 2013, he continued to use an arm sling to support his right shoulder. Manual therapy was performed with ultrasound to reduce pain, along with trigger point therapy.

On October 30, 2013, Mr. Reyes underwent a CT scan of his right shoulder. (PX 2). The radiologist noted that he had an intact acromioclavicular and glenohumeral joints with no fractures or acute osseous abnormalities. No bone lesions were noted. (PX2). He also underwent MRI studies of his cervical spine without contrast on October 30, 2013. The radiologist noted posterior disc/osteophyte complexes from C5-C7 contributing to neuroforaminal stenosis. At C5-6, there was disc bulging more severe toward the right with moderate right neuroforaminal stenosis and facet joint hypertrophy. At C6-7, there was endplate spurring and a disc bulge with mild to moderate left and mild right neuroforaminal stenosis exacerbated by facet joint hypertrophy.

Dr. Levi reviewed his CT scan on November 6, 2013. He noted that he was still unable to determine what was causing the severe pain in his right shoulder. He diagnosed him with a right shoulder anterior labrum tear and recommended a MR arthrogram to rule out an anterior labrum tear. He noted that the previous MRI did not show a labrum tear, but it was not an arthrogram.

In November, 2013, Mr. Reyes attended nine more visits with Chiropractor Carrion. Over the course of that month, Mr. Reyes noted a decrease in pain in his right shoulder with therapy, but he continued to use an arm sling as of November 11, 2013. On November 15, 2013, he noted that he tried to work, but had increased pain in his

neck and right shoulder. (PX1). A re-evaluation was performed on November 20, 2013 by Chiropractor Carrion. He recommended continued treatment 2-3 times per week for 4-6 weeks including ultrasound therapy, E.M.S. on the right shoulder to reduce pain and manual therapy to the right shoulder area. He now expected maximum medical improvement at 72 visits. At the initial evaluation, he expected MMI at 48 visits. (PX1).

On November 26, 2013, Mr. Reyes had a MR arthrogram. (PX 2). The radiologist noted that he had intact rotator cuff tendons and glenoid labrum. The biceps labral anchor appeared intact. There was no evidence of a cartilage, ligament or tendon tear.

On November 27, 2013, Dr. Anatoly Gorovits, a doctor Board Certified in internal medicine, examined Mr. Reyes at Illinois Orthopedic Network. (PX2). He complained of right shoulder pain traveling down to his wrist. He also had neck pain. Dr. Gorovits diagnosed him with a right shoulder sprain and cervical radiculopathy. He recommended physical therapy three times per week for four weeks. He prescribed Gabapentin, Meloxicam and Protonix as well as Norco. If he did not improve, bilateral upper extremity EMG studies were recommended.

On December 27, 2013, Dr. Nemickas performed a records review. (RX3). Dr. Nemickas reviewed additional records and films and noted that Mr. Reyes has a right shoulder strain and cervicalgia with right upper extremity C6 and C7 radicular pain. He also noted that the chiropractic treatment that Mr. Reyes continued to undergo was not reasonable, necessary, or related to his claimed work injury. Dr. Nemickas stated that his injury was as a result of the alleged incident on March 5, 2013 and claimed by history from Mr. Reyes to be re-aggravated on July 30, 2013. He recommended that he be evaluated by an orthopedic spine surgeon or neurosurgeon for conservative management. He noted that he may require a decompression if symptoms remain an issue after undergoing a cervical epidural steroid injection. Dr. Nemickas opined that he had reached maximum medical improvement with regard to his claimed shoulder injury no more than 12 weeks following the claimed re-aggravation on July 30, 2013. Dr. Nemickas noted that he was capable of returning to work without use of his right upper extremity beyond fine motor skills and dexterity tasks.

In January, 2014, Mr. Reyes underwent nine additional visits with Chiropractor Carrion. On January 3, 2014, another progress report was issued by Chiropractor Carrion. (PX 1). Chiropractor Carrion diagnosed him with shoulder pain, shoulder stiffness, muscle spasms and a glenoid fracture, even though the glenoid fracture had been ruled out. His treatment plan remained the same. Chiropractor Carrion noted that he had improved since his first evaluation.

On January 16, 2014, Dr. Sajjad Murtaza examined Mr. Reyes at Illinois Orthopedic Network. (PX2). Mr. Reyes related a history of a work injury on July 30, 2013. He stated that told his supervisor that a door, which was similar to a garage door, was not working properly. He stated that his supervisor told him to continue working

and he shortly felt a pop and immediate pain along the right side of his neck, right shoulder and right ear. Dr. Levi ruled out any significant shoulder pathology. He diagnosed him with cervical radiculopathy. He had been in physical therapy and stated that this does help greatly, but his pain has not improved. Dr. Murtaza noted that his cervical MRI revealed endplate spurring and disc bulging more severe toward the right with stenosis exacerbated by facet joint hypertrophy at C5-6 and C6-7. His pain intermittently radiates down the right upper extremity. He had numbness and tingling in the first and second digits of the right hand along with radicular pain. Dr. Murtaza authorized him off work. He recommended physical therapy for 3-4 more weeks if this does provide temporary relief. He prescribed a right paramedian C5-6 epidural steroid injection. If there was no relief, EMG/NCV studies were recommended. Dr. Murtaza prescribed Gabapentin as well.

On January 23, 2014, Dr. Murtaza re-examined him. He administered an epidural injection into Mr. Reyes' cervical spine at C5-6. (PX2).

On February 6, 2014, Dr. Murtaza saw Mr. Reyes. He authorized him off work and recommended EMG/NCV studies of the bilateral upper extremities since he did not receive any relief with the cervical epidural injection. Continued physical therapy 2-3 times a week for the next three to four weeks was recommended.

On February 28, 2014, Mr. Reyes underwent EMG/NCV studies at New Life Medical Center (PX1). A chiropractic neurologist read these studies, noting mild to moderate right cervical radiculitis at C7-8. (PX2 at 32).

He had eight visits with Chiropractor Carrion in February, 2014. On February 24, 2014, he had a re-evaluation. (PX1). At that time, the chiropractor claimed that Mr. Reyes would reach maximum medical improvement by the 48th week, which was 108 visits or earlier. (PX1). He claimed that Mr. Reyes' condition has improved. Mr. Reyes attended eight visits in March, 2014.

On March 13, 2014, Dr. Murtaza examined Mr. Reyes. He continued to have pain shooting down the right upper extremity with weakness and burning. Dr. Murtaza noted that he had an EMG which showed radiculitis. He recommended another cervical epidural injection at C6-7. On March 20, 2014, Dr. Murtaza administered the epidural injection at C6-7. (PX2 at 25).

On March 24, 2014, Mr. Reyes was examined by Dr. Wellington Hsu at Northwestern University for a Section 12 examination. (PX2 at 7, RX1). Dr. Hsu reviewed the medical records and obtained a history. Mr. Reyes claimed an initial injury on March 5, 2013 due to repetitive motions with a heavy door. He returned to work and told Dr. Hsu he had a new injury on July 30, 2013 when he was lifting a door from a machine and his symptoms became worse. He had right-sided shoulder pain at that time and one week later, this developed into neck pain. He noted that he must

carry up to 80 pounds for his job on a regular basis. He had been back to work a couple times unsuccessfully. He denied any past medical history. Upon examination of his lumbar spine, he exhibited positive Waddell's signs with supersensitivity and axial compression. His cervical exam revealed limited range of motion with 40 degrees of flexion, 20 degrees of extension and only 50 degrees of left and right lateral rotation. He exhibited a positive Spurling sign and negative Lhermitte's sign. There was questionable effort with the range of motion of his cervical region. Dr. Hsu reviewed his MRI of his cervical spine. There was mild to moderate stenosis in the foramen bilateral at C5-6 and C6-7 as well as posterior osteophyte complexes or mild to moderate in size. He diagnosed Mr. Reyes with a cervical strain, resolved, and cervical spondylosis or degeneration. Dr. Hsu noted that the work incident as reported by Mr. Reyes on July 30, 2013 caused an acute cervical strain based upon the mechanism of action, which was consistent with a soft tissue injury. Although his initial pain was in his shoulder, it was later diagnosed as cervicalgia. As the mechanism was low impact, he did not believe that a structural injury occurred to his neck. Dr. Hsu noted that Mr. Reyes did exhibit some positive Waddell's signs. Dr. Hsu opined that his cervical spondylosis was not related to his injury and he had reached maximum medical improvement with regard to his claimed work injury. With regard to his work-related condition, Dr. Hsu noted that he was capable of working full duty and he was a good candidate for a functional capacity evaluation to determine any restrictions that may be required for his pre-existing cervical spondylosis.

Dr. Murtaza examined him on April 3, 2014. As he had no relief with the epidural injections, he referred him to a spine surgeon for further recommendations. He authorized him off work and prescribed a compound cream and other medications. He also prescribed Ibuprofen 800 mg.

On April 15, 2014, Dr. Hsu issued an addendum report. (RX1). He reviewed Mr. Reyes' job description. He noted that Mr. Reyes would be able to work with light duty restrictions six weeks after his claimed injury in July 2013.

On April 18, 2014, Dr. Geoffrey Dixon saw Mr. Reyes. (PX 3). He reported pain primarily located in the neck, right shoulder, arm, and hand from repeated use of a broken machine door at work on March 5, 2013. Dr. Dixon recommended an anterior cervical discectomy and fusion at C5-6 and C6-7.

Mr. Reyes continued to attend visits with Chiropractor Carrion in April, 2014. At a re-evaluation on April 21, 2014, Chiropractor Carrion documented less stiffness in his right shoulder with therapy. He was no longer using an arm sling to support his right shoulder. Chiropractor Carrion noted that he had reached MMI for the right shoulder and Dr. Levi recommended continued pain management for his neck. He was discharged at that time.

Additional records were forwarded to Dr. Hsu for his review. He issued a third report on May 6, 2014 reviewing Dr. Dixon's exam on April 18, 2014. (RX 1). Dr. Hsu noted that the prescribed surgery may be reasonable, but it would be secondary to the treatment for his pre-existing cervical spondylosis, which was not related to the claimed work injury given the fact that he had a low impact injury and did not exert a force significant enough to cause structural injury to the cervical spine. (RX1).

On May 16, 2014, Dr. Geoffrey Dixon re-examined Mr. Reyes. His notes document pain primarily in the neck with radiation down the right shoulder, arm and hand due to repeated use of a broken machine door on March 5, 2013. (PX2 at 5). Dr. Dixon continued to recommend a cervical discectomy and fusion at C5-6 and C6-7.

A final report was issued on October 14, 2014 by Dr. Hsu (RX1). He reviewed the last office note from Dr. Dixon. Dr. Hsu noted that none of his prior opinions have changed. Dr. Hsu opined that the work injury only caused a soft tissue injury due to his low impact nature reported by Mr. Reyes and the MRI findings suggested a chronic appearance with nothing acute in his cervical spine.

The parties proceeded with Dr. Dixon's evidence deposition on October 28, 2014. Dr. Dixon testified that he understood that Mr. Reyes had an injury on March 5, 2013. (PX3 at 8). Dr. Dixon admitted that he did not have an understanding of the mechanism of injury beyond what was recorded in his notes about repeated use of a broken machine door at work. (PX3 at 829). Dr. Dixon confirmed that his diagnosis would be herniated discs at C5-6 and C6-7 with C6 and C7 radiculopathy. (PX3 at 14). He recommended an anterior cervical discectomy and fusion at C5-6 and C6-7. (PX3 at 14).

On cross-examination, Dr. Dixon testified that he was not aware that Mr. Reyes never had any medical treatment until July 30, 2013. (PX3 at 22). Dr. Dixon admitted that he was also not aware until immediately prior to his deposition that Mr. Reyes had been working from March, 2013 through July 2, 2013. (PX3 at 33). Dr. Dixon was unable to recall all of the records that he reviewed. (PX3 at 34). He was not aware of the amount of weight Mr. Reyes was required to lift as part of his job duties. (PX3 at 35). Dr. Dixon stated that he was not aware of the weight of the machine door that Mr. Reyes lifted. (PX3 at 36). He was also not aware if there were any shocks to help lift the machine door. (PX3 at 36). Dr. Dixon admitted that he was not sure whether Mr. Reyes used one or both hands to lift the door. He only knew that Mr. Reyes told him that he was repeatedly lifting it with his right arm. (PX3 at 36). Dr. Dixon testified that he was not aware how many times Mr. Reyes lifted the door on March 5, 2013. (PX 3 at 36). When asked what types of repetitive activities Mr. Reyes was engaged in at work from March, 2013 through July 30, 2013, Dr. Dixon could not say. (PX3 at 36). When questioned about whether the details of Mr. Reyes' job would be helpful or alter his causation opinion, Dr. Dixon stated that any details would be unlikely to change his opinion. (PX3 at 37). Dr. Dixon also was not aware of any subsequent work accidents other than what Mr. Reyes told him occurred on March 5, 2013. (PX3 at 38). Dr. Dixon

described disc osteophyte complexes as an area where the disc has protruded beyond its traditional borders and bone spur growth occurs. (PX3 at 46-47). Dr. Dixon stated that Mr. Reyes had no prior neck complaints before March 5, 2013. (PX3 at 59).

Dr. Hsu testified at his deposition on February 2, 2015. (RX 1). He stated that he is a Board Certified orthopedic surgeon who performs surgeries of the cervical, thoracic and lumbar spine. Dr. Hsu understood that Mr. Reyes had an initial injury on March 5, 2013, which caused him right shoulder pain. He then told Dr. Hsu that he exacerbated his symptoms on July 30, 2013 by using a heavy door. Initially, he had right shoulder pain on July 30, 2013, and one week later he told Dr. Hsu he had neck pain. (RX1 at 9). Dr. Hsu noted that he was able to get more range of motion when he examined him compared to his effort during the actual testing. (RX1 at 13). Dr. Hsu stated that Mr. Reyes was not able to heel and toe walk or tandem walk. He indicated that this could indicate spinal cord dysfunction or that he was not participating with the exam. (RX1 at 14). Dr. Hsu testified that his review of the MRI films from October 30, 2013 showed C5-6 and C6-7 posterior osteophyte complexes, which implied chronic changes. (RX1 at 17). Dr. Hsu described an osteophyte complex as an old disc herniation that calcifies and can compress the nerves around it. (PX1 at 17). He noted that it takes years to form a posterior osteophyte complex. (RX1 at 18). Dr. Hsu noted that given his reported history, Mr. Reyes had a cervical strain as a result of the claimed aggravation on July 30, 2013. His opinion was based upon Mr. Reyes' statement to him that he had pain in his shoulder as a result of repetitive activity on that date. Dr. Hsu indicated that Mr. Reyes claimed that he did not have neck pain right away, but he reported neck pain later on, so he gave him the benefit of the doubt that a cervical injury did actually occur on July 30, 2013. (RX1 at 20). Dr. Hsu noted that Mr. Reyes reached maximum medical improvement with regard to the strain at the time of his initial evaluation on March 24, 2014. Dr. Hsu also noted that Mr. Reyes told him he had to lift 80 pounds on a regular basis at work while the job description showed that he had to lift 50 pounds on a regular basis. (RX1 at 24).

Dr. Hsu testified that the recommended surgery would address Mr. Reyes' posterior osteophyte complexes, which are the bone spurs that grew off the disc space. (RX1 at 30-31). On cross-examination, Dr. Hsu was asked a series of questions assuming for purposes of the deposition that there was no prior treatment and no prior symptoms in Mr. Reyes' neck (RX1 at 31). Dr. Hsu noted that he did not find that a cervical injury occurred in March because there was no neck pain noted. (RX1 at 32). He did note that neck pain eventually was reported after the claimed incident in July and that is when he concluded that a cervical strain occurred per Mr. Reyes' report that he had neck pain at that time. (RX1 at 32). Dr. Hsu noted that the mechanism of injury that Mr. Reyes described to him on or about July 30, 2013 did not support the conclusion that he aggravated the structure of his spine. (RX1 at 38-39). Dr. Hsu continued to maintain that his activities were not of sufficient impact to cause or aggravate the underlying structural issues in Mr. Reyes' spine. (RX1 at 39-40).

Dr. Hsu also noted that Mr. Reyes told him there were no cervical complaints after March, 2013. (RX1 at 45). Mr. Reyes' attorney questioned him further asking whether Dr. Hsu's opinion would change by posing a hypothetical question. He asked Dr. Hsu to assume that the door in the King B turret was stuck and Mr. Reyes had to yank if very forcefully. (RX1 at 45-46). Dr. Hsu stated that, if the mechanism of injury was one where a person had to apply a certain amount of force with the neck in an awkward position, thereby causing a twisting injury of the cervical spine, this could potentially cause a structural injury. (RX1 at 46-47). Dr. Hsu then testified that if there was a cervical spine injury that was debilitating in March, he would have expected Mr. Reyes to seek medical treatment before July, 2013. (RX1 at 48).

II. CONCLUSIONS OF LAW

The Arbitrator adopts the above findings of material fact in support of the following conclusions of law:

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

D. What was the date of accident?

Mr. Reyes testified that he sustained an injury while opening and closing the door of the King B turret machine during the first week of March, on March 4th or 5th, 2013. He claimed that the door weighed 80-100 pounds and the shocks were not working at all. Both Martha Quintero and Steve Szybowicz confirmed that the shocks were still working, but they were not the correct shocks for the machine. Mr. Reyes' Application for Adjustment of Claim alleges an injury on July 30, 2013 to his right arm and neck.

At trial, Mr. Reyes testified about a specific accident to his right shoulder on March 4th or 5th of 2013 while lifting the broken door of the King B Turret Machine. Martha Quintero and Steve Szybowicz confirmed that Mr. Reyes reported some right shoulder pain on March 5th of 2013. He did not report neck pain. He declined medical treatment and continued working full duty for almost five months with no apparent pain behaviors.

After March 5, 2013, there is conflicting testimony about what occurred. Mr. Reyes agreed he did not seek treatment from March 5, 2013 until July 30, 2013, but he claimed Ms. Quintero ignored his complaints of pain and just gave him ibuprofen on a weekly basis. Martha Quintero testified that this was not true as she only gave him ibuprofen when he originally mentioned right shoulder pain and declined treatment on March 5, 2013. Ms. Quintero stated that he never had any continued complaints during those five months.

On July 30, 2013, Mr. Reyes testified that he was running another similar machine with heavier material. He said he felt back, neck, right shoulder and ear pain. On cross-examination, he stated that he did not have a new injury, but his pain increased and he asked to seek treatment. Mr. Reyes did not explain on which machine he worked on July 30, 2013 and he never told Martha that he had increased pain from operating any machine or performing his work activities on that date.

The day before his request to seek medical treatment on July 30, 2013, Mr. Reyes was called into a disciplinary meeting to investigate sexual harassment complaints against him by a male co-worker. On cross-examination, Mr. Reyes claimed he was in pain during the meeting on July 29, 2013, but he did not ask to seek medical treatment until the following day. At that time, he told Martha Quintero that he had pain in his ear which he thought was related to his original incident in March, 2013. Martha Quintero testified that Mr. Reyes did not report a new injury to her on July 30, 2013 or say that any work activities caused his ear pain on that date. Instead, he merely told her that he had ear pain which he thought was related to his incident in March 2013.

The histories in the medical records include different details of the mechanism of injury and raise a question about whether Mr. Reyes sustained an injury on March 5, 2013 or July 30, 2013. In order to better understand what Mr. Reyes alleged, the initial history of injury reported to each doctor is outlined below:

1) **Advocate Occupational Health on July 30, 2013** (PX 1): Mr. Reyes claimed he injured his right shoulder and neck four months ago while lifting a heavy door. He stated his pain became worse. The notes mention an accident date of April 12, 2013.
2) **Dr. Gregory Caronis on August 1, 2013** (PX 1): Mr. Reyes stated that he injured his shoulder at the end of March. He indicated that he lifted something heavy at work.
3) **Dr. Gabriel Levi on August 7, 2013** (PX 2): Mr. Reyes related a history of an injury on July 30, 2013 while closing a machine door that weighed 100 pounds. He felt a pop in his shoulder.
4) **Aldrin Carrion, D.C. on August 9, 2013** (PX 1): Mr. Reyes stated that he worked on the VIPRO machine that had broken springs. The door weighed 80-100 pounds. He felt cracking in his right shoulder. He told Martha Quintero, but received no advice. He continued to tell her his right shoulder was worse, especially when using that machine. Two months later he reported it to Martha again and received no advice. By July 30, 2013, his pain was unbearable.
5) **Dr. Tomas Nemickas on October 14, 2013** (RX 2): Mr. Reyes claimed an original injury while lifting a table with his right arm on March 5, 2013 while working on the King B Turret. He then indicated that, on July 25, 2013, he worked on a machine that was also defective and he had to slam the handle forward repeatedly. He felt neck, shoulder and arm pain.

6) **Dr. Wellington Hsu on March 24, 2014** (RX 1): Mr. Reyes claimed an initial injury on March 5, 2013 due to repetitive motions with a heavy door. He then had a new injury on July 30, 2013 when he was lifting a door from a machine and his symptoms became worse. He first had right shoulder pain and then neck pain developed a week later.
7) **Dr. Geoffrey Dixon on April 18, 2014** (PX 3): Mr. Reyes reported neck, right shoulder, hand, and arm pain from repeated use of a broken machine door at work on March 5, 2013.

The law is clear. The burden is on the Petitioner seeking an award to prove by a preponderance of credible evidence all the elements of his claim, including the requirement that the injury complained of arose out of and occurred in the course of his employment. *Martin v. Industrial Comm'n*, 91 Ill.2d 288, 294 (Ill. 1982). It is also true that a claimant's testimony, standing alone, may support an award in a situation where all the facts and circumstances do no preponderate in favor of the opposite conclusion. *Seiber v. Industrial Comm'n*, 82 Ill.2d 87, 97 (Ill. 1980). However, uncorroborated testimony may only support an award if all the facts and circumstances support such a decision. If the sole basis for an award is the claimant's own testimony and the claimant's actual behavior and conduct is inconsistent with that testimony, Illinois Courts have held that the award may not stand. *McDonald v. Industrial Comm'n*, 39 Ill.2d 396, 403 (Ill. 1968).

There is credible evidence to support the conclusion that Mr. Reyes sustained a minor injury to his right shoulder on March 5th, 2013 when he lifted the door of the King B Turret. This incident did not result in the need for medical treatment and Mr. Reyes continued working full duty. He also worked overtime in the next five months as shown on his time card with no documented issues. He did not claim this as an accident date in this clam. (RX 6).

Mr. Reyes worked full duty until July 30, 2013, the day after the disciplinary hearing, despite his testimony that he was in constant pain. He claimed his complaints of pain were ignored by Martha Quintero. He could not explain why he did not tell anyone else about his ongoing pain, except to say there was a rule prohibiting him from going from one part of the Company to another, so he did not want to make a complaint. Both Martha Quintero and Steven Szybowicz also denied noticing any pain behaviors when they saw Mr. Reyes from March 2013 through July 30, 2013. Ms. Quintero specifically denied that Mr. Reyes continually reported pain and issues to her from March 5th until July 30, 2013 despite his testimony to the contrary.

Mr. Reyes also informed all of his doctors and the Section 12 examiners that he never had neck, right shoulder, or ear pain before March 2013. This is not true as he clearly had treatment in 2005 for a cervical and trapezius strain with pain throughout his right ear, right shoulder and neck that radiated to his right elbow. (RX 17). There was a diagnosis of cervical spondylitis as well as strains of his neck and trapezius.

Upon review of the medical evidence and testimony at trial, there is no credible evidence to support the contention that Mr. Reyes sustained a new injury on July 30, 2013. On direct examination and in some records, Mr. Reyes claimed to have a new injury on July 30, 2013 while working on a similar machine. On cross-examination, he admitted that he did not have a new injury on July 30, 2013. At most, the credible evidence shows that he claimed to have increased pain in his right ear and requested treatment. There was no credible evidence introduced about the repetitive nature of his job duties causing increased pain or any information to suggest that he sustained repetitive trauma manifesting on July 30, 2013. Based on this record, the Arbitrator finds that is impossible to conclude with any certainty whatsoever that Petitioner sustained an accident on July 30, 2013 as alleged herein.

While his Application for Adjustment of Claim alleges an accident date of July 30, 2013, the Arbitrator finds that March 5, 2013 was the only date on which he may have sustained a minor injury to his right shoulder that did not necessitate any treatment or result in any continued problems. Accordingly, the Arbitrator finds that Mr. Reyes failed to prove that he sustained accidental injuries that arose out of and occurred in the course of his employment on July 30, 2013. All other issues are moot.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Gary Allen,

Petitioner,

vs. NO. 12 WC 2279

16IWCC0638

Steak 'N Shake,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, permanent disability, and 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 March 2, 2016 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 $41,000.00. 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: SEP 3 0 2016
SJM/sj
o-9/8/2016
44

Stephen J. Mathis

Mario Basurto

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ALLEN, GARY
Employee/Petitioner

Case# **12WC002279**

STEAK N SHAKE
Employer/Respondent

16IWCC0638

On 3/2/2016, 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 0.48% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in 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 MEIKAMP
3100 N KNOXVILLE AVE
PEORIA, IL 61603

0358 QUINN JOHNSTON HENDERSON ETAL
JOHN F KAMIN
227 N E JEFFERSON ST
PEORIA, IL 61602

16IWCC0638

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

GARY ALLEN,
Employee/Petitioner

v.

STEAK N SHAKE,
Employer/Respondent

Case # **12** WC **2279**

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 **Peoria**, on **2/16/16**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of 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] The 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 **7/23/11**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$35,157.99**; the average weekly wage was **$676.12**.

On the date of accident, Petitioner was **52** years of age, *single* with **no** 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 **$8,874.74** for TTD, **$00.00** for TPD, **$00.00** for maintenance, and **$00.00** for other benefits, for a total credit of **$8,874.74**.

Respondent is entitled to a credit under Section 8(j) of the Act for all reasonable and necessary medical expenses that were paid by respondent's group carrier.

ORDER

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, for all treatment to petitioner's right shoulder from 7/23/11 through 7/16/14, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay reasonable and necessary medical services related to the injuries petitioner sustained on 7/23/11, through 7/16/14 as identified in Petitioner's Exhibit 12, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $405.67/week for 100 weeks, because the injuries sustained caused the 20% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

Signature of Arbitrator

2/29/16
Date

ICArbDec p. 2

MAR 2 - 2016

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 52 year old manager, sustained an accidental injury to his right shoulder that arose out of and in the course of his employment by respondent on 7/23/11, while scraping the grill with a spatula. The petitioner's accident is not in dispute. While petitioner was scraping the grill with a spatula he felt a pop in his right shoulder, as well as pain, burning, and tingling in his right shoulder. Petitioner is right hand dominant.

Petitioner first sought treatment for his injuries at Proctor First Care on 7/26/11. Petitioner presented with a chief complaint of a right shoulder injury at work on Saturday night while cleaning the grill. He reported that he sustained something that felt like a tear, and has had pain ever since. On 8/19/11 petitioner returned to Proctor First Care and reported that his right shoulder pain was not any better. Petitioner reported that he could not sleep on his right side and that the pain keeps him up. Petitioner was prescribed Vicodin and Keflex, and assessed with rotator cuff tendinitis. On 9/6/11 petitioner followed-up after undergoing an x-ray of the right shoulder. X-rays did not show any acute fractures or dislocation. Petitioner complained of a pins and needle sensation. Petitioner reported his aggravating factors as lifting and movement. Flexeril was added to petitioner's prescriptions. Petitioner was prescribed therapy. On 11/17/11 Dr. Williams ordered an MRI of the right shoulder.

Petitioner underwent a course of physical therapy at Premier Physical Therapy. He started on 9/21/11. Petitioner underwent 7 visits by 11/14/11. At that time petitioner reported that he felt he could do most of his job with zero to minimal pain. He reported pain in the anterior shoulder region and radiating tingling into his fingers. Therapist Nimrick recommended that petitioner be taken off work for 2-3 days, and continue in physical therapy through 11/21/11.

On 1/11/12 petitioner presented to Dr. Blair Rhode at Orland Park Orthopedics, for consultation of right shoulder pain and neck pain, secondary to an injury while at work. Petitioner reported that he had maintained modified duty per the parameters of Prompt Care. Dr. Rhode injected petitioner's right shoulder. He diagnosed shoulder pain (right), neck pain, rotator cuff sprain, acromioclavicular internal derangement, and cervical radiculopathy. He prescribed Norco, Mobic and Ultram. Dr. Rhode was of the opinion that petitioner demonstrated evidence of a work related right shoulder and cervical injury sustained on 7/23/11 while cleaning a grill. He further noted that petitioner demonstrated a positive impingement sign, positive acromioclavicular findings, and a positive right-sided Spurling maneuver. Dr. Rhode ordered an MRI of the cervical spine and right shoulder.

On 1/18/12 petitioner underwent an MRI of the right shoulder. The impression was 16 x 9 mm partial interstitial tear of the supraspinatus tendon insertion, involving approximately 80% of the tendon craniocaudal thickness, with underlying tendinosis. Mild subacromial subdeltoid bursitis was also noted.

Petitioner followed-up with Dr. Rhode on 1/25/12. He shared the results of the MRI of the right shoulder with petitioner. Petitioner reported that he was significantly symptomatic with forward reaching and overhead lift. Due to failed conservative treatment, Dr. Rhode recommended surgical intervention and petitioner agreed. Petitioner continued to follow-up with Dr. Rhode while they continued to wait for approval of the recommended surgery.

On 3/18/12 petitioner presented to St. Francis Medical Center after working on the grill for respondent and feeling a "burning" pain in his right shoulder. He reported "pins and needles" in his shoulder.

On 3/20/12 petitioner underwent a right shoulder subacromial decompression, arthroscopic distal clavicle excision, and arthroscopic rotator cuff tear. Dr. Rhode's post operative diagnosis was right shoulder rotator cuff impingement, acromioclavicular pain, and rotator cuff tear. He followed up post-operatively with Dr. Rhode. This treatment included another course of physical therapy.

On 6/26/12 petitioner underwent a Section 12 examination performed by Dr. Hauter, at the request of the respondent. Petitioner's chief complaint was "I have pain and trouble moving my right shoulder". Following his examination and record review Dr. Hauter's impression was 1) right shoulder impingement syndrome-repaired, that was not related to the injury on 7/23/11. He thought it might be related to the fall down the stairs at home on 9/3/11. 2) partial tear of the supraspinatus tendon with underlying tendonitis-repaired. He believed that the detailed reenactment and demonstration of the grill cleaning procedure by petitioner did not involve significant abduction of the right shoulder. He believed the tear was caused by the impingement syndrome causing friction of the sub-acromion bursa and supraspinatus tendon, evidenced by the bursitis, the location of the tear, and associated tendonitis at the point of the partial tear. Dr. Hauter was of the opinion that these findings did not suggest trauma, but rather long term degeneration of the supraspinatus tendon. 3) Chronic narcotic dependent right shoulder pain post surgical. 4) Numbness and tingling of the right hand. Dr. Hauter was of the opinion that this was claimed immediately after the fall down the stairs at home on 9/3/11. 5) Coronary artery disease.

On 7/11/12 petitioner presented to Dr. Rhode. He reported that he stopped receiving temporary total disability benefits after he was examined by respondent's doctor. Dr. Rhode continued petitioner in physical therapy and released him to modified-sedentary work with no overhead activity. On 7/25/12 petitioner reported to Dr. Rhode that his employer was not honoring his restrictions and was making him perform a significant

amount of overhead activity. He also reported that he was performing a significant amount of fry duty. He complained of worsening symptomatology including becoming weaker when doing forward reach, and waist to crown. Dr. Rhode noted that an ultrasound of the right shoulder showed a recurrent rotator cuff defect. Dr. Rhode ordered a repeat MRI. He took petitioner off work for a few days and then returned him to restricted work. On 8/15/12 Dr. Rhode authorized petitioner off work because respondent was not honoring his restrictions. Petitioner continued to follow-up with Dr. Rhode pending his repeat MRI. Dr. Rhode released petitioner to return to work on 9/5/12 with no use of the right upper extremity. He was of the opinion that petitioner sustained a failure of his repair.

On 9/18/12 petitioner was again evaluated by Dr. Hauter at the request of the respondent. His chief complaint was "I went back to work and wrecked my shoulder". Following an examination and record review his impression was right shoulder impingement syndrome. He agreed that if petitioner was working outside his restrictions this could give him some pain. He was of the opinion that petitioner should return to work with restrictions of light duty (lifting 10 pounds max if frequent, and 20 pounds max if occasional lifting). He was also of the opinion that petitioner should be restricted from working above his right shoulder. He also did not believe petitioner should work until he was no longer taking Hydrocodone.

On 11/20/12 petitioner underwent a repeat MRI of the right shoulder. The impression was recurrent interstitial tear of the anterior supraspinatus tendon measuring 11mm x 8 mm and involving 80% of the tendon volume. Mild subacromial subdeltoid bursitis was also noted.

Petitioner followed-up with Dr. Rhode on 11/28/12. Dr. Rhode told petitioner that he had a high-grade partial thickness tear which essentially represents a full-thickness tear. Treatment options were discussed. Petitioner decided that he was unwilling to live with his current symptomatology. He agreed to an arthroscopic revision of his right shoulder. Petitioner followed-up with Dr. Rhode pending authorization of surgery. Petitioner continued to follow-up with Dr. Rhode while waiting for authorization.

On 2/20/13 the evidence deposition of Dr. Rhode was taken on behalf of the petitioner. Dr. Rhode specializes in sports medicine and is an orthopedic surgeon. Dr. Rhode opined that the rotator cuff repair did not heal and the exposure the patient was placed in caused the repair to pull away. He further opined that petitioner's activity of cleaning the grill was causative to his rotator cuff pathology. Dr. Rhode opined that the original injury was secondary to the described mechanism of injury of cleaning the grill. He also opined that the area of the tear recurrence is where he initially repaired the rotator cuff and that this repair did not have the chance to heal and it pulled away.

On cross examination Dr. Rhode opined that his opinions are based in part on petitioner's history of accident and the assumption that there have not been any other intervening events or injuries to petitioner's right shoulder. Dr. Rhode opined that although petitioner told him that respondent was not honoring his restrictions, some rotator cuff tears aren't destined to heal. He believed that the tear occurred between July 11th and August 8th.

Petitioner returned to Dr. Rhode on 4/9/13 for follow-up of his right shoulder. Petitioner continued with significant symptomatology. Dr. Rhode noted that the MRI did not demonstrate a frank disruption. Treatment options were discussed. He was of the opinion that petitioner would require restrictions. He ordered an FCE. He continued petitioner's restrictions.

On 4/25/13 Dr. Hauter drafted a letter to John Kamin, respondent's attorney, after reviewing an MRI of petitioner's right shoulder dated 11/20/12. He compared it to the MRI dated 1/8/12. He was of the opinion that the 80% tear off the supraspinatus was still present and measured slightly less than the 16mm x 9mm size, a 39% decrease in the size of the defect, the mild subacromial bursitis persisted, and the infraspinatus tendon was unremarkable. He opined that the MRI images were more consistent with a surgical failure than an exact reinjury at the exact area of the supraspinatus tendon.

On 6/11/13, the evidence deposition of Dr. Hauter was taken on behalf of respondent. Dr. Hauter specializes in occupational medicine. He testified that when he saw petitioner he was still having pain and was still taking narcotics for the pain. Dr. Hauter opined that the impingement syndrome and partial tear of the spuraspinatus tendon were not caused by the injury. He opined that it was caused by an abnormally shaped acromion with degenerative changes at the AC joint, and not related to the injury. He further opined that the detailed reenactment petitioner showed did not involve abduction of the shoulder, which is the job of the supraspinatus tendon. He believed it is difficult to get a partial tear from a traumatic injury. He believed it was a chronic problem, related to the impingement syndrome. He made reference to a fall down the stairs on 9/3/11.

On 2/11/14 petitioner presented to Dr. Jeffrey Garst at Great Plains Orthopaedics for a second opinion regarding his right shoulder. Following his examination and record review, as well as x-rays that he took and interpreted, Dr. Garst's diagnoses were right shoulder pain and weakness, and previous right shoulder rotator cuff repair with suspected retear. He recommended a repeat MRI of the right shoulder. He told petitioner to keep working as he was.

On 3/19/14 petitioner underwent another MRI of the right shoulder. The impression was evidence of prior rotator cuff repair, acromioplasty and resection distal clavicle, and mild tendinosis without evidence of rotator cuff tear. Mild subacromial bursitis was also noted.

On 4/1/14 petitioner returned to Dr. Garst. Petitioner demonstrated motion in his right shoulder with about 150 degrees of flexion and 140 degrees of abduction; pain with maximum flexion, abduction, and internal rotation; and a little bit of weakness with flexion and external rotation at the right shoulder compared to the left. Dr. Garst reviewed the MRI and was of the opinion that the rotator cuff repair was still intact. He did not think a repeat surgery was in his best interests. He was of the opinion that petitioner was always going to have some troubles with the right shoulder. He gave petitioner restrictions with respect to the right arm. If there were questions on this he recommended an FCE.

On 4/3/14 and 6/17/14 petitioner underwent a Functional Capacity Evaluation. Petitioner was found capable of functioning with the following restrictions. Material Handling: **Occasional** floor to waist 40#, waist to shoulder height 30#, shoulder to overhead 20#, carry 30#, pushing 27#, pulling 22#. **Frequent** floor to waist 35#, waist to shoulder 30#, shoulder to overhead 20#, carry 15#, pushing 13.5#, pulling 11#. **Constant** floor to waist 17.5#, waist to shoulder 15#, shoulder to overhead 10#, carry 7.5#. Non-Material Handling: **Occasional:** squatting, bending, kneeling, crawling. **Frequent** standing, walking, reaching, climbing, grip/fine motor. **Constant:** sitting.

Petitioner last followed up with Dr. Rhode on 7/16/14. He believed that the petitioner had plateaued. He was of the opinion that petitioner required permanency in the form of light-medium modified duty, with an overhead restriction of 10/20 pounds. He stated that petitioner may occasionally push, pull, perform repetitive grasp, and have exposure to vibratory tools. He was of the opinion that these restrictions were permanent. Dr. Rhodes was of the opinion that petitioner had reached MMI, and could follow-up as needed.

On 11/13/14 Steve Nichols, District Manager for respondent, drafted a memo to petitioner regarding "Assuring That You Perform No Tasks Outside Your Permanent Restrictions". This memo identified Dr. Rhode's restrictions as of 7/16/14 as 1) Right Arm: Light Medium - max 35 lift/carry; frequent at 20 lbs; 2) Above Shoulders: max 20 lbs and frequent 10lbs; 3) Activity Modification: a) Push/Pull -Occasional (0-33%), b) Repetitive Grasp - Occasional (0-33%), and c) Vibratory Tool - Occasional (0-33%). Although these restrictions preclude petitioner from performing all his essential functions of Manager, Nichols ensured petitioner that respondent was willing to attempt to work with him to facilitate his continued work. It was noted that in order to ensure that he does not perform any work outside his permanent restrictions, and can effectively function as a Manager, he was told that he must perform no work that could violate his restrictions, must

effectively perform his work responsibilities as a Manager, and remain at all times an at-will employee. Petitioner signed this Memo. There was also another signature, whose writing was illegible.

On 12/7/15 petitioner underwent a Section 12 examination by Dr. Fletcher, Internal Medicine, at SafeWorks Illinois, at the request of the respondent. Dr. Fletcher had petitioner complete a Quick DASH Outcome Measure. He scored a 50, which Dr. Fletcher noted represents moderate self-reported disability. He diagnosed a status post 3/20/12 right shoulder video assisted subacromial decompression, arthroscopic distal clavicle excision and arthroscopic rotator cuff repair. He opined that petitioner had incurred permanent loss and although permanent job restrictions are necessary, he felt petitioner could do more than Dr. Rhode suggested. He further opined that petitioner had reached MMI. He noted that petitioner continues to work his Manager job with restrictions. He noted that petitioner's FCE showed valid effort.

Petitioner reported that his right arm is painful at times, and limited on certain things. He testified that if he sleeps wrong he wakes up in pain. He testified that he no longer mows the lawn, and is careful with lifting. He does not do repetitive things. Petitioner testified that he has some overhead weakness, and his strength is not 100%. He complains of pain every day. He denied any problems with his right arm prior to the injury.

Petitioner still works as a Manager for respondent. He is making more money now than at the time of the injury. Petitioner works with permanent restrictions and gives directions to employees. He also gets the employees to help him when needed.

F. IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY?

It is unrebutted that petitioner sustained an accidental injury that arose out of and in the course of his employment by respondent 7/23/11. An issue exists as to whether or not petitioner's current condition of ill-being, as it relates to his right shoulder, is causally related to the injury he sustained on 7/23/11.

Petitioner complained of right shoulder pain, and tingling after feeling a pop in his right shoulder while scraping the grill at work. Petitioner had no previous history of any problems with his right shoulder.

Petitioner first sought treatment with Proctor First Care. His complaints continued, and he also reported his symptoms keeping him up at night and a pins and needles sensation. He was assessed with rotator cuff tendinitis. He reported aggravating factors of lifting and movement. Petitioner underwent a course of physical therapy, but still reported pain in the anterior shoulder region and radiating tingling into his fingers.

Petitioner next treated with Dr. Rhode. Dr. Rhode injected his right shoulder. He was of the opinion petitioner demonstrated evidence of a work related shoulder and cervical injury sustained on 7/23/11 while cleaning a grill. An MRI of the right shoulder was again recommended. It reveled a partial interstitial tear of

the supraspinatus tendon insertion, with underlying tendinosis. A mild subacromial subdeltoid bursitis was also noted. Post MRI petitioner was still significantly symptomatic with forward reaching and overhead lift. Due to failed conservative treatment Dr. Rhode recommended surgical intervention. Petitioner underwent a right shoulder decompression, arthroscopic distal clavicle excision and arthroscopic rotator cuff tear. Petitioner followed up post-operatively with Dr. Rhode. Dr. Rhode opined that petitioner's activity of cleaning the grill was causative to his rotator cuff pathology.

The only other opinion with respect to causation came from Dr. Hauter, at the request of the respondent. Dr. Hauter thought petitioner's right shoulder condition might be related to the fall down the stairs at home on 9/3/11. He also believed that the detailed reenactment and demonstration of the grill cleaning procedure by petitioner did not involve significant abduction of the right shoulder. However, he then goes on to opine that the findings on petitioner's right arm did not suggest trauma, but rather long term degeneration of the supraspinatus tendon. Dr. Hauter was of the opinion that petitioner's numbness and tingling of the right hand did not appear until after the fall on 9/3/11.

The arbitrator finds the opinions of Dr. Hauter inconsistent and not supported by the credible record. Immediately after the injury and before 9/3/11 the petitioner complained of a pins and needle sensation. Additionally, the arbitrator finds it inconsistent that Dr. Hauter believed petitioner's symptoms might be related to a fall down the stairs at home on 9/3/11, which would be a traumatic incident, but then opined that the findings on petitioner's right arm do not suggest trauma. The arbitrator finds it significant that there does not appear to be any treating records related to the alleged fall at home on 9/3/11, especially as it relates to the mechanism of that fall. The arbitrator also finds it significant that petitioner's complaints as they relate to his right shoulder were essentially the same before and after 9/3/11.

Based on the above, as well as the credible evidence, the arbitrator finds the opinions of Dr. Rhode, petitioner's treating physician, more persuasive that those of Dr. Hauter's, which seem inconsistent. As such, the arbitrator finds the petitioner's current condition of ill-being as it relates to his right shoulder is causally related to the injury on 7/23/11. The arbitrator also finds it significant that after petitioner returned to work following his surgery and was required by respondent to perform tasks in excess of his restrictions, he sustained an aggravation of his preexisting condition as it relates to his right shoulder. Dr. Rhode opined that petitioner's activity of cleaning the grill after his surgery was a causative factor as it relates to his current rotator cuff pathology.

F. WERE 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 as it relates this right shoulder is casually related to the injury on 7/23/11, the arbitrator further finds the treatment petitioner received for his right shoulder from 7/23/11 through 7/16/14 was reasonable and necessary to cure or relieve petitioner from the effects of his injury on 7/23/11.

The arbitrator finds the respondent shall pay for all reasonable and necessary medical services that petitioner received from 7/23/11 through 7/16/14 for his right shoulder, pursuant to Sections 8(a) and 8.2 of the Act.

L. WHAT IS THE NATURE AND EXTENT OF THE INJURY?

As a result of the injury petitioner sustained on 7/23/11 petitioner sustained an accidental injury to his right shoulder. For this injury petitioner underwent a right shoulder subacromial decompression, arthroscopic distal clavicle excision and arthroscopic rotator cuff tear. Dr. Rhode's post operative diagnosis was right shoulder rotator cuff impingement, acromioclavicular pain and rotator cuff tear.

After petitioner returned to work and performed duties in excess of his restriction, he reported worsening symptomatology. Dr. Rhode performed an ultrasound of the right shoulder. It showed a recurrent rotator cuff defect. Petitioner underwent a repeat MRI that showed recurrent interstitial tear of tear of the anterior supraspinatus tendon measuring 11mm x 8mm and involving 80% of the tendon volume. Petitioner continued with significant symptomatology.

Petitioner sought a second opinion from Dr. Garst. Following a third MRI of the right shoulder Dr. Garst was of the opinion that the rotator cuff repair was still intact. He did not think a repeat surgery was in his best interests. He was of the opinion that petitioner was always going to have some troubles with his right shoulder. He gave petitioner paperwork with restrictions only on the right arm. He also recommended an FCE.

Petitioner underwent an FCE. Following that FCE, Dr. Rhode opined on 7/16/14 that petitioner had plateaued. He was of the opinion that petitioner required permanency in the form of light-medium modified duty, with overhead restriction of 10/20 pounds. He was of the opinion that petitioner may occasionally push, pull, perform repetitive grasp, and exposure to vibratory tools, He opined that these restrictions were permanent.

Petitioner reported that he currently has pain in his right shoulder at all times, and is limited in the use of his right arm. He testified that if he sleeps wrong he wakes up in pain. He testified that he no longer mows the

lawn, and is careful with lifting. He stated that he does not do any repetitive things. He reported some overhead weakness, and his strength is not 100%.

Based on the above, as well as the credible evidence, the arbitrator finds the petitioner sustained a 20% loss of use of his person as a whole, pursuant to Section 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)
			☐ PTD/Fatal denied
		☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Terry Smith,

Petitioner,

vs. NO. 13 WC 40180

Central Illinois Scale Co, Inc.,

Respondent.

16IWCC0639

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, credit due to Respondent, penalties and fees, 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 Novembers 23, 2015 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 $41,100.00. 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: SEP 3 0 2016
SJM/sj
o-9/8/2016
44

Stephen J. Mathis

Mario Basurto

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION

NOTICE OF ARBITRATOR DECISION

CORRECTED

SMITH, TERRY P Case# **13WC040180**

Employee/Petitioner

16IWCC0639

CENTRAL ILLINOIS SCALE COMPANY

Employer/Respondent

On 11/23/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.33% 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:

4707 LAW OFFICE OF CHRIS DOSCOTCH
DAMON YOUNG
2708 N KNOXVILLE AVE
PEORIA, IL 61604

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

STATE OF ILLINOIS)
)SS.
COUNTY OF **MCLEAN**) **16IWCC0639**

- [ ] 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
CORRECTED

TERRY P. SMITH
Employee/Petitioner

Case # **13** WC **40180**

v.

Consolidated cases: ______

CENTRAL ILLINOIS SCALE COMPANY
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gregory Dollison**, Arbitrator of the Commission, in the city of **Bloomington**, on **August 27, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [ ] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What 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. [x] Should penalties or fees be imposed upon Respondent?
N. [x] Is Respondent due any credit?
O. [ ] Other ______

FINDINGS

On **09/09/13**, 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 **$35,000.00**; the average weekly wage was **$675.00**.

On the date of accident, Petitioner was **58** 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 **$2,019.77** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$18,981.00** for other benefits, for a total credit of **$21,000.77**.

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

ORDER

Respondent shall pay Petitioner additional permanent partial disability benefits of $405.00/week for 82 weeks, because the injuries sustained caused the 40% loss of the left hand, as provided in Section 8(e) of the Act. Petitioner also sustained permanent partial disability to the extent of 50% loss of a left thumb in accordance with Section 8(e)(1) based on the amputation, which has been paid.

Respondent shall pay reasonable and necessary medical services of $17,389.00, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay to Petitioner penalties of **$1,898.10**, as provided in Section 16 of the Act; and **$9,490.50**, as provided in Section 19(k) of the Act.

Respondent shall be given a credit of $18,981.00 for 50% of a left thumb amputation payment and $2,019.77 for a TTD overpayment.

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

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

11/22/15
Date

ICArbDec p. 2

NOV 2 3 2015

STATEMENT OF FACTS:

Petitioner testified he was an employee at Central Illinois Scale Company. Petitioner stated that his employment started in July of 2010. Petitioner testified that on September 9, 2013, he was loading rental scales to transport to Macomb, Illinois. Petitioner testified the scales were loaded onto a fork truck. The scales were stacked 3 high and were varied in size and weighed about 900 pounds a piece. When the fork truck began to move, Petitioner put his hands on the scales to try and keep them from sliding. When the top scale began to slide, Petitioner's left thumb got caught in the scale. Petitioner stated that when the scale hit the floor, he brought his left arm back and his thumb was just hanging by a tendon. Petitioner testified that after the accident, he went to the emergency room.

On September 9, 2013, Petitioner followed up with OSF Emergency Department in Peoria, Illinois. Petitioner presented to the Emergency Department with traumatic thumb amputation. The records states Petitioner was trying to stabilize a floor scale and upon doing so his left thumb got stuck under a scale and the blunt medal end of a scale caught the thumb shearing the distal portion. The final diagnosis was partial amputation of the left thumb. Petitioner was life flighted to St. John's Hospital in Springfield, Illinois. (PX. 2)

On September 9, 2013, Petitioner arrived at St. John's Hospital and Dr. Berry from SIU HealthCare performed a complete amputation of the left thumb with a skin graft to complete closure. Dr. Berry's post operative diagnosis was left thumb amputation just distal to the DIP joint. (PX. 3)

On September 17, 2013, Dr. Berry performed a first dorsal metacarpal artery flap to the left thumb, involving the left index finger. Dr. Berry's post operative diagnosis was left thumb partial amputation with persistent tip wound. (PX. 3)

On September 25, 2013, Petitioner followed up with Dr. Berry for post operative visit. On physical exam, Petitioner's incision lines were clean, dry and intact. The flap appeared good and viable. There were no signs of infection. The assessment plan was to continue conservative management and see the patient back in ten days. Petitioner followed up with SIU HealthCare on October 7, 2013. The first metacarpal artery flap of the thumb was doing well. The doctor advised Petitioner to follow up in one week. (PX. 4)

Petitioner started physical therapy on October 21, 2013. The diagnosis was stiff left thumb and index finger following revision amputation of the left thumb for his dorsal metacarpal artery flap on September 17, 2013. Petitioner was to perform exercises and use a buddy strap. (PX. 4)

Petitioner next followed up with SIU HealthCare on October 21, 2013. Petitioner was healing well and there was no evidence of infection. Dr. Berry noted Petitioner's distal nerves ripped out along with the amputated part. Petitioner was to follow up in three weeks. (PX. 4)

Petitioner followed up with Dr. Berry on November 4, 2013. Dr. Berry noted Petitioner's sensation over the ulnar aspect of the kite flap did not improve significantly since the last time. (PX. 4)

Petitioner followed up with SIU HealthCare on December 20, 2013. It was noted the kite flap was well healed with no complications. Petitioner had a small amount of sensation in the kite flap but about 75% of it was insensitive. Petitioner demonstrated stiffness of the index finger on the left in both MC and PIP joints. He was unable to make a complete fist. Dr. Berry's recommendation was to continue with a hand therapy program to try to increase range of motion. (PX. 4) Petitioner was returned to work without restrictions.

On January 27, 2014, Dr. Berry stated Petitioner returned after mutilating hand injury. Petitioner was experiencing stiffness of his left index finger MCP at the kite flap but otherwise had good positioning with the thumb making progress in therapy. It was now four months out from the kite flap. Petitioner was to continue physical therapy and see him return on an "as needed" basis. (PX. 4)

Petitioner's final follow up with Dr. Berry was on March 17, 2014 (RX. 3) Dr. Berry noted Petitioner was six (6) months from trauma. Petitioner was having more mobility at the MP joint of the index finger after the kite flap. Petitioner could punch and grab between the thumb and index finger. Sensation was returning at the level of the kite flap, but it was not all sensate. Petitioner was released on an as needed basis.

On January 19, 2015, Respondent had Petitioner seen by Dr. Stephen F. Weiss for an AMA rating. Dr. Weiss found a total hand impairment at 33%, 27% upper extremity impairment and 18% total person impairment. (PX. 7)

Dr. Weiss' evidence deposition was taken on April 10, 2015. (PX. 7). Dr. Weiss testified he was a board certified orthopedic surgeon and treated amputations as part of his practice. (PX. 7, pg 4-5). Dr. Weiss stated he performed a physical examination and reviewed medical records. Dr. Weiss diagnosis was an amputation of the thumb and a digital implant for the index finger at the metacarpal with digital loss of motion. (PX. 7, pg 11). Dr. Weiss noted the left thumb revealed no independent motion of the remainder of the distal phalanx. The PIP joint was essentially fused. (PX. 7, pg 14). Also, Dr. Weiss noted Petitioner lacked distal flexion by three centimeters, meaning he did not have full range of motion of his index finger and he could not touch the flexion crease in the palm of his hand with his fingertips. (PX. 7, pg 15-16). The flexion of the MP joint at the left index finger was sixty (60) degrees. Dr. Weiss noted this is abnormal and should be in the neighborhood of ninety (90) degrees. (PX. 7, pg 16). Flexion of the left index finger at the PIP joint was seventy (70) degrees which Dr. Weiss noted was abnormal as it should be around one hundred (100) degrees. (PX. 7, pg 16-17).

Dr. Weiss testified Petitioner had a prior stroke and had lost some movement with his right side and had to rely more upon his left hand and arm. (PX. 7, pg 10).

Dr. Weiss testified Petitioner had loss of range of motion of his hand and that his injury would affect his ability to grip. (PX. 7, pg 23-24). Dr. Weiss also noted Petitioner would have mild to moderate difficulty to perform fine manipulation or skills such as holding a pen and opening a jar. (PX. 7, pg 25). Also the injury could limit his ability to lift certain items. (PX. 7, pg 26). Dr. Weiss testified Petitioner had a hand impairment of 33%, 27% of the upper extremity and 18% total permanent impairment in accordance with the Sixth Edition of the AMA guide. (PX. 7, pg 30).

On cross examination, Dr. Weiss admitted he made a mistake with the calculations and a total hand impairment was 30% instead of 33% 19% of the upper extremity instead of 27% and would be 16% of a person as a whole impairment instead of 18%. (PX. 7, pg 42).

Petitioner testified at trial he did not have the same grip strength in the left hand as he did prior to the accident. Petitioner stated he had a hard time picking up a cup of coffee or bottles. He also stated that if he goes through a drive-thru he can't reach out with his left hand and obtain the order. Petitioner testified he could open and close his hand but he could not make a complete fist. Petitioner testified when he returned to work he had to compensate for his left hand and could not perform all the job duties that he could perform prior to the amputation.

Petitioner testified that he did not receive a lump sum amount of money for his amputation until May 6, 2014.

Respondent placed into evidence two specific paychecks from September 14, 2013, through September 19, 2013; and September 15, 2013, through September 21, 2013. (RX. 1). The total amount of these two checks is $743.94. Respondent also put into evidence proof of payment of TTD benefits for those two pay periods. (RX. 2). Petitioner testified at trial the two September paychecks were vacation and sick pay.

In support of Arbitrator's decision relating to (J), were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services? The Arbitrator finds and concludes as follows:

Accident and causation have been stipulated by the parties.

Petitioner presented into evidence the following medical expenses incurred as a result of Petitioner's September 9, 2013 work accident:

St. John's Hospital	$16,613.00
OSF Hospital	$ 776.00
TOTAL:	$17,389.00

Based on the prior stipulation relating to accident and causation, Arbitrator finds the medical treatment to Petitioner with regards to his left thumb/hand injury was reasonable, necessary and causally related to a work accident of September 9, 2013. Respondent is entitled to a credit for all bills paid.

With respect to the issue of (L) What is the nature and extent of the injury? The Arbitrator finds as follows:

Pursuant to Section 8.1(b) 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's license to practice medicine in its the branches of preparing permanent partial disability report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but not limited to: loss of range of motion; loss of strength; measured atrophy of tissue, mass consistent with injury; and any other measurements that establish the nature and extent of the impairment.

(b) Also, the Commission shall base its decision on the following factors:

(i) The report level of impairment;
(ii) The occupation of the injured employee;
(iii) The age of employee at the time of injury;
(iv) The employee's future earning capacity; and
(v) Evidence of disability collaborated by medical records.

16IWCC0639

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

(i) Petitioner presented an AMA report which indicated a 30% impairment rating of the hand, 18% of the upper extremity and 16% of a person indicating residual loss of function with normal range of motion. The Arbitrator accords some weight to this factor.

(ii) With regards to (ii) Section 8.1(b) of the Act. Petitioner is a retired from manual labor work. Prior to retirement, Petitioner returned to his job without restrictions but had difficulty performing the tasks. The Arbitrator accords little weight to this factor.

(iii) With regard to (iii) Section 8.1(b) of the Act. Petitioner was 58 years old at the time of injury and is currently retired. The Arbitrator accords little weight to this factor.

(iv) With regard to paragraph (iv) of Section 8.1(b) of the Act. Petitioner worked for Respondent for 2 ½ years. Petitioner's return to his full duty job with no loss of earnings and subsequent voluntary retirement, the Arbitrator accords no weight to this factor.

(v) With regards to paragraph (v) of Section 8.1(b) of the Act. Petitioner's subjective complaints are collaborated by the treating medical records of SIU Health Care, OSF Hospital, and the AMA examiner. Petitioner sustained a left thumb amputation just distal of the DIP joint and first distal metacarpal artery flap to the left thumb that included the left index finger. Petitioner testified to a loss of range of motion, stiffness and pain, and difficulty with daily activities. These complaints are consistent with the nature of the injury, and by the examination of Dr. Weiss at the AMA evaluation on January 19, 2015.

The Arbitrator had the opportunity to review the medical records and to observe the Petitioner's testimony. The Arbitrator finds that the Petitioner's testimony is credible and consistent with the medical records.

The Arbitrator finds Petitioner sustained permanent partial disability to the extent of 50% loss of a left thumb in accordance with Section 8(e)(1) based on the amputation and 40% of the left hand in accordance with Section 8(e)(9) based on the substantial problems Petitioner demonstrated with his hand.

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

On September 9, 2013, Petitioner sustained an amputation of the left thumb. No evidence was presented that there are any issues in regards to accident or causation at time of amputation. Petitioner admitted into evidence the statutory payment of $18,981.00 that is dated May 7, 2014 (PX. 1). Petitioner testified at trial that he received his check in May of 2014. Based on this information, the Arbitrator finds a delay of 8 months for the statutory amputation payment is unreasonable and vexatious, and awards 50% of the statutory payment in penalties under Section 19(k) in accordance with Greene Welding and Hardware vs. Illinois Workers'

Compensation Commission. Also, Arbitrator awards Section 16 attorney's fees in the amount of $1,898.10 which represents 20% of the penalties under 19(k).

In support of Arbitrator's decision relating to (N), Is Respondent due any credit? The Arbitrator finds and concludes as follows:

Respondent placed into evidence proof of payment of TTD in the amount of $5,491.20. The records demonstrate Petitioner was temporarily and totally disabled from September 9, 2013, until November 24, 2013, or 75 days. The Petitioner's average weekly wage is $675.00 making his temporary total disability benefit $450.00. 10-5/7 weeks equates to a total benefit owed of $3,471.43. Thus, Respondent is entitled to a credit of $2,019.77 for an overpayment of temporary total disability benefits.

Respondent submitted into evidence paychecks to Petitioner from September 8, 2013, through September 21, 2013, totaling $743.94. These two (2) paychecks were paid in conjunction with TTD benefits. Petitioner testified these were not paychecks but payment for sick time and vacation. Based on this testimony, Respondent is not entitled to a credit for these payments in accordance with TEE-Pak, Inc., vs. Industrial Com., 141 Ill.App3d 520 (1986).

Petitioner placed into evidence 50% of the left thumb amputation payment made by Respondent of $18,981.00. (PX.1) Respondent is given a credit of $18,981.00 for the statutory payment.

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 Choose reason	☐ Second Injury Fund (§8(e)18)
			☐ PTD/Fatal denied
		☒ Modify (Wage/benefit rates)	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Lawrence Byington,

Petitioner,

vs. NO: 13 WC 40806

Mr. Bults, Inc. (MBI),

Respondent.

16IWCC0640

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

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

- Petitioner is a 47 year old employee of Respondent, who described his job as a tractor/trailer driver. Petitioner is a widower with one minor dependent son. Petitioner testified that he has a 12th grade education and that he has had no vocational or military training. Petitioner was not currently actively working but he was still an employee of Respondent. Petitioner testified that he believed he started working for Respondent

January 12, 2013; he had gone to their O'Fallon, Missouri station and talked to Nathan about employment. Petitioner noted that they discussed employment and he was given a W-2, paperwork and a company pamphlet. Petitioner stated that he completed the paperwork and was hired a few days later. Petitioner testified his position at O'Fallon was basically a tractor/trailer driver. He noted they had a 2 story (building) and trash was dumped on the top floor from the garbage trucks. Petitioner stated that there was a hole and a dozer pushed the garbage through the hole to the tractor/trailer below. Petitioner pulled the trucks out and got another trailer to put under the hole; it was all day long. Petitioner believed his hours then was starting at 5:00am and there was no set time for the end of the day. Petitioner testified that the last truck came in and all the garbage had to be off the upper floor and the tractor/trailers had to be ready for the drivers to come in and pick up and take to the landfill. Petitioner indicated his normal end time was 4:30-5:00, a few times he would be out at 3:30pm, but there were times he was there until 6:00 or 6:30pm. Petitioner testified that he worked that schedule 5 days per week and one scheduled Saturday per month. Petitioner indicated that he was working about 12 hours per day, 5 days per week. Petitioner stated that he had to talk to Nathan if there were questions regarding hours or schedule. Petitioner testified he had approached Nathan at the beginning of employment to discuss different hours, hour adjustment. Petitioner stated that was shortly after he had started. Petitioner noted that there were 3 guys in the yard and they could not leave until the floor was cleaned off. Petitioner indicated then he was hoping to get home by 4:00pm to be there when his son returned from school; he testified his request was denied, he had to stay there. Petitioner testified that he worked at the O'Fallon facility for a couple months; maybe 1/13—3/13. Petitioner stated that he then moved to the Madison, Illinois facility to the mechanic's shop to a different job than what he had started. Petitioner stated at Madison he was actually doing mechanics on the trucks, replacing transmissions and such things; he was not driving the trucks. Petitioner stated that he did have to lift in that job when they had to pull transmissions or work tires. The tires were the heaviest thing he had to lift on his own. He pretty much did transmissions and rear ends and they had jacks to move the several hundred pound parts. For that job he believed that Nathan approached Petitioner about that with another person. Petitioner indicated in that position there was supposed to be a pay increase and better hours so he could get home for his son; Petitioner believed he was paid $12.50 per hour when he first started in O'Fallon and then more when he switched positions. The new hours then, per Nathan, were like 5:00 to 2:30pm.; 5 days per week, sometimes 6 days. Petitioner testified that the schedule changed after being at the new position for a matter of weeks. Petitioner indicated then maintenance was getting behind so Nathan said they had to get it done. Petitioner was promoted and was checking out all the trucks, pre-tripping and getting trucks started for the drivers. There were times he was there at 2:00am on a pretty regular basis; 2:30pm was still his regular quitting time, 5 days per week. Petitioner indicated he was the only mechanic at the shop. Gene was the trailer mechanic, and there was a third guy there occasionally but he mostly worked out in the field. Petitioner viewed PX18 and testified that it was evidence of his average weekly wages; it indicated that Petitioner did not work less than 47 hours per week and often

worked 55 to 78 hours per week. Petitioner testified that hours over 42 hours were not voluntary as he understood. He indicated that if he did not work the hours he would not have a job. He did not ask for a reduction in hours in Madison as requests in O'Fallon had been denied. It was noted that the 1st week he worked was only 2 days for 20 hours and $240.00. He worked Christmas week and he had received a bonus of $200 in a card. Petitioner agreed the last week noted on the exhibit was a partial week, January 17, 2014 for $372.81.

- Petitioner agreed when they filed this claim the date of accident was noted as June 2015; he did not recall the exact date, but he believed it was near the end of the month and it was a typical workday until he was hurt. Petitioner believed it had occurred between 10:00 and 10:15 and he had started at 2:00 that day so he had already then worked about 8 hours and had to work until 2:30pm. Petitioner testified, that on the date of accident the rear window was coming out of the rubber seal on he believed truck 527. Petitioner testified that he was short and able to stand up inside the middle of the cab to put the window into the seal. Petitioner stated that he was facing the back of the truck and he went to get out between the seats and got to the front seat and stepped off to the left to exit the truck. Petitioner testified that he was moving his feet towards the door and he went to step out onto the step and get to the fuel tank and ladder. Petitioner stated that he put his foot out to the step and noted the driver had a broken broomstick on top of the step that Petitioner did not see. Petitioner stated that the broomstick is used to dip into the fuel tank as the fuel gauges do not work on the trucks. He indicated normally the broomstick is stuck in the valley by the round gas tanks. He stated that the driver had the stick on top of the step with a bungee cord wrapped around it and when Petitioner put his foot on it and transferred his weight to his left foot, that was when the broomstick rolled off the step and his foot rolled off the step. Petitioner stated that he felt himself falling from the cab so he grabbed a handle to help get into the truck, and he went down. He felt pain when he drove his knee into the step and his right foot was tangled up in the doorjamb. Petitioner stated that he caught himself from hitting the floor completely. He eventually got off the truck and told Nathan, who was standing behind the truck, that he had fallen from the truck. When he fell backwards he grabbed the handle with his right arm and braced himself with the left; the window was down and he put his hand up on the door and grabbed. He did prevent himself from hitting the ground. Petitioner stated at that time basically he had arm and knee pain. He noted the steps are a corrugated metal for traction and he drove his knee into it so it hurt. He indicated his back was hurting; he did not recall then if his neck was hurting, he thought the neck pain was later that day. He again noted it occurred at the Madison City, Illinois mechanic shop. Petitioner testified since the accident he had difficulties with his work activities. Petitioner again noted immediately after the accident he told Nathan Wilson who was behind the truck with a couple other guys. Petitioner thought Nathan saw the accident as when Petitioner looked back after the fall, Nathan was looking in Petitioner's direction, but he did not know if Nathan was focusing on him or something else, but Petitioner had gone and reported what happened. Petitioner stated that he was not taken to the office to file an injury

report. Petitioner indicated Nathan basically asked if Petitioner needed a doctor right then and suggested Petitioner take some Ibuprofen and get back to him later. Petitioner did finish his shift that day and he was in pain during that time. Petitioner testified that he was in pain the next day as his whole body was hurting, but it was his right shoulder, knee, neck, and back, everything. Petitioner indicated he tried to reach out to Nathan several times to tell him that he needed to go to a doctor, but Petitioner indicated that Nathan did a lot of driving around so he was not in the shop every day. Petitioner had communicated via texting. Petitioner stated he also had communicated with Gene the trailer mechanic. Petitioner indicated he made efforts to get sent to a doctor for at least 2 weeks before he told Gene one day that he did not know how long he could stay that day, but he was going to leave and go to a doctor on his own. Petitioner stated that Gene said to wait and he texted Nathan. Nathan came about 30 minutes to an hour later and they talked before Nathan then sent Petitioner to Concentra. Petitioner assumed an injury report was then done as he was filling out something, but Petitioner was not sure what it was. He would not disagree if documents and records indicated July 9, 2013. Petitioner indicated that they also send Petitioner to a doctor, Dr. Zahid at Concentra (PX 1), that day. Petitioner indicated the doctor looked at him and put him down for therapy twice per week, but Petitioner did continue working. Petitioner indicated the doctor was nice but there were communication issues as Petitioner could not understand him. While waiting at the doctor's office Petitioner filled out forms that asked what the injuries were and why he was there. No one explained how to fill out the forms. Petitioner testified that he probably did indicate back and knees hurting then as that was what was hurting most. He did explain to the doctor other areas he had injured, including shoulder, neck, knee and back. He may not have identified neck and shoulder on the form as the other areas were hurting more then. Petitioner saw Dr. Zahid for about a month and was then referred to Dr. Khariton at the Manchester Concentra (PX 2). Petitioner did recall telling Dr. Khariton of all the body parts that were bothering him, including his neck, shoulder, back and knees. The initial record there noted the referral for back pain, right neck pain, and right upper extremity paresthesia. Petitioner testified that after he saw Dr. Khariton, Respondent sent Petitioner to see Dr. Coyle for the back and neck complaints. Petitioner testified to being given restrictions of no lifting over 20-25 pounds. Petitioner returned to Respondent with the restrictions but Respondent had him doing more than the restrictions. He stated he was still doing tire and transmission repair. He indicated he did 2 transmissions and 3-4 rear ends after he had the restrictions by Dr. Khariton. Petitioner testified Respondent did not give him work that was within the restrictions; all was beyond the restrictions.

- When Petitioner saw Dr. Coyle he did complain of his neck and back and the doctor did put Petitioner on light duty restrictions; about the same restrictions. Petitioner believed despite the restrictions he continued to work outside the restrictions and that caused more pain and affected his symptoms. Petitioner believed in the beginning he had one rotator cuff tear and when it was done he had 3 tears in his rotator cuff, per the last doctor. He was not sure about his knee, neck, and back. Petitioner viewed PX 3, Dr. Coyle's records,

and stated that they had not explained how to fill out the chart; identifying the percentage of pain in the various places. He identified arm was 50%, leg was 25% neck and back were 85%. Petitioner complained to Dr. Coyle of the neck, back and other parts. Petitioner recalled Dr. Coyle ordered a cervical MRI. Petitioner testified to seeing a Dr. Nogalski on referral from Dr. Coyle, he believed regarding the shoulder and knee. Petitioner did not recall when he first saw Dr. Nogalski (11/6/13 per records). He had follow-up with Nogalski but he did not recall a diagnosis from him or opinion regarding the injury. Petitioner testified that Dr. Nogalski did schedule surgery he believed December 10 for the right shoulder, but that was not done as WC cancelled it. Petitioner testified that Dr. Nogalski told him the mechanism of injury and need for surgery was directly related to the '7/9/13' accident. Respondent did not send him to a doctor after the surgery was cancelled. Petitioner then hired counsel and he chose to see Dr. Droege who started therapy on the knees, neck, beck, and shoulder and referred Petitioner for MRI's. Petitioner was also then referred to Dr. Solman for the shoulder and Dr. Bradley for the knee. Petitioner testified that Dr. Solman told him the cause of the injury was the work incident and stated that Petitioner needed surgery. Dr. Solman did perform the surgery and after surgery Petitioner stated that therapy was performed on his shoulder by Dr. Droege. Dr. Bradley treated Petitioner's knee and told him the work injury caused the need for surgery proposed; that surgery was not done. Petitioner did wear a sling/brace after the shoulder surgery. Petitioner did see Dr. Wilke regarding his neck and back and Petitioner testified that the doctor wanted to do neck and back surgery. Petitioner had no back and neck treatment with any doctors since Dr. Wilke. After Dr. Droege, Petitioner did not have further therapy for the neck and back. Petitioner testified that Dr. Droege took him off work December 31, 2013 and Petitioner testified that he has not been back to work since then. To the best of his knowledge he was still employed by Respondent and no one had asked when he would return to work.

- Petitioner testified that currently his knee was hurting with walking around, sitting, standing, and his back was killing him and his neck hurt. Petitioner testified that the surgery definitely helped his shoulder. The shoulder feels good but he cannot throw a football, but it is better as he is still in recovery; it is not as good as before the accident. Petitioner testified that his neck is sore all the time and he does have to stretch his neck. He does have numbness in his finger and thumb and his neck does affect his ability to sleep as he wakes at night every 1.5-2 hours because of it. He has difficulty falling back to sleep after waking. Petitioner indicated he does not have full ROM with his neck; he can somewhat turn his neck without turning his shoulders. He indicated when he moves his neck it makes noises; pops, cracks, and hurts. He does have shoulder recovery pain now that does not wake him from sleep. He indicated it was either his neck or back that wakes him from sleep all the time. Petitioner indicated he can sit for about 45 minutes then he starts to hurt and he has to twist, move, reposition, and stand up. He indicated standing too long it goes down his right leg and he gets butt numbness and his foot goes numb. His right knee is painful and he has problems on steps. He cannot get up from sitting without knee pain; he can barely put any pressure on it. His knee makes noises and

he constantly has to change positions. He was not taking any current prescription medications for pain; just Ibuprofen and Tylenol. Petitioner testified that he cannot throw a football, baseball or snowballs with his son. Petitioner indicated he has difficulty with laundry and cooking and he cannot reach up in the cabinet for spices, he has to use a stool now. Petitioner does have a grandchild that he has not been able to hold and he cannot play football with his 7 year old grandson. Petitioner testified that he does ride a motorcycle (Harley); pretty much a recreational activity for him; he had been riding since he was 14. Petitioner did ride a lot before the accident. He indicated they used to ride to Tennessee, Ohio, Illinois, and Iowa before. He stated now he can ride 20 minutes down the road and he has to stop and stand and walk, and get limbered up again, and then ride another 20 minutes. Petitioner testified his cycle riding has definitely been limited since the accident. Petitioner agreed he had posted on social media (Respondent exhibit) about bike riding. He indicated he does a 45 mile ride in 2 hours as he has to stop. He does have a car. He indicated in his present condition it was easier on the bike as he has a very comfortable seat and he can easily get on and off it rather than getting in and out of car or truck and he indicated the bike much better to ride. He testified he cannot just turn his neck, he turns his shoulders too, so it is easier on the bike for that, and there are no windows so his vision is better driving the bike. Petitioner indicated it would not be accurate if anyone said he rode a BMX bike and did jumps

- Petitioner agreed he had prior injuries, 2001-2002 and he had prior surgery in 2000. Petitioner had previously seen a Dr. Krause regarding a WC injury. Petitioner stated that he last saw Dr. Krause for a knee brace about 2010-1022 as Petitioner was doing martial arts then and he wanted to protect his knee. He did martial arts prior to this injury but he never was hurt doing that; he wanted the brace to protect his knee from kicks, and jumps and things as he had the prior knee surgery and he had no knee pain complaints at that time that he recalled. He may have then had some knee discomfort as he had his knee carved up so there was pain there; he indicated at that point he wanted the knee brace and he felt he was in perfect condition. When he saw Dr. Krause for the knee brace the doctor did not say Petitioner needed surgery. He had neck or shoulder pain prior about 2010-2012 and he had seen Dr. Burns and Dr. Lieb for those complaints and he did recall a CTS diagnosis then; the pain was radiating from his wrist up into his shoulder and neck. The doctors then did not diagnose any neck or shoulder problems that needed treatment. He still has the CTS and he had a brace/band to wear for a time that alleviated the complaints. He then did not continue to have neck/shoulder pain. Petitioner did not have neck/shoulder pain immediately before this accident. Petitioner saw Dr. Orell for the knee surgery in 2000. Immediately prior to this accident he did not have ongoing complaints or pain or loss of range of motion in his neck, back, shoulder or right knee. He indicated if anything this accident exacerbated/aggravated his prior injuries

- Mr. Winton testified he has been the terminal manager for Respondent for 13.5 years. He was familiar with Petitioner through work and he was Petitioner's supervisor at the time

of the alleged accident. Mr. Winton stated that he was actually in his office when the accident happened and Gene came to the office and told him Petitioner fell. Witness stated that he went to the shop floor, at the back of the truck, and saw Petitioner and talked to him about it. He did not witness the accident. Mr. Winton completed RX 7, accident report, and he reviewed it here. He indicated he typed what they told him of how the accident happened and where the injury was. He completed the form with Petitioner and he included as much detail as possible. He stated the only thing Petitioner said was he bumped his knee and his back was a little sore; he testified there was no mention of the right shoulder or cervical complaints. Mr. Winton stated per the report the incident occurred July 9, 2013. He indicated Petitioner did not request to go to a medical provider after the incident. He believed the report was done the same day Petitioner went to Concentra, or 1-2 days prior. The report was closer to July 18-20, 2013. He testified after July 9, 2013 Petitioner continued to work full duty. Mr. Winton stated Petitioner's job duties were changing tires, grease jobs, transmissions, rear ends, brake chambers; minor repairs, and some major, transmission repairs. He did not recall Petitioner saying anything about right shoulder or cervical complaints. He agreed that after Petitioner went to Concentra he was given light duty restrictions and he did not agree that Respondent did not accommodate the restrictions. He stated Petitioner was told to take it easy; they had Petitioner doing grease jobs and such things. Witness testified that they found Petitioner was doing transmissions, major repairs, but he stated Petitioner was never told to do that. He was not in the shop all the time to see if Petitioner was exceeding the restrictions. He indicated it was rare he was out in the shop as there was paperwork and chasing around 25 drivers and he had 15 employees so he was not in the shop all that much but he stated Petitioner was told to take it easy.

- Mr. Winton testified that prior to this incident he told the guys they were going to cut back to a maximum 50 hours. Most guys wanted more hours because of bills, and he stated Petitioner had a long drive and had gas expense. He indicated it was pretty much left up to them but they were told they were cutting back to 50 hours. Mr. Winton testified that the normal hours were 50-60 hours per week; he stated it was not required but that was what they felt they needed to make their bills. He stated the typical workweek would be closer to 50 hours, and he testified, that was of their own choosing. He agreed over 40 hours was when overtime kicked in, at time and a half. He stated in the shop they alternated one Saturday per month; 4 per year at O'Fallon. Mr. Winton agreed he told Petitioner he had to stay until the trucks were done unloading (at O'Fallon); he stated they all stayed until the floor was cleaned. He stated it was not 6:00pm, he stated the facility shut down at 4:00 and it did not take an hour to finish cleaning so 4-5 was normal being out of there. He stated it was mandatory they be there to clean up. Petitioner had transferred to Madison. He stated Petitioner mentioned he needed to be home for his son and they did start getting behind on services and he told Petitioner he had to be there when trucks were parked so he did not tell Petitioner to come in at 2:30 as Petitioner suggested. He stated Petitioner suggested coming in earlier, service equipment and get

the guys started in the morning. Mr. Winton testified he did not tell Petitioner a specific time he had to stay until; he testified that was up to Petitioner.

- Mr. Jackson testified that he has been a mechanic for Respondent for 4 years and he knew Petitioner as a co-employee. He was employed with Respondent on July 9, 2013. Witness testified that he did not witness the accident; he was in the next bay. Mr. Jackson stated what he remembered was walking to the office and he looked over at Petitioner, he was limping, and he asked what happened. Witness testified that Petitioner said he fell off the truck. He stated he was on the way to the office and he told Nathan he might want to check Petitioner as Petitioner said he fell off the truck. Mr. Jackson indicated Petitioner then did not complain of particular pain in certain areas to him then. He was aware later Petitioner hurt his knee and it was pretty painful after. He did not recall Petitioner having shoulder problem until 6-8 months prior to date of hearing when Petitioner came to pick up some tools from the shop and his arm was in a sling and he asked Petitioner and Petitioner told him it was part of the accident. Mr. Jackson is not in the position there to handle Workers' Compensation claims and he has no authority in that regard. He agreed after the accident Petitioner did not ask him about medical care. As to hours and wages at Madison, witness stated he was hired by the prior manager to work 6:00am to 2:30pm and no Saturdays. He stated after Nathan arrived they got a little busier so they were required to work a Saturday per month, 6-2:30. He agreed anything over 40 hours was overtime; he stated that was not mandated by Nathan. He indicated generally if they asked they could leave early.

- Mr. Wilson testified that he has been a driver for Respondent for 2.5 years. He had occasion to meet Petitioner as a laborer at the O'Fallon location and he knew Petitioner was then a mechanic at Madison. He was with Respondent in June 2013. He was listed as a witness on the accident report. He did recall Petitioner was up in the air on a fuel tank and it looked like he stepped back, and he stated there was a bungee cord and Petitioner kind of fell back and had grabbed the rail; he did not recall him falling to the ground; he indicated he was 4-5 feet away. He did not recall Petitioner's pain complaints then. He stated at the time he had been on light duty in the office. He did not recall Petitioner hitting his knee.

The Commission finds that there was some issue of the exact date of accident and the timing of reported symptoms to the various doctors, but different doctors treated different injuries based on their specialty/focus of practice. Petitioner's testimony is not totally rebutted. There is a pretty clear and fairly consistent described mechanism of injury of stepping out of the truck cab onto the broom handle and slipping, twisting and grabbing the bar and twisting/hitting the knee causing injury to multiple body parts; those being addressed by the various specialists. Petitioner clearly had multiple pre-existing conditions and prior injuries, but there is no evidence of treatment to the various conditions for some time prior to this incident and clearly Petitioner continued to work, including significant overtime, preforming his various job duties prior to this

incident. Based on the accident report and some medical records, the date of accident is evidenced as July 9, 2013.

The Commission, with the supporting evidence and testimony, finds that Petitioner clearly met the burden of proving accident that occurred July 9, 2013. While Petitioner obviously had the pre-existing conditions and prior accidents, he had been working and subsequent to the accident received the care for the various body parts affected that follow a causal chain that evidences an aggravation/acceleration of the pre-existing conditions. Furthermore the treating records indicate a causal connection and some opinions as to an aggravation/acceleration type of injury. The evidence and testimony finds Petitioner met the burden of proving accident and further met the burden of proving a causal relationship to his current condition of ill-being. The Commission finds the decision of the Arbitrator as not contrary to the weight of the evidence, and, herein, affirms and adopts the Arbitrator's finding of accident that arose out of and in the course of employment and also affirms and adopts the Arbitrator's finding as to causal connection to Petitioner's current condition of ill-being.

The Commission notes that as to the admission of Dr. Nogalski's report that Respondent argued that the Arbitrator's decision allowing Dr. Nogalski's December 2, 2013 narrative report into evidence was incorrect and must be overturned. Respondent argued Petitioner was not evaluated in conjunction with the report and the report was addressed to the carrier and should have been excluded from evidence. The Commission takes notice that Respondent did not indicate and preserve this as an issue on Review. Regardless, Dr. Nogalski's records were admitted via other treating records (his partner) with no objection. It is a non-issue as Respondent did not properly preserve the issue on Review.

The Commission, regarding wage/benefit rates, with the supporting evidence and testimony, finds that the hours of the job were clearly over 40 hours weekly, regularly, whether considered 'mandatory' or not. Respondent witnesses indicated they clearly worked more than 40 hours per week, 50+, though the supervisor indicated the overtime was if the employee wanted to. In addition to Petitioner's testimony, Respondent's payroll exhibit evidenced overtime in the vast majority of weeks; most 50+. Overtime is clearly normal and regular

	Hours	per hour	week-straight hourly rate
1. 1/25/13	20	$12	$240
2. 2/1/13	50	$12	$600
3. 2/8/13	59.5	$12	$714
4. 2/15/13	54.5	$12	$654
5. 2/22/13	54.5	$12	$654
6. 3/1/13	55.5	$12	$660
7. 3/8/13	57.5	$12	$690
8. 3/15/13	56.5	$12	$578
9. 3/22/13	58.5	$12	$643.50
10. 3/29/13	59.5	$12	$714
11. 4/5/13	59	$12	$708

12. 4/12/13	58.5	$12	$702
13. 4/19/13	48	$12	$576
14. 4/26/13	59.5	$12	$714
15. 5/3/13	47	$12	$564
16. 5/10/13	58	$12	$696
17. 5/17/13	57.5	$12	$690
18. 5/24/13	57	$12	$684
19. 5/31/13	62	$12	$744
20. 6/7/13	59	$12	$708
21. 6/14/13	57.5	$12	$690
22. 6/21/13	59	$12	$708
23. 6/28/13	58	**$16**	$928
24. 7/5/13	60	**$16**	$960
25. 7/12/13	65	**$16**	$1,040
			===========
			$17,259.50 total for 25 weeks

25 weeks==**AWW=$690.38; TTD=$460.25; PPD=$414.23**
Accordingly, the Commission finds the decision of the Arbitrator as contrary to the weight of the evidence, and, herein, modifies average weekly wage and benefit rates as indicated above.

The Commission, with above finding of accident and causal connection, finds evidence of the medical restrictions and/or off work medical authorizations to affirm and adopt the decision, except for the temporary total disability (TTD) rate as noted above. The Commission finds the decision of the Arbitrator as not contrary to the weight of the evidence as to the period of lost time, and herein, affirms and adopts the Arbitrator's finding as to total temporary disability period awarded but modifies as to the TTD rate at $460.25 per week.

The Commission, with the evidence and testimony, and the above findings of accident and causal connection, finds evidence of the medical care ongoing to the various injured body parts. The evidence and testimony finds Petitioner met the burden of proving entitlement to the medical expenses and prospective medical care as awarded. The Commission finds the decision of the Arbitrator as not contrary to the weight of the evidence and, herein, affirms and adopts the Arbitrator's finding as to medical expenses/prospective medical care.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of **$460.25** per week for a period of 73-3/7 weeks ($33,795.40 total TTD-Respondent entitled to $10,756.08 for TTD benefits paid), 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 $156,930.43 for medical expenses under §8(a) of the Act and Respondent shall authorize and pay for any medical treatment recommended by Dr. Bradley, Dr. Solman, and Dr. Wilkey, including but not limited to, surgeries as provided under §8(a) and §8.2 of the Act, and, Respondent shall receive credit for any §8(j) medical paid and hold Petitioner harmless for which Respondent shall receive such credits.

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: OCT 3 - 2016
o-8/4/16
DLG/jsf
045

David Gore

Stephen Mathis

Mario Basurto

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

BYINGTON, LAWRENCE
Employee/Petitioner

Case# **13WC040806**

MR BULT'S INC (MBI)
Employer/Respondent

16IWCC0640

On 2/17/2016, 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 0.41% 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:

5382 JOHNSON GRAY LLC
RICHARD K JOHNSON
770 CARONDELET AVE SUITE 303
CLAYTON, MO 63105

0000 WIEDNER & McAULIFFE LTD
KRISTOPHER DUNARD
8000 MARYLAND AVE SUITE 550
ST LOUIS, MO 63105

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Lawrence Byington
Employee/Petitioner

v.

Mr. Bults, Inc. (MBI)
Employer/Respondent

Case # **13** WC **040806**

Consolidated cases: **N/A**

16IWCC0640

An *Application for Adjustment 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 K. Nowak**, Arbitrator of the Commission, in the city of **Collinsville**, on **May 27, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

B. ☐ Was there an employee-employer relationship?

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

D. ☒ What was the date of the accident?

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

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

G. ☒ What were Petitioner's earnings?

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

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

J. ☒ Were the 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 **The admissibility of exhibits**

FINDINGS

On the date of accident, **7/9/2013**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the 24 2/7 weeks preceding the injury, Petitioner earned **$17,299.56**; the average weekly wage was **$712.33**.

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

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

Respondent shall be given a credit of **$10,756.08** for TTD, **$0** for TPD, **$0** for maintenance, and **$8,400.74** in other benefits, for which credit may be allowed under Section 8(j) of the Act, for a total credit of **$19,156.82.**

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $474.89/week for 73 3/7 weeks, commencing 12/31/13 through 5/27/15, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from 7/9/13 through 5/27/15, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall be given a credit of $10,756.08 for temporary total disability benefits that have been paid.

Respondent shall pay reasonable and necessary medical services of $156,930.43, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit of $8,400.74 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 any medical treatment recommended by Dr. Bradley, Dr. Solman and Dr. Wilkey including, but not limited to, surgeries as provided in Section 8(a) and 8.2 of the Act.

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

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

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

Signature of Arbitrator

2/10/16
Date

ICArbDec19(b)

FEB 17 2016

FINDINGS OF FACT

Petitioner, a 49 year old widower has worked for Mr. Bults, Inc. (MBI) since January of 2013. He has one minor child. He was hired at the O'Fallon, Missouri, facility but then transferred to the Madison, Illinois, facility in Madison County, Illinois. When initially hired Petitioner drove trucks at Respondent's facility in O'Fallon. That facility was a two story enclosure with a large hole in the floor of the upper level. Garbage trucks would pull into the upper level, dump the garbage on the floor, and depart. Tractors would then push the garbage through the hole into a trailer located on the floor below. When loaded these trailers would be pulled into the holding area until trucks came to haul the garbage to the land fill. New trailers would then be placed beneath the hole. Petitioner testified that while his daily schedule would fluctuate depending on when the work was completed he was required to stay at work until the work was done. Respondent's terminal manager, Nathaniel Winton, confirmed "It was mandatory because they all had to do their part in cleaning up." (T 117). Petitioner testified that he remembered working between 55 to 78 hours a week. His wage records however show that he typically worked between 50 and 60 hours per week. (PX18, RX9) Petitioner requested a reduction in hours so he could be at home when his son returned from school. This request was denied.

In approximately March of 2013 Petitioner transferred to Respondent's facility in Madison, IL where he worked as a diesel mechanic. Petitioner testified he made this move because he was told the hours would be 5:00 a.m. to 2:30 p.m. which would allow him to be home for his son. Petitioner testified that "maintenance was getting behind so Nathan was saying we had to get the maintenance done. Then I got promoted, I guess, to checking out all the trucks, pre-tripping the trucks and getting trucks started for the drivers, so on and so forth, and, I mean, there were times I got there at two o'clock in the morning." (T 26) He indicated he would regularly work from 2:00 a.m. to 2:30 p.m. Petitioner testified this overtime was mandatory. Mr. Winton testified:

> "He had mentioned that, you know, he needed to be home for his son and we did start getting behind on services and I told him, you know, that he had to be there when the trucks were parked so I didn't tell him to come in at 2:30, that was what he suggested, he would come in earlier, service equipment and then get guys started in the morning....I didn't tell him a specific time that he had to stay 'till...." (*Id.*, at 117-118)

Mr. Winton further indicated Petitioner's quitting time "would have been up to him." (T 118) Gene Jackson, a coworker of Petitioner at the Madison facility, testified that "[w]hen I was hired I was <u>required</u> to work 6:00 to 2:30 and no Saturdays.... That was the previous manager. When Nathan came we were a little busier and the need for Saturdays was there so my time was the same except for we were required to work one Saturday a month. (T. 131) (emphasis added) When specifically asked about overtime, Mr. Jackson indicated that any hours over 40 were considered overtime. When asked if overtime was "something that is mandated by Nathan," he replied "No." On cross examination Mr. Jackson testified his current hours were from 3:00 a.m. to 3:30 p.m. He then volunteered "...I'm required to be there 40 hours. I choose to work more because I provide for my family, nobody else." (T 136)

Petitioner claims that he sustained injuries to his neck, right shoulder, right bicep, back and right knee when he slipped on a broomstick which was attached by a bungee cord to the step of the cab of the truck that he was repairing. Petitioner testified that on the date of the injury he started work around 2:00 a.m. and the injury

occurred around 10:15- 10:20 a.m. Petitioner testified that he was facing the back of the truck and stepped off to the left to exit the truck. His foot landed on the broomstick which rolled off the step and he fell from the cab of the truck. He stopped his fall by grabbing a handle with his right arm, driving his right knee into the step and causing his right foot to get tangled in the doorjamb, twisting his whole body. He was able to keep himself from hitting the floor by grabbing the handle and the door. Warren Wilson, another coworker, corroborated this testimony. He indicated ..."I remember Lawrence was up in the air on a fuel tank working on the side of a truck. Looked like he stepped back. I think there was like a bungee cord there and he kind of fell backwards. He grabbed onto the rail." (T 139). Petitioner testified that he felt immediate pain to his neck, right shoulder and arm, back and right knee. Petitioner reported the injury to Nathaniel Winton on the date of injury. Petitioner's testimony in this regard is corroborated by Mr. Winton as well as his coworkers.

Petitioner testified that he could not remember the exact date of the injury but believed it to be the end of June. Mr. Winton testified that the injury occurred on July 9, 2013. Petitioner and Mr. Winton also testified that the Employer's First Report of Injury was not filled out on the date of injury, but on the date he was first sent for medical treatment. Mr. Winton also testified that he dated this report incorrectly and the date shown on the Employer's First Report of Injury, "May 20, 2013," is wrong and was a typographical error. (T 112-119) He indicated it should have been dated "July 20th maybe, July 18th." (T 112)

Petitioner was treated at Concentra in Hazelwood, Missouri, from July 18, 2013, until July 29, 2013 at the referral of Respondent. The type written Record from the initial visit indicates that he had complaints to his back and knee. (PX1 at 17) However, the pain diagram from the same date indicates symptoms to the lumbar spine, right knee, and right shoulder. (*Id.*, at 16) Petitioner testified that he also reported pain in his neck, shoulder and arm but that Concentra did not document these. He was placed on restricted duty at the initial visit. (*Id.*, at 19) On July 29, 2013 Petitioner was referred to Dr. Khariton, a physiatrist at the Concentra facility in St. Louis, Missouri. (*Id.*, at 8)

Petitioner first saw Dr. Khariton on August 23, 2013. The note from that visit indicates "[t]he patient was seen today at the suggestion of Dr. Zahid for evaluation of low back pain, right neck pain and right upper extremity paresthesia." (PX2 at 76) During his second visit MRIs of Petitioner's cervical spine, lumbar spine and right shoulder were ordered. (*Id.*, at 78) When Petitioner returned on September 20, 2013 The MRIs had not been authorized, and physical therapy was ordered. (*Id.*, at 79) Petitioner was last seen at Concertra on October 9, 2013. On that date it was noted that "physical therapy has not yet been approved." (*Id.*, at 80) Trigger point injections in the lumbar paraspinal muscles were performed on this date as well. (*Id.*) He was to follow up in one week.

Respondent sent Petitioner to Dr. James Coyle on Oct. 16, 2013, for injuries to his neck, back and right shoulder. (T. 46) MRIs were obtained on Oct. 23, 2013, which showed annular disc bulges at L4-5 and L5-S1, disc bulging at C4-5, C5-6 and C6-7, and numerous tears in the right shoulder, including a complete full-thickness tear of the supraspinatus tendon with retraction. (PX3 at 96-99) Dr. Coyle recommended referral to a shoulder specialist. For the lumbar and cervical spine he recommended physical therapy and referral to a physiatrist for consideration of epidural steroid injections. (*Id.*, at 88) He was continued on light duty.

Petitioner was then sent by the Respondent to Dr. Nogalski. Petitioner first saw Dr. Nogalski on Nov. 6, 2013, for evaluation of his right shoulder. The records of Dr. Nogalski were admitted into evidence without objection with the exception of an Addendum which was generated on December 2, 2013. Before generating the report at issue on December 2, 2013, the doctor had seen Petitioner on two prior occasions. On the first visit the doctor modified Petitioner's physical therapy and prescribed medications. When Petitioner returned to Dr. Nogalski on November 20, 2013 he remained symptomatic and Dr. Nogalski recommended a shoulder arthroscopy and probably rotator cuff repair. Respondent made no objection to the admission of the notes regarding these two visits. Respondent then initiated an ex parte communication with Dr. Nogalski within which he was provided a report from a February 25, 2011 MRI. At the time of this communication, Dr. Nogalski's recommendation for surgical intervention was still pending. The Arbitrator addressed the admission of this note in the Conclusion section below. Following review of the MRI study from Feb. 25, 2011 Dr. Nogalski noted that there was tendinopathy of the subscapularis and intersubstance injury without frank through and through tear. Dr. Nogalski states that, "His mechanism of injury as well as physical findings support that the need for surgery is directly related to the claimed slip and fall from 7/9/2013. There are indeed underlying tendinopathic issues within the shoulder but there does appear to be at minimum, a small full thickness tear in the study of 10/23/2013 and his ongoing symptoms suggest that he does indeed have supraspinatus problems which continue. It therefore appears that his claimed 7/9/2013 event would be the prevailing factor in his need for surgical intervention on his shoulder." (PX4 at 107) Petitioner testified that surgery was scheduled by Dr. Nogalski for his right shoulder in December of 2013, but that "It got cancelled by work comp." (T 54)

Petitioner then began seeing Dr. William Droege, D.C., who ultimately recommended an MRI's of Petitioner's right knee which was performed on Jan. 27, 2014. The study showed an extensively macerated and torn medial meniscal body and posterior horn, absent ACL and suprapatellar effusion with debris. (PX5 at 117-118) Petitioner was then referred to Dr. Bradley.

Petitioner's counsel sent him to Dr. Keith Wilkey on February 11, 2014. (PX12) Dr. Wilkey testified by way of deposition. He diagnosed rotator cuff pathology in the right shoulder; injured cartilage of the knee and potentially the meniscus as well; herniated discs in his neck with right arm radiculopathy; and injury to the disc at L5-S1 with some evidence of right leg radiculopathy. (PX13 at 11) With respect to causation Dr. Wilkey testified:

> With regards to the things that I'm going to opine upon, that's going to be his cervical and his lumbar condition. Without a doubt he had preexisting cervical disease. You can't have the changes that I noted on those studies without having some type of degeneration occurring over a time period—I hate that word—let's call it osteoarthritis developing over a certain time period. However, he was essentially asymptomatic in both his neck and his lower back, so I opined, and I will continue to opine, that at least the accident aggravated his neck and back condition." (*Id.*, at 12)

Dr. Wilkey last saw Petitioner April 6, 2015. At that point Petitioner still had cervical and lumbar symptoms. With regard to the cervical symptoms the doctor noted that his shoulder surgery had resolved many of his symptoms, but he continued to have axial neck pain. He recommended waiting an additional two months to see if the condition resolved. If it did not he would proceed with an "ACDF at C6-7." (PX12 at 315) The doctor

also wrote "The lumbar spine will be watched at this point. He is due to undergo evaluation and treatment for his knee problem with Dr. Bradley, and this may help his back pain. That remains to be seen, however." (*Id.*)

Dr. Bradley first examined Petitioner on Feb. 24, 2014. Dr. Bradley testified by way of deposition. He indicated that with regards to Petitioner's knee, the radiographs showed that he had some previous degenerative disease and an ACL deficient knee. (PX9 at 8-9) However, Dr. Bradley further noted that this work injury exacerbated that preexisting condition and was the reason that he currently needs medical treatment. (*Id.*, at 9) Dr. Bradley testified that both he and Dr. Krause, the Respondent's IME doctor, agree that the Petitioner had some fairly severe preexisting disease and arthritis. However, Dr. Bradley continued, "What I disagree with and what I continue to believe to today is that Mr. Byington was able to do a fairly physically-demanding job that required him climbing in and out of semi-trucks, on ladders, crawling around in tight spaces. And the guy—the guy was able to do this on a daily basis without missing any time from work. So, you know, the fact that he had a fairly significant injury, a fall twisting his knee, and is now unable to do activities he was able to do prior to the injury led me to believe that the injury is certainly a contributing factor towards his ongoing pain and symptoms and need for continued treatment." (*Id.*, at 13) Dr. Bradley recommends a total knee replacement and states that he does not feel that anything short of a total knee replacement would give him the pain control and function that he needs to return to work. He also testified that he thinks his chance for success with the total knee replacement is still very good despite the delay in treatment due to the legal process. (*Id.*, at 15-16) Dr. Bradley referred the Petitioner to his partner, Dr. Solman for treatment of his right shoulder.

Petitioner first saw Dr. Solman on March 5, 2014. (PX10 at 242) Dr. Solman testified by way of deposition. He diagnosed Petitioner with a right shoulder rotator cuff tear and some biceps tendon pathology. (PX11 at 9) He testified that the work injury was a factor in the development of his rotator cuff tear and need for further treatment. (*Id.*, at 9-10) He recommended and then performed a right shoulder arthroscopy with subacromial decompression, distal clavicle resection, a rotator cuff repair, and a biceps tendodesis. (*Id.*, at 10-11) The surgery involved fixation of his biceps and repair of the rotator cuff. Surgery was performed on September 23, 2014. Dr. Solman testified that the surgery went well and that he had regained most of his strength and was gaining more confidence with his shoulder. He was going to continue with therapy for more strengthening. (*Id.*, at 11-12) Dr. Solman went on to testify that if he had a full thickness tear in 2011, that he would have some atrophy, some potential fatty infiltrations, some atrophic changes in the tendon and the muscle and that he did not see any of those things. (*Id.*, at 28-29) The Petitioner had a "fairly normal-appearing muscle belly with no atrophy, no fatty infiltration, and no real thinning or atrophy of the tendon itself; just a tear with some retraction." (*Id.*)

Respondent sent Petitioner to Dr. David Lange pursuant to §12 on March 24, 2014. (RX1, 2) Dr. Lange testified by way of deposition. Dr. Lange diagnosed axial neck pain without radiculopathy, carpal tunnel syndrome, intrinsic pathology within the right shoulder, and axial lower back pain without radiculopathy. (RX2 at 16-17) He felt that the back condition is work related, but disputes the causal relationship of the neck "because there really was no documentation of any neck problems, particularly for the first two months of –of care." (*Id.*, at 17) Dr. Lange did not believe Petitioner required surgery for his neck or low back conditions and did not feel injections would be beneficial. (*Id.*, at 18-19)

Respondent also sent Petitioner to Dr. Krause pursuant to §12 on June 16, 2014 regarding Petitioner's knee. Dr. Krause noted that he first evaluated petitioner's right knee in 2010 as Petitioner's treating physician. At that time, petitioner reported right knee pain over his medial joint line of gradual onset. After obtaining X-rays, Dr. Krause diagnosed petitioner with severe degenerative arthritis, and performed an injection. In September 2010 Dr. Krause provided a hinge joint brace and instructed petitioner to follow up as needed. (RX 4 at 6) There is no evidence in the record to indicate Petitioner received any treatment between that release this accident. On June 16, 2014 Dr. Krause diagnosed a knee contusion and severe degenerative arthritis. He believed that Petitioner could have suffered a contusion as a result of the alleged incident. Dr. Krause did not believe that Petitioner's degenerative joint disease was accelerated or aggravated by the work incident. He based this conclusion, however on the premise that there was a significant delay between the accident and Petitioner seeking treatment for the knee. Dr. Krause's report indicates the date of accident in this case was June 1, 2013. (RX3). His report goes on to indicate that Petitioner did not report a history of any twisting mechanism, and did not seek initial treatment for approximately four to six weeks after the incident. (*Id.*, RX4 at 19) These assumptions are simply not accurate. Petitioner credible testified that he did twist his knee when his foot became caught on the in the doorjamb of the truck he fell from. Further, When Petitioner was first sent for treatment at Concentra on July 18, 2013, just 9 days after the accident, the record reflects he was there for treatment of his knee, among other things. Dr. Krause stated that petitioner was a candidate for a total knee replacement prior to the work incident, and continued to remain a candidate for a total knee replacement after the incident. (RX4, p. 12) With respect to petitioner's work restrictions, Dr. Krause believed Petitioner could likely return to work full duty. He felt this was supported by the fact that petitioner had continued working after the incident, and was able to ride go-carts and motorcycles in the Internet mining investigation. Petitioner's ability to perform these activities raised doubt in Dr. Krause's mind as to whether he required any work restrictions. (RX 4, p. 13-14) The Arbitrator disagrees. With regard to his characterization of Petitioner's injury as minor, Dr. Krause again testified that his characterization was based on the fact that petitioner failed to present for initial treatment immediately after the incident. In the event petitioner did suffer a significant injury, he would have expected petitioner to present for care shortly thereafter. (RX 4, p. 18-19)

Respondent sought yet another opinion from Dr. Craig Beyer who performed a medical records review and issued a report dated May 25, 2015, just 2 days prior to the hearing. (RX11) Dr. Beyer diagnosed advanced knee osteoarthritis, right shoulder post rotator cuff repair, and multi-level cervical/lumbar disc disease. Dr. Beyer believed that Petitioner at most suffered a transient aggravation of his pre-existing degenerative lower back and knee conditions and that both conditions would have resolved within 4-6 weeks. (RX11) Dr. Beyer indicated that Petitioner had severe degenerative arthritis in his knee, which pre-existed the alleged work incident. He believed that Petitioner's pre-existing condition was responsible for his current complaints. (*Id.*) Dr. Beyer did not believe that Petitioner suffered any work related injury to the cervical spine or right shoulder. His opinion is based upon the fact that Petitioner had no cervical or right shoulder complaints documented in the medical records until his August 23, 2013 visit with Dr. Khariton. With respect to the reasonableness and necessity of Petitioner's treatment Dr. Beyer believed it had been reasonable with the exception of Petitioner's chiropractic care with Dr. Droege in December of 2013, and the right knee MRI. He noted that the medical literature indicated that chiropractic treatment for spinal pathology may be effective within 30 days of an acute incident. However, it has no long term benefit in a chronic situation. With respect to the January 27, 2014 right

knee MRI, Dr. Beyer noted that Petitioner already had advanced degenerative osteoarthritis. He further indicated Petitioner did not have complaints of knee pain for several months prior to the test and therefore the MRI would not add any additional information of benefit. (*Id.*)

Petitioner submitted the following medical bills into evidence:

Facility	Charges
Concentra	$4,702.45
Dr. James Coyle	$375.00
Dr. Nogalski	$1,034.72
Dr. Droege	$13,648.00
Professional Imaging	$466.00
Greater Missouri Imaging	$1,200.00
Dr. Bradley	$5,581.94
Dr. Solman	$58,684.07
Dr. Wilkey	$1,332.00
Chesterfield Surgery Center	$41,763.00
Physician Anesthesia Services	$2,232.00
Jason Gay PA-C	$22,916.25
Medsource LLC	$2,995.00
Total Charges	$156,930.43

CONCLUSIONS OF LAW

Issue (C): **Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?**

Issue (D): **What was the date of the accident?**

These issues are somewhat overlapping, therefore the Arbitrator will address them jointly. *Elizabeth Boettcher v. Spectrum Property Group and First Merit Venture*, 99 I.I.C. 0961 (1999)

Petitioner's testimony was forthright and credible. His testimony regarding the occurrence of the accident was not only unrefuted, but was corroborated by each of the witnesses called by Respondent. Petitioner did initially claim an accident date of "June 2013." He initially testified that it occurred at the end of June 2013. He further testified, however that if all the paperwork stated that the injury occurred on July 9, 2013,

then that could be correct. (T. 31, 86) The Arbitrator finds it significant that Petitioner's supervisor, Mr. Nathaniel Winton, testified that the incident occurred on July 9, 2013. It is unrefuted that Petitioner provided oral notice to Respondent on the date of the accident when he reported it to Nathaniel Winton. Mr. Winton prepared an accident report on July 18, 2013, the day he sent Petitioner to Concentra for medical treatment.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner has met his burden of establishing that he sustained an accident which arose out of and in the course of his employment with Respondent on July 9, 2013.

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

In this case, the evidence showed that Petitioner's mechanism of injury was that while he was facing the back of a truck he stepped off and to the left to exit the truck. His foot landed on a broomstick which rolled off the step and he fell from the cab of the truck. He stopped his fall by grabbing a handle with his right arm, driving his right knee into the step and causing his right foot to get tangled in the doorjamb, twisting his whole body. He was able to keep himself from hitting the floor by grabbing the handle and the door. Warren Wilson, another coworker, corroborated this testimony. The Arbitrator found the Petitioner to be credible in his testimony. In addition, Respondent's witnesses corroborated Petitioner's testimony for the most part.

Dr. Bradley, Dr. Solman, Dr. Wilkey, and Dr. Droege all agree that the Petitioner's current conditions of ill-being for the neck, right shoulder/arm, back and right knee are causally related to the injury. Dr. Nogalski agrees that the Petitioner's right shoulder is causally-related and agrees that he needed surgical repair as a result. All of the aforementioned doctors are treating doctors. Even Dr. Lange agrees that the current condition of Petitioner's low back is related to the accident. Dr. Krause agreed that Petitioner suffered an injury to his knee, which he describes as a contusion. Dr. Krause also agrees that Petitioner is a candidate for a total knee arthroplasty, although he does not agree that the need for said arthroplasty is causally related to the work injury. These two doctors were IME doctors for the Respondent. Dr. Beyer only performed a records review for Respondent and never examined the Petitioner. He does not believe that Petitioner currently has a condition of ill-being, but only had a transient aggravation of a preexisting condition with respect to the knee and low back but that they are resolved.

The Arbitrator found the opinions and testimony of Dr. Bradley, Dr. Solman, Dr. Wilkey, Dr. Droege, and Dr. Nogalski to be based on sound medical evidence and more persuasive than those of Dr. Lange, Dr. Krause, and Dr. Byer. In fact Respondent chose and directed all of the medical treatment up to the point that they chose to ignore the recommendations of Dr. Nogalski.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner has met his burden of establishing that the current condition of ill-being of his neck, right shoulder/arm, back and right knee are causally related to the accident of July 9, 2013.

Issue (G): What were Petitioner's earnings?

Petitioner testified that while working in Missouri, his daily schedule would fluctuate depending on when the work was completed. This was confirmed by Respondent's terminal manager, Mr. Winston.

Petitioner requested a reduction in hours so he could be at home when his son returned from school. This request was denied.

In approximately March of 2013 Petitioner transferred to Respondent's facility in Madison, IL where he worked as a diesel mechanic. He was told the hours would be 5:00 a.m. to 2:30 p.m. Maintenance began getting behind which required him to work from 2:00 a.m. to 2:30 p.m. Petitioner testified this overtime was mandatory. Mr. Winton testified:

> "He had mentioned that, you know, he needed to be home for his son and we did start getting behind on services and I told him, you know, that he had to be there when the trucks were parked so I didn't tell him to come in at 2:30, that was what he suggested, he would come in earlier, service equipment and then get guys started in the morning....I didn't tell him a specific time that he had to stay 'till...." (*Id.*, at 117-118)

Mr. Winton further indicated Petitioner's quitting time "would have been up to him." (T 118) Gene Jackson, a coworker of Petitioner at the Madison facility, testified that "[w]hen I was hired I was required to work 6:00 to 2:30 and no Saturdays.... That was the previous manager. When Nathan came we were a little busier and the need for Saturdays was there so my time was the same except for we were required to work one Saturday a month. (T. 131) (emphasis added) When specifically asked about overtime, Mr. Jackson indicated that any hours over 40 were considered overtime. When asked if overtime was "something that is mandated by Nathan," he replied "No." On cross examination Mr. Jackson testified his current hours were from 3:00 a.m. to 3:30 p.m. He then volunteered "...I'm required to be there 40 hours. I choose to work more because I provide for my family, nobody else." (T 136) The Arbitrator did not find the testimony indicating that the overtime was not mandatory to be persuasive. The Arbitrator finds the overtime Petitioner worked was, in actuality, mandatory.

Petitioner testified that he remembered working between 55 to 78 hours a week. His wage records, however show that he typically worked between 50 and 60 hours per week, but worked overtime in every week. (PX18, RX9) The Arbitrator further finds the overtime was regular. The wage records reveal that Petitioner worked for Respondent 24 2/7 weeks prior to the week of his injury. He received a pay increase from $12.00 to $15.32 per hour beginning in week 23. His total earnings, including overtime hours at the straight time rate, were $17,299.56 as calculated below.

Week No.	Pay Date	Hours	Rate	Earnings
1	1/25/2013	20	$12.00	240
2		50	$12.00	660
3		59.5	$12.00	831
4		54.5	$12.00	741
5		54.5	$12.00	741
6		55.5	$12.00	759
7		57.5	$12.00	795
8		56.5	$12.00	777
9		58.5	$12.00	813
10		59.5	$12.00	831

11		59		$12.00	822	
12		58.5		$12.00	813	
13		48		$12.00	624	
14		59.5		$12.00	831	
15		47		$12.00	606	
16		58		$12.00	804	
17		57.5		$12.00	795	
18		57		$12.00	786	
19		62		$12.00	876	
20		59		$12.00	822	
21		57.5		$12.00	747	
22		59		$12.00	822	
	Period total	1208	X	$12.00		$14,496.00
23		58		$15.32	1072	
24		60		$15.32	1120	
25		65		$15.32	1240	
26	Period total	183	X	$15.32		$2,803.56
27						
28						$17,299.56 ÷ 24 2/7 = $712.33

Based upon the foregoing and the record taken as a whole, the Arbitrator finds that Petitioner's earnings during the 24 2/7 weeks preceding the week of accident were $17,299.56 and the average weekly wage is $712.33.

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?

The Arbitrator finds that all services which have been provided to Petitioner have been reasonable and necessary. Illinois law allows for chiropractic treatment of injuries. The chiropractor that Petitioner treated with in this case also provided the post-surgical rehabilitation as prescribed by Dr. Solman following Petitioner's shoulder surgery. This treatment was very similar to physical therapy routinely performed following surgery. Additionally, the MRI for the knee is also found to be reasonable and necessary as the Petitioner had suffered a knee injury that was not responding to conservative care and thus it was reasonable and necessary for the doctor to order an MRI.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds the treatment provided to Petitioner thus far has been both reasonable and necessary. The Arbitrator further finds that Petitioner is entitled to prospective medical care. Respondent shall pay reasonable and necessary medical services of $156,930.43, as set forth above pursuant to Sections 8(a) and 8.2 of the Act. Respondent shall

be given a credit of $8,400.74 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. Further, Respondent shall authorize and pay for future medical treatment, as recommended by Dr. Bradley, Dr. Solman and Dr. Wilkey including, but not limited to, surgeries, as provided in Section 8(a) and 8.2 of the Act.

Issue (L): What temporary benefits are in dispute?

Petitioner was taken off work on 12/31/2013 by Dr. Droege and has remained off work pursuant to various doctors' orders through the date of hearing. He currently remains off work due to restrictions placed on him by Dr. Bradley pending treatment for his knee. As indicated above, the Arbitrator found the opinions and testimony of Dr. Bradley, Dr. Solman, Dr. Wilkey, Dr. Droege, and Dr. Nogalski to be more persuasive than those of Dr. Lange, Dr. Krause, and Dr. Byer.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner has been temporarily and totally disabled from 12/31/13 through 5/27/15, the date of hearing, a period of 73 3/7 weeks.

Respondent shall pay Petitioner temporary total disability benefits of $474.89/week for 73 3/7 weeks, commencing 12/31/13 through 5/27/15, as provided in Section 8(b) of the Act. Respondent shall be given a credit of $10,756.08 for temporary total disability benefits that have been paid.

Issue (O): The admissibility of exhibits?

Respondent objected to the admission of a report of 12/2/13 which is contained within Dr. Nogalski's records as well as those of Dr. Wilkey. The basis of the objection was hearsay and relevance. Clearly, the records are relevant. The Arbitrator admitted the record as an admission against interest. This was incorrect under *Greaney v. Industrial Comm'n*, 358 Ill. App. 3d 1002; 832 N.E.2d 331; 295 Ill. Dec. 180 (2005). The Court in *Westin Hotel v. Industrial Comm'n*, 372 Ill. App. 3d 527(2007) pointed out "[i]n *Greaney*, 358 Ill. App. 3d at 1010-11 we held that a party's independent medical expert is not *per se* an agent of the party who hired him or her, and, therefore, the expert's opinions are not admissible as admissions against that party's interest. In this case, therefore, the fact that Dr. Levin was retained by respondent did not render his report admissible as an admission against respondent's interest." (*Westin* at 536-537) However, Dr. Nogalski is not a retained examiner pursuant to §12 of the Act, as were the Physicians in *Greaney* and its progeny. Instead, Dr. Nogalski was a treating physician to whom Petitioner was sent by Respondent. The Court in *Greaney* pointed out "Moreover, because Dr. Brackett was hired by [Respondent] to perform an independent medical examination of the claimant, rather than to assist in the treatment of his injury, his report is not admissible under the exception to the hearsay rule we announced in *Fencl-Tufo Chevrolet, Inc. v. Industrial Comm'n*, 169 Ill. App. 3d 510, 514-15, 523 N.E.2d 926, 120 Ill. Dec. 15 (1988)." (*Greaney*, 832 N.E.2d at 340-341) Further, Rule 803 of the Illinois Rules of Evidence provides, in pertinent part:

Rule 803. Hearsay Exceptions; Availability of Declarant Immaterial

> The following are not excluded by the hearsay rule, even though the declarant is available as a witness:....
>
> (4) Statements for Purposes of Medical Diagnosis or Treatment. (A) Statements made for purposes of medical treatment, or medical diagnosis in contemplation of treatment, and describing medical history, or past or present symptoms, pain, or sensations, or the inception or general character of the cause or external source thereof insofar as reasonably pertinent to diagnosis or treatment but, subject to Rule 703, not including statements made to a health care provider consulted solely for the purpose of preparing for litigation or obtaining testimony for trial...(Ill. R. Evid. § 803(4)(A) (eff. Jan. 1, 2011)) (emphasis added)

Unlike an ordinary medical record prepared by a treating physician, an IME's medical report is generated in anticipation of litigation. Documents prepared in anticipation of litigation are not admissible as business records because they do not possess the same trustworthiness of other records prepared in the ordinary course of business. For the same reason, Illinois Rule of Evidence 803(4)(A), which creates an exception to the hearsay rule for statements made for purposes of medical diagnosis or treatment, does not include reports of §12 examiners.

In this case there is no question Dr. Nogalski was a treating physician, albeit one chosen by Respondent. Before generating the report at issue on December 2, 2013, the doctor had seen Petitioner on two prior occasions. On the first visit the doctor modified Petitioner's physical therapy and prescribed medications. When Petitioner returned to Dr. Nogalski on November 20, 2013 he remained symptomatic and Dr. Nogalski recommended surgery. Respondent made no objection to the notes regarding these two visits. When Respondent initiated its ex parte communication with Petitioner's treating physician on December 2, 2013, Dr. Nogalski's recommendation for surgical intervention was still pending. (PX4 at 107) Respondent had sent Dr. Nogalski a report from a prior MRI of Petitioner's right shoulder for review. After reviewing the prior MRI Dr. Nogalski prepared an "ADDENDUM," which is the subject of Respondent's objection, comparing the MRI from 2011 to that of 2013. This was clearly done for the purpose of moving forward with the surgery which had already been recommended. The propriety of such an ex parte contact with a treating physician aside, the Arbitrator finds the Addendum contains "statements made for purposes of medical treatment, or medical diagnosis in contemplation of treatment, ... describing medical history , or past or present symptoms," and incidentally commenting upon "the inception or general character of the cause or external source thereof" as provided in § 803(4)(A) of the Illinois Rules of Evidence. Dr. Nogalski was clearly not a health care provider consulted solely for the purpose of preparing for litigation or obtaining testimony for trial.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds the certified records of Dr. Nogalski contained in PX4 are admissible under § 803(4)(A) of the Illinois Rules of Evidence as well as *Fencl-Tufo Chevrolet, Inc.*.

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

Kristine Melody,
Petitioner,

vs. NO: 05 WC 12983

Employco n/k/a Work Place Solutions,
Respondent,

16IWCC0641

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of employer/employee relationship, notice, statute of limitations, motion to dismiss 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 19, 2016, 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: OCT 3 - 2016
o092216
DLG/mw
045

David L. Gore

Stephen Mathis

Mario Basurto

STATE OF ILLINOIS)
)
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
DECISION

Kristine Melody
Employee/Petitioner

v.

Employco n/k/a Work Place Solutions
Employer/Respondent

Case # 05 WC 012983

16IWCC0641

The *respondent* filed a petition or motion for **dismissal of the case as to the Self Insurers Advisory Board** on **December 7, 2015**, and properly served all parties. The matter came before me on **February 10, 2016** in the city of **Chicago**. After hearing the parties' arguments and due deliberations, I hereby *grant* the petition.

A record of the hearing *was* made.

FINDINGS OF FACT AND CONCLUSIONS OF LAW:

Counsel for Petitioner and for the Self Insurers Advisory Board (by L. Madigan, Attorney General of the State of Illinois) were present and provided argument on the Motion to Dismiss.

The following documents were considered by this Arbitrator herein, marked as Arbitrator's Exhibits and received of Record:

1. **Self-Insurers Advisory Board's Motion to Dismiss Respondent Employco n/k/a Work Place Solutions;**

2. **Petitioner's Reply Brief to Respondent's Motion to Dismiss;**

3. **Self-Insurers Advisory Board's Response to Petitioner's Reply Brief to Respondent's Motion to Dismiss; and**

4. **Decision of Arbitrator Cronin, entered in this matter on May 18, 2007.**

Additionally, this Arbitrator took judicial notice of matters of Record in this case, including the Transcript of Proceedings on Arbitration (February 22, 2007) and that the review of Arbitrator Cronin's decision was dismissed herein on January 3, 2008.

After review of the above documents (including the exhibits) and consideration of the arguments of the Parties, this Arbitrator grants Respondent's Motion and dismisses this case based upon the law of the case doctrine.

The findings relevant to this Arbitrator's granting of the Motion to Dismiss herein are as follows:

1.)Petitioner was injured at work on May 20, 2004. She filed an Application for Adjustment of Claim against Convention All, her employer, in April of 2005. The matter proceeded to trial before Arbitrator Cronin on February 22, 2007. At Trial, the Parties stipulated that there was an employee/employer relationship between Petitioner and Convention All and Arbitrator Cronin found that such a relationship existed in his decision.

Furthermore, at trial, the following testimony was ellicited from Petitioner: Q: (Calling your attention to May 20, 2004)...By whom were you employed? A: Convention All Services. (P.8)

2.)An Amended Application, naming Employco as the Respondent/Employer was filed on February 25, 2011. Employco subsequently went bankrupt in 2012 and the defense of the case was eventually taken over by the Self-Insurers Advisory Board as it distribues self insured's bond proceeds in the event of a bankruptcy.

3.)The Amended Application naming Employco was not timely filed herein. There had been a hearing on the merits (See: Rule 7020.20(e) and Irizarry v. The Industrial Commission, 337 Ill. App. 3d 598 (2003) Applications may be amended prior to a hearing on the merits by filing an Amended Application (the Amended Application was filed after the 2/22/2007 hearing on the merits). Where an issue is once litigated and decided, that should be the end of that matter and the unreversed decision on a question of law or fact made during the course of litigation settles that question for all subsequent stages of the case. 337 Ill. App. 3rd at 606 (2003) The question of employee/employer was resolved by the Stip Sheet, Petitioner's testimony and Arbitrator Cronin's final decision.

4.)The SIAB was free to waive this issue by allowing the matter to proceed to trial, but it chose to file a Motion to Dismiss, which this Arbitrator finds to be well taken.

MOTION TO DISMISS GRANTED. CASE DISMISSED.

Unless a *Petition for Review* is filed within 30 days from the date of receipt of this order, and a review perfected in accordance with the Act and the Rules, this order will be entered as the decision of the Workers' Compensation Commission.

Signature of arbitrator

Date 2/19/2016

FEB 19 2016

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

Beatriz A. Aguilar,
Petitioner,

vs. NO: 15 WC 07729

Joliet Catholic Academy,
Respondent,

16IWCC0642

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 23, 2016, 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 $15,700.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: OCT 3 - 2016
o092916
DLG/mw
045

David L. Gore

Stephen Mathis

Mario Basurto

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

AGUILAR, BEATRIZ A
Employee/Petitioner

Case# **15WC007729**

JOLIET CATHOLIC ACADEMY
Employer/Respondent

16IWCC0642

On 3/23/2016, 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 0.44% 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:

0787 MEYERS & FLOWERS LLC
MICHAEL P HELLMAN
3 N SECOND ST SUITE 300
ST CHARLES, IL 60174

1295 SMITH AMUNDSEN LLC
GAIL A GALANTE
3815 E MAIN ST SUITE Q-1
ST CHARLES, IL 60174

16IWCC0642

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)

Beatriz A. Aguilar
Employee/Petitioner
v.
Joliet Catholic Academy
Employer/Respondent

Case # 15 WC 07729

An *Application for Adjustment 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 **New Lenox**, on **February 2, 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. ☐ 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 **January 30, 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 **$23,7474.40**; the average weekly wage was **$457.20**

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

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

Respondent shall be given a credit of **$5,486.40** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$5,486.40**

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 $99,971.31 as in accordance with in Sections 8(a) and 8.2 of the Act.
Respondent shall authorize and pay for all reasonable and necessary costs relative to the evaluation and treatment of petitioner's right shoulder sprain, and the attendant care, as well as any follow up necessary for treatment to her lower back by Dr. Sweeney, pursuant to §8 and §8.2.
Temporary Total Disability
Respondent to pay Temporary total Disability for the period from February 11, 2015 through February 2, 2016, or 51 weeks, at the rate of $306.67 per week.
Credits
Respondent shall be given a credit of **$5,486.40** for TTD and for any payments made for medical bills claimed either directly or through Blue Cross and Blue Shield pursuant to §8j.

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.

Christine M Ory

Signature of Arbitrator
IC ArbDec19(b)

03/22/2016
Date

MAR 2 3 2016

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Beatriz A. Aguilar	)
Petitioner,	)
vs.	) **No. 15 WC 07729**
Joliet Catholic Academy	)
Respondent.	)
	)

ADDENDUM TO ARBITRATOR'S DECISION
FINDINGS OF FACTS AND CONCLUSIONS OF LAW

This matter proceeded to hearing in New Lenox under the provisions of §19b/§8a on February 2, 2016. The parties agree that on January 30, 2015, the Petitioner and Respondent were operating under the Illinois Worker's Compensation or Occupational Diseases Act and that their relationship was one of employee and employer. They agree that Petitioner gave Respondent notice of the accident within the time limits stated in the Act. They further agree that in the year preceding the injuries, the Petitioner earned $23,774.40, and that her average weekly wage calculated pursuant to §10 was $457.20.

At issue in this hearing is as follows:

1. Whether the petitioner sustained accident injuries that arose out of and in the course of her employment;
2. Whether petitioner's current condition of ill-being is causally connected to the claimed accidental injury.
3. Whether respondent is liable for the unpaid medical bills totaling $99,971.31.
4. Whether petitioner is entitled to payment for prospective medical treatment.
5. Whether petitioner is due TTD.

The Petitioner does not speak English; her native language is Spanish. She testified with the assistance of Marco Garcia, a certified interpreter, qualified to translate Spanish to English and English to Spanish. After being duly qualified and accepted by both parties, Mr. Garcia served as an interpreter for the Petitioner.

FINDING OF FACTS

Petitioner testified through an interpreter that she was employed by respondent for seven years as a janitor. On January 30, 2015, petitioner arrived at work at 12:00 noon. She felt fine. She was cleaning a table when she slipped on a banana peel and fell. She landed on her tailbone/buttocks. She struck her right arm on the table as she fell. Her arm swelled. Prior to January 30, 2015, petitioner denied suffering any injuries, denied having any prior back pain, and denied receiving any treatment to her lower back or right shoulder.

After her fall, the petitioner went to see the school nurse, who examined petitioner's hand. The nurse asked petitioner how she fell and then gave her ice. Petitioner denied the nurse examined any part of her body. The nurse gave petitioner ice for her right hand. Petitioner

finished her workday. She did not seek treatment until February 10, 2015, when she went to Will County Health and Wellness Center and saw Dr. John Kravarik.

Petitioner testified she waited to see a doctor until February 10, 2015, by taking ibuprofen. When she couldn't stand the pain any longer she went to see Dr. Kravarik. On February 10, 2015, she told Dr. Kravarik of her fall at work. Dr. Kravarik ordered an MRI and an EMG. Dr. Kravarik kept petitioner off work. She underwent a MRI to her lower back on February 25, 2015 and to her sacrum and coccyx on March 2, 2015 at Homer Glen Open MRI.

She returned to Dr. Kravarik on March 5, 2015. Dr. Kravarik referred her to Dr. Sharma at Pain and Spine Institute. Petitioner first saw Dr. Sharma on March 10, 2015. She gave Dr. Sharma the history of falling at work. Dr. Sharma recommended petitioner undergo a repeat MRI to her lower back. That was the only time petitioner saw Dr. Sharma

Petitioner obtained an EMG on May 2, 2015 by Dr. Osman. She also had another MRI of her lower back on May 14, 2015 as well as an ultrasound at Homer Glen Open MRI. She returned to Dr. Kravarik on May 22, 2015. Dr. Kravarik then referred her to Dr. Sweeney; whom she saw on May 28, 2015. She gave Dr. Sweeney a history of falling at work. Dr. Sweeney examined petitioner and then recommended surgery to her back and recommended she remain off work.

She was examined by Dr. Jack Casini at DuPage Medical Group on June 10, 2015 at the request of respondent pursuant to §12. Dr. Casini spent seven minutes with petitioner at the time of her exam. Petitioner testified that Dr. Casini did not talk to petitioner as to how she was injured. He squeezed her hands.

Petitioner saw Dr. Sweeney on June 25, July 30 and August 27, 2015. At each visit, Dr. Sweeney recommended petitioner remain off work and recommended surgery to her lower back. Dr. Sweeney ordered another MRI of petitioner's buttock or pelvis which was performed on September 1, 2015. On October 1, 2015, Dr. Sweeney referred petitioner to a shoulder specialist for her right shoulder.

On October 3, 2015 petitioner had pre-operative testing at St. Joseph Hospital. She also had another MRI on October 23, 2015 to her lumbar spine at Tinley Park Open MRI at a referral from Dr. Sweeney.

Petitioner remained under the care of Dr. Kravarik at the same time she was seeing Dr. Sweeney. On November 16, 2015 Dr. Sweeny removed a cyst from petitioner lower spine at his surgical center in Mokena. She returned to Dr. Sweeney on December 3 at which time petitioner began physical therapy and remained off work. Petitioner started her physical therapy with Dr. Kravarik's office.

The last time petitioner saw Dr. Sweeney was on January 14, 2016, at which time he recommended petitioner continue physical therapy and remain off work. Dr. Sweeney also continued to recommend petitioner see a specialist for her shoulder.

Petitioner indicated the surgery helped her walk and took away the pain in her back. She has another appointment to see Dr. Sweeney on February 11, 2016. She also testified she intends to make an appointment to see a specialist for her right shoulder.

Petitioner testified that her right shoulder continues to hurt. She denied having any new injury to her arm or back since January 30, 2015. She was paid workers' compensation benefits from February 11, 2015 through June 16, 2015.

On cross examination, petitioner confirmed she fell at 12:25 P.M. and went to see the nurse, who gave her an ice pack for her right wrist and ibuprofen. She went back to the nurse at about 1 P.M. and obtained a wrist wrap. She agreed she had returned to the nurse of February 3, 2015.

She continued to work from January 30, 2015 until February 10, 2015; forty hours a week at her usual job as a custodian. She also admitted she worked overtime during that same period.

Petitioner admitted she told Dr. Sharma that three days [after her fall] while working she lifted a bucket of water, felt severe back pain and could not move. She also advised Dr. Sweeney on May 28, 2015 that a week after her fall of January 30, 2015 she felt pain when she bent over to empty a bucket of water and couldn't get back up. She agreed she did not tell Dr. Casini of the bucker lifting incident. Petitioner testified her back was numb before the bucket-lifting incident.

Petitioner called her daughter, Lourdes Gonzalez, to testify in her behalf. Gonzalez had accompanied her mother to the appointment with Dr. Casini of DuPage Medical Group. Gonzalez testified that Dr. Casini spent between five and seven minutes with her and her mother. Gonzalez testified Dr. Casini asked no questions of petitioner.

Gonzalez testified Dr. Casini had petitioner stand on the left and right legs and do different movements with her arms. Dr. Casini had petitioner squeeze his hands, lifting her arms and standing on each leg at a time. Gonzalez testified Dr. Casini was blunt and mean.

Kerry Frescura testified in behalf of respondent. Frescura was employed by Silver Cross Hospital as shift coordinator for charge nurse in the intensive care unit and for respondent as the school nurse. Frescura is a licensed nurse. Frescura works one day a week for respondent. Her job for respondent requires her to tend to the needs of the students and faculty. She also tends to injuries of respondent's employees.

According to Frescura, when an employee is injured, the nurse completes an incident report. The nurse asks what happened and what the injuries are. The nurse also asks them to return for a follow-up a few days later. The nurse then fills out the follow-up part of the incident report. The report is then printed and put in the business office mailbox and the school president's mailbox. A copy is left in the health office.

Frescura testified she was familiar with petitioner from petitioner working for respondent. Frescura identified the incident report (RX.1). Frescura completed the entries of January 30, 2015 and February 3, 2015 on the incident report.

Frescura testified she had a conversation with petitioner in respondent's health department on January 30, 2015 at approximately 12:25. Petitioner advised Frescura she had slipped on a banana peel and fell in the cafeteria and fell. Petitioner complained of right wrist,

buttocks and sacral area. Frescura testified petitioner did not complain of hitting the table. Frescura iced petitioner's wrist and gave her ibuprofen.

That day, petitioner returned to Frescura at 1 o'clock and asked for the wrist to be wrapped. At that time, the athletic trainer, Bobby Stroud was present. Frescura noted the right wrist was red and had a small abrasion. At the second visit, petitioner had no other noted complaints. Frescura recorded no complaints of pain to petitioner's arm or back in her report.

Petitioner returned to see Frescura again on February 3, 2015. Petitioner requested to have the wrist wrapped. Petitioner had no complaints relative to her right shoulder or back or sacral area. Frescura recommended petitioner see Bobby, the athletic trainer, for her wrist. Frescura does not know if petitioner followed up with Bobby. Frescura had no further conversation with petitioner after February 3, 2015. Frescura testified she communicated with petitioner in English. Frescura indicated she understood petitioner and it seemed petitioner understood her, even though the conversation was in English.

On cross-examination, Frescura admitted she did not put everything in the report that may have been discussed with petitioner. Frescura testified she charted in the report any complaints the petitioner had. Frescura indicated petitioner never mentioned a prior injury; therefore, it was not mentioned in the report.

On rebuttal, petitioner testified she complained of right shoulder pain to Frescura. Petitioner testified that Frescura did not ask a lot of questions and she did not understand everything Frescura said. Petitioner testified she injured her wrist when she tried to break her fall. Petitioner testified that although she complained of problems with her buttock and sacrum, Frescura didn't seem to pay any attention to these complaints.

Petitioner introduced the records of Dr. Kravarik, D. C. of Will County Health & Wellness Center. The records indicate petitioner first saw Dr. Kravarik first saw petitioner on February 10, 2015. Her complaints were that of severe low back pain and radiating bilateral leg pain and numbness and right shoulder pain which was constant. Her history to Dr. Kravarik was that she slipped on a banana peel causing her to fall backwards hitting a table and falling on a large wheel at the base of the table. Petitioner advised she was seen by the school nurse, who didn't do much for her. (PX.1)

Dr. Kravarik indicated his examination supports a diagnosis of lumbar disc herniation, lumbar radiculopathy, lumbar sprain strain and right shoulder sprain. Dr. Kravarik believed these findings were common injuries from the accident described by petitioner. He, therefore, opined that these injuries were the direct result of the work accident of January 30, 2015. Lumbar MRI and EMG were ordered (PX.1)

Dr. Kravarik's records contain the February 25, 2015 MRI report of the lumbar spine. The MRI was negative for impingement at the L2-3, L3-4 or L4-5 levels. At the L5-S1 level, the MRI showed a possible synovial cyst. (PX.1)

The February 26, 2015 MRI of the right shoulder was reported showing supraspinatus tendinonis with interstitial tear in it distal portion; the rest of the rotator cuff was normal. The report also showed a paralabral cyst at the anterosuperior margin of the glenoid labrum. A MRI arthrogram was suggested if clinically indicated. (PX.1)

On March 3, 2015, Dr. Kravarik referred the petitioner for a sacrum MRI and Dr. Sharma for an evaluation. (PX.1)

The EMG performed by Dr. Osman of May 2, 2015 showed right L4-5 and L5-S1 radiculopathy and right C5-6 radiculopathy. The March 2, 2015 MRI of petitioner's sacrum/coccyx showed a synovial cyst. The May 14, 2015 MRI of the lumbar spine indicated an inflammatory area/mass rather than synovial cyst at the L5-S1 level. The May 14, 2015 ultrasound indicated the mass at the L5-S1 level was a non-vascular lesion, possibly complex cyst. (PX.1)

Petitioner continued treatment with Dr. Kravarik. The last report of treatment was January 9, 2016. Dr. Kravarik's records confirm petitioner was to remain off work from February 11, 2015 through June 20, 2015. (PX.1)

The March 10, 2015 records of Dr. Samir Sharma, with Pain & Spine Institute, were introduced by petitioner. Petitioner provided a history through family members of slipping and falling backwards. She also admitted she felt severe low back pain three days after the accident when lifting a bucker. Dr. Sharma ordered another MRI and ultrasound of the lumbar sacral spine to evaluate the right paraspinal mass. (PX.2)

Petitioner introduced the records of Dr. Patrick J. Sweeney of Minimally Invasive Spine Specialists. The records reflect that petitioner had been referred to Dr. Sweeney by her chiropractor [Dr. Kravarik]. She was first seen by Dr. Sweeney on May 28, 2015. At that time, petitioner had complaints of low back pain that radiates into the buttocks, as well as right shoulder pain when she lifts. Petitioner's was that she slipped on a banana peel cleaning the cafeteria and fell on her buttocks and right shoulder. She continued to work and a week later felt a lot of pain after bending to empty a bucket of water. The following day she went to a chiropractor. (PX.3)

Dr. Sweeney reviewed the MRIs. According to Dr. Sweeney the MRI of the lumbar spine showed a large right-sided L5-S1 cyst, likely post-traumatic, as well as a small central herniated disc (HNP) at L5-S1, left foraminal HNP at L2-3, L3-4 and L4-5, along with a large annular tear at L4-5. The MRI of the sacrum and coccyx showed the same as the lumbar MRI image. The right shoulder MRI showed a rotator cuff tear, according to Dr. Sweeney. Dr. Sweeney recommend surgical procedure to excise the cyst which was likely synovial, and possibly facetectomy. He also referred petitioner to a shoulder specialist and kept her off work. (PX.3)

Petitioner returned to Dr. Sweeney on June 25, 2015. Dr. Sweeney stated that the cyst was probably directly due to the work injury but even if it was pre-existing, it was asymptomatic and became painful from the injury. It was work related. She was seen again on July 30, 2015 and August 27, 2015. Her condition was unchanged. She was kept off work. (PX.3)

Petitioner obtained an MRI of the pelvis on September 1, 2015. Dr. Sweeney reported on September 3, 2015, after reviewing the new MRI, that petitioner had a work-related back injury; post-traumatic synovial cyst that needed to be excised. Dr. Sweeney saw the petitioner again on October 1, 2015. His recommendation remained the same. (PX.3)

Dr. Sweeney testified in behalf of petitioner via deposition on October 16, 2015 (PX.4). Dr. Sweeney confirmed petitioner's history to him when he first saw her on May 28, 2015 (PX.4, p.7). Dr. Sweeney believed the bone marrow edema of the sacrum noted on the MRI was consistent with the mechanism of the injury as described by petitioner (PX. 4, pp.11-12).

Dr. Sweeney also reviewed the right shoulder MRI. According to Dr. Sweeney, the MRI showed a supraspinatus tendinosis with an interstitial tear, which is a rotator cuff tear. (PX.4, p.13)

According to Dr. Sweeney, the MRIs showed disc protrusions at L2-3, L3-4, L4-5 and an annular tear. Dr. Sweeney also noted a diffused disc protrusion at the L5-S1 level as well as the synovial cyst on the lumbar MRI of February 25, 2015. Dr. Sweeney believed the findings on the MRI were consistent with his physical findings on examination of the petitioner. (PX.4, pp.14-15)

Dr. Sweeney confirmed that in the several months he provided treatment to petitioner her complaints have been consistent. Dr. Sweeney believed the synovial cyst was posttraumatic. Dr. Sweeney stated the herniated disc may or may not be related to her injury. (PX.4, p.16)

Dr. Sweeney confirmed that the findings on the subsequent MRI from May 14, 2105 were basically the same as the previous MRI (PX.4, p.18). Petitioner returned to Dr. Sweeney on June 25, 2015 and her findings remained the same (PX.4, p.19). Petitioner returned to Dr. Sweeney on July 30, 2015 and her condition remained the same (PX.4, p.20).

Dr. Sweeney also had the opportunity to review Dr. Casini's report. He disagreed with Dr. Casini's opinion that there was no causal relationship between petitioner's symptoms and her fall. Dr. Sweeney based his contradictory opinion to that of Dr. Casini on the fact that he had treated petitioner for months; petitioner had worked for respondent with no problems prior to her work injury; and the pathology on the MRIs confirmed the condition. (PX.4, pp.20-21)

Dr. Sweeney testified he never found petitioner to be malingering or dishonest (PX.4, p.22).

Dr. Sweeney saw petitioner again on August 27, 2015. She continued to have severe back pain. She complained of possible leakage. She also had a very tender and swollen left buttock. Dr. Sweeney sent her for another MRI of the pelvis. The MRI of the pelvis obtained on September 1, 2015 was reported by Dr. Sweeney on September 3, 2015 to be essentially the same as the other MRIs (PX.4, pp.23-24)

Dr. Sweeney last saw petitioner before the deposition on October 1, 2015, at which time petitioner's condition remained the same. (PX. 4, p. 25)

Dr. Sweeney opined that petitioner's synovial cyst was either directly caused by the work accident or inflamed by the accident; either way Dr. Sweeney believes the pain was caused by the work accident (PX.4, p.26). Dr. Sweeney was not able to state at the time of his deposition whether the herniated discs were caused by the work accident (PX.4, pp. 26-27). Dr. Sweeney stated that if after the cyst is removed and her complaints get better than the herniated discs would be considered incidental findings (PX.4, p.27). Dr. Sweeney opined that surgery to remove the synovial cyst is necessary due to the work injury as petitioner had an undisputed

work-related injury that resulted in pain that is, and has been, disabling for months; pathology is present on the MRIs; and she had failed conservative care (PX.4, p.28). Dr. Sweeney also believed the treatment to date was reasonable and necessary (PX.4, p.28-29)

The records of Dr. Sweeney after the deposition include an MRI of the lumber spine from October 23, 2015. The MRI was redemonstration of the abnormality at the L5-S1 level. Petitioner returned to Dr. Sweeney on October 29, 2015. Petitioner's complaints remain the same. Dr. Sweeney reviewed the MRI and indicated that he thought the condition was a synovial cyst but there was a small possibility it was a tumor. (PX.3)

Dr. Sweeney performed surgery to excise the right L5 abnormal tissue on November 16, 2015. Dr. Sweeney's post-operative diagnosis was posttraumatic L5-S-1, right facet synovial cyst that was possibly cystic. On December 3, 2015, petitioner had her first post-operative visit with Dr. Sweeney. At the time of this visit, petitioner thanked Dr. Sweeney for giving her life back as the old pain was pretty much gone.

Petitioner returned to Dr. Sweeney on January 14, 2016. Dr. Sweeney wrote that the post traumatic necrotic hemorrhage muscle/L5-S1 facet cyst/mass, as well as the right shoulder pain, were the result of her work injury of January 30, 2015. Petitioner was making strides in physical therapy and would likely be released from the lumbar injury after four more weeks of physical therapy. (PX.3)

Dr. Jack Casini testified in behalf of respondent via deposition on October 29, 2015 (RX.2). Dr. Casini testified he reviewed the records of Dr. Kravarik and Dr. Sharma, as well as the February 25, 2015 lumbar MRI and right shoulder MRI, and the March 2, 2015 MRI of the of petitioner's sacrum/coccyx, in conjunction with his examination of petitioner on June 10, 2015 (RX.2, p. 7). Dr. Casini testified petitioner provided a history that she slipped on a banana peel and fell suffering injuries to her tailbone, lower back, right shoulder, and back of the head (RX.2, p.9). At the time of her exam of June 10, 2015, petitioner had complaints related to her lower back, legs and right shoulder (RX.2, p.9).

Dr. Casini testified he found petitioner sitting comfortably in the examining chair and in a gown upon arrival in the examining room (RX.2, p.11). When Dr. Casini asked petitioner to walk, she had a shuffling gait (RX.2, p.12). When she was asked to stand on her toes and heels she assumed a nonanatomic posturing (RX.2, p.12). Dr. Casini classified nonanatomic as "faking" (RX.1, p.33). Petitioner reportedly could not lift her right arm greater than 60° (RX.2, p. 12). She also grimaced on any attempt to move her arm (RX.2, p.12). She would not allow Dr. Casini to lift her arm greater than 90° (RX.2, pp.12-13). She had complaints of pain and demonstrated cogwheel weakness to manual muscle testing of the right shoulder (RX.2, p.13).

Dr. Casini reported petitioner had cutaneous hyperesthesia to soft touch and reported petitioner showed good range of motion with her back passively and limited when asked to do active range of motion of the lumbar spine (RX.2, p.13). When petitioner was asked to sit on the examining table she reportedly could not sit on her left buttock (RX.2, p.14). Dr. Casini reported passive range of motion of the hips were pain free (RX.2, p.15). Dr. Casini reported petitioner demonstrated cogwheel weakness to manual muscle testing in the lower extremities (RX.2, p.15). Petitioner straight-leg-raising test produced pain whether her knee was flexed or extended (RX.2, p.15). He also watched petitioner walk with a normal gait as she walked down the hall to

exit the building (RX.2, p.15). Dr. Cassini claimed all these actions demonstrated petitioner was magnifying her symptoms or malingering (RX.2, p.15). For the reasons Dr. Casini enumerated, he found petitioner to falsifying her claim (RX.2, pp.21-23).

Dr. Casini reported the MRI of the right shoulder showed tendinosis in the supraspinatus tendon and a paralabral cyst (RX.2, p.16). In his opinion, Dr. Casini found no evidence of tears of the rotator cuff or labral (RX.2, p.16). In his opinion, there was nothing on the right shoulder MRI that would cause petitioner pain (RX.2, pp.16-17).

Dr. Casini reviewed the February 25, 2015 lumbar MRI. He reported the MRI was negative except for a hyper intense mass to the right side of the facet at L5-S1 outside of the spinal canal. Dr. Casini opined this condition was usually a degenerative cyst, but could be other things. Dr. Casini did not believe the mass was caused by the January 30, 2015 accident. Dr. Casini could not say if the mass was aggravated by the work accident of January 30, 2015, as he was not sure what it was. (RX.2, pp.18-19)

Dr. Casini disagreed with Dr. Sweeney's opinion that petitioner had multiple herniated discs (RX.2, pp.19-20). According to Dr. Casini, the March 2, 2015 sacrum MRI was normal (RX.2, p.21). Dr. Casini did not form a diagnosis as of the time of June 10, 2015 exam (RX.2, p.21).

Dr. Casini did not believe petitioner required treatment to her right shoulder (RX.2, p.26). Dr. Casini believed petitioner would benefit for further assessment of the mass on her back, but did not believe the treatment was related to any work injury from January 30, 2015 (RX.2, p.26). Dr. Casini did not believe surgery proposed by Dr. Sweeney to remove the lumbar cyst would do anything to change petitioner's complaints (RX.2, pp.26-27). Dr. Casini believed petitioner could return to work in regard to both her right shoulder and back (RX.2, p.28). Dr. Cassini agreed that petitioner could return to work, regardless of her occupation (RX.2, 46).

Dr. Casini clarified that, although he believed the March 2, 2015 sacrum MRI was negative at the sacrum, it showed a multiseptate cystic lesion L4-L5 and L5-S1 representing a synovial cyst (RX.2, p.41). Dr. Casini also agreed that if petitioner's symptoms were consistent with the MRI findings then further testing would be necessary (RX.2, p.42).

Dr. Casini disagreed with the radiologist report that there was an L2-3 foraminal disc protrusion effacing the thecal sac (RX.2, pp. 42-43). Dr. Casini agreed with the radiologist's interpretation there was a disc protrusion effacing the thecal sac at L3-4 (RX.2, p.43). Dr. Casini agreed with the radiologist's interpretation that there was a disc protrusion with annular tear effacing the thecal sac at the L4-5 level (RX. 2, p.43). Dr. Casini disagreed that the lateral recesses were narrowed bilaterally at the L4-5 level (RX.2, pp. 43-44). Although Dr. Casini did not believe the spinal canal was compromised at any of these levels (RX.2, pp.42-43).

Dr. Casini could not recall specifically if he agreed or disagreed with the radiologist interpretation that disk material and facet hypertrophy causing bilateral neural foraminal narrowing that effaces the left and right L4 existing nerve roots were present at L4-5. Dr. Casini agreed with the radiologist's interpretation that there was a disc protrusion at L5-S1 that effaced the thecal sac, but disagreed it compromised the spinal canal. (RX.2, p.44)

Although Dr. Casini disagreed with the radiologist's findings on the March 2, 2015 MRI of the sacrum and coccyx of marrow edema/contusions in the 4th and 5th segments of the sacrum, he agreed these would be consistent with a fall on petitioner's butt on a hard surface (RX.2, p.45).

Dr. Casini recommended petitioner should undergo an MRI with and without contrast of the lumbar spine to determine the nature of the mass (RX.2, p-45-46).

Dr. Casini had not performed surgeries for ten years (RX.2, p.47). If surgery is necessary, he refers the patients out to surgeons (RX.2, p.47). He estimates that approximately one percent of his practice is doing exams; all one percent in behalf of respondents (RX.2, p.48).

Dr. Cassini testified a lot of his testing done at the time of petitioner's exam was Waddell testing to determine what if petitioner was honest during the exam (RX.2, p.52).

CONCLUSIONS OF LAW

The Arbitrator adopts the Finding of Facts in support of the Conclusion of Law.

The Arbitrator finds the petitioner to be credible and any discrepancies in her testimony appear to be the result of the language barrier. Although Kerry Frescura, the school nurse, believed she was able to communicate with petitioner in English, petitioner testified she did not completely understand everything Frescura was saying. Petitioner brought an interpreter with her at each doctor visit. Furthermore, during her testimony, the petitioner had difficulty communicating even through the translator.

C. With respect to the issue of whether an accident occurred that arose out of and in the course of Petitioner's employment by respondent, the Arbitrator finds the following facts:

Petitioner testified that on January 30, 2015 she was doing her job as a janitor for respondent. On that day, while working in respondent's cafeteria, petitioner slipped on a banana peel, landing on her tailbone/buttocks, striking her right arm as she fell. She sought immediate attention from the respondent's nurse, Kerry Frescura.

Frescura completed the report of the accident which recited the facts of this occurrence of January 30, 2015 indicating petitioner injury to her sacrum and right wrist. She noted redness and abrasion of the right wrist (RX.1).

Petitioner's history contained in all of the records of the treating and examining physicians is consistent with petitioner slipping on a banana peel and landed on her buttocks while working in respondent's cafeteria on January 30, 2015.

Based upon this overwhelming evidence, The Arbitrator finds petitioner was injured in an accident that arose out of and in the course of her employment with respondent on January 30, 2015.

F. With respect to the issue of whether the petitioner's condition of ill-being is related to the injury, the Arbitrator finds the following:

Although petitioner did not seek medical treatment from a doctor until February 10, 2015, she did seek treatment from respondent's nurse immediately after the occurrence. The nurse recorded petitioner's complaints of pain soreness to the sacral, coccyx area, as well as her right wrist. The nurse did not perform an examination.

Petitioner testified she lived and worked with the pain until February 10, 2015, when she could no longer tolerate it. She then saw Dr. Kravarik, a chiropractor, with Will County Health and Wellness. Dr. Kravarik diagnosed a lumbar disc herniation, lumbar radiculopathy, lumbar sprain/strain and right shoulder sprain. Dr. Kravarik believed these injuries were consistent with the January 30, 2015 accident as described by petitioner.

Dr. Sweeney, who next treated petitioner, reviewed the MRIs and concluded petitioner had a large right-side L5-S1 cyst, as well as small herniated discs at L2 through S1, as well as an annular tear at L4-L5. Dr. Sweeney also believed petitioner had a rotator cuff tear of the right shoulder. Dr. Sweeney believe the cyst was likely post-traumatic. (PX.3)

In his deposition, Dr. Sweeney testified that the bone marrow edema noted on the MRI at the sacrum was consistent with the mechanism of the injury described by the petitioner (PX.4, pp.11-12). Dr. Sweeney testified he based his opinion that the mass noted on the MRI at the L5-S1 level was caused by the work accident on the fact that he had treated petitioner for months [and the petitioner's complaints remained the same]; petitioner had worked for respondent for many years as a janitor without problems; and the pathology found on the MRIs (PX.4, pp20-21). Dr. Sweeney further testified that in his opinion petitioner's synovial cyst was either directly caused by the work accident or inflamed by the work accident (PX.4, p.26). At the time of his deposition, Dr. Sweeney could not confirm whether the herniated discs were caused by the work accident (PX.4, 26-27). Dr. Sweeney further testified that if after the mass was removed and the petitioner received relief, than the herniated discs were incidental findings (PX.4, p.27).

After performing surgery to remove the mass on November 16, 2015, Dr. Sweeney concluded on January 14, 2016, that the post traumatic necrotic hemorrhage muscle was the result of the work accident of January 30, 2015. As of January 14, 2016, Dr. Sweeney continued to opine that petitioner's right shoulder pain was the result of the work accident that warranted further evaluation by a shoulder specialist. (PX.3)

Based upon the foregoing evidence, the Arbitrator finds that petitioner's post traumatic necrotic hemorrhage muscle that was surgically removed by Dr. Sweeney on November 16, 2015 was caused by the work accident of January 30, 2015. The Arbitrator further finds the herniated discs reported by Dr. Sweeney were not caused by the work accident. This is based upon the testimony of Dr. Sweeney that if petitioner received relief from the removal of the mass, and she did, than the herniated discs were merely incidental findings. The Arbitrator also finds that petitioner's right shoulder supraspinatus tendinosis, for which Dr. Sweeney recommended further evaluation by a shoulder specialist, was caused by the work accident.

The Arbitrator makes these findings, despite the opinion of Dr. Casini. Dr. Casini did not have a diagnosis for the mass found on the MRI at the L5-S1 level. Although Dr. Casini believed this finding was usually a degenerative cyst, he agreed it could be other things. Even though Dr. Casini would not agree the mass was caused by the work accident, he had no opinion as to whether the mass had been aggravated by petitioner's fall on January 30, 2015.

Although the MRI of the right shoulder and Dr. Casini's opinion do not support Dr. Sweeney's diagnosis of a right shoulder rotator cuff tear, the evidence supports a finding that petitioner sustained a right shoulder sprain from the work accident.

There is no evidence the bucket-lifting incident caused the injury, only triggered petitioner's back pain. The testimony of Dr. Sweeney confirmed the cause of the mass was petitioner's fall on January 30, 2015. Dr. Casini agreed the fall on petitioner's butt could cause the findings on the MRI. None of the treating or examining doctors suggested the bucket-lifting incident caused or contributed to petitioner's back injury.

J. In support of the Arbitrator's decision with regard to the medical bills incurred, the Arbitrator finds the following:

The Arbitrator, having found petitioner sustained a work accident that arose out of an in the course of her employment on January 30, 2015 and that the work accident caused petitioner's post traumatic necrotic hemorrhage muscle, which required surgery to remove the mass performed by Dr. Sweeney on November 16, 2015, and as petitioner obtained relief from the surgery performed, as evident by petitioner giving thanks after the surgery to Dr. Sweeney for giving her life, finds the treatment rendered to date petitioner reasonable and necessary.

The Arbitrator makes this finding despite the opinions of Dr. Casini. Dr. Casini did not have a diagnosis of petitioner's mass/cyst at the L5-S1 level. Dr. Casini would not say if the mass was aggravated by the work accident. Furthermore, Dr. Casini did not believe surgery to remove the mass would do anything to change the petitioner's complaints. However, as petitioner remarked to Dr. Sweeney that she had her life back after the surgery and further testified the surgery had taken away her pain and she was able to walk again, this is evidence the surgery was necessary to cure her of her back injury.

At the time of hearing, the only ongoing complaints petitioner had relative to her right shoulder. The only real treatment petitioner had to her right shoulder was an MRI on February 26, 2015. There are no medical bills claimed outstanding for treatment directly to her right shoulder.

There was no utilization review of the bills by respondent. Dr. Sweeney testified the treatment to date was reasonable and necessary. Dr. Kravarik provided direct care and then physical therapy as ordered by Dr. Sweeney. The Arbitrator, having found the lower back condition was caused by the work accident awards the following bills in accordance with §8 and §8.2 I accordance with the fee schedule:

$28,068.31 Will County Health & Wellness

$4,000.00 Tinley Park MRI and Imaging
$20,000.00 Center for Minimally Invasive Surgery
$43,333.00 Minimally Invasive Spin surgery/Dr. Sweeney
$250.00 - Pain & Spine Institute
$4,320.00 – Homer Glen Open MRI

Respondent to be given credit for any payments made, or by any payments made by Blue Cross and Blue Shield pursuant to §8j of the act.

K. In support of the Arbitrator's decision with regard to prospective medical care, the Arbitrator finds the following:

According to Dr. Sweeney, other than ongoing physical therapy, treatment of petitioner's lower back was likely to be completed within four weeks of her last visit with him on January 14, 2016. The fact that petitioner obtained relief from the surgery, per Dr. Sweeney the herniated discs were incidental findings and thus there is no need for treatment as the diagnosed herniated discs do not appear to be related to the work accident. Therefore, the only prospective medical treatment that is awarded for treatment to petitioner's back is the physical therapy is the period through the four weeks as of January 14, 2016, and the follow up necessary with Dr. Sweeney.

The MRI and Dr. Sweeney's testimony support a finding that petitioner has some pathology in her right shoulder caused by the work accident which warrants a referral to a shoulder specialist. The Arbitrator awards the cost of further evaluation by a shoulder specialist for treatment of petitioner's right shoulder injury.

L. In support of the Arbitrator's decision with regard to TTD, the Arbitrator finds the following:

Dr. Kravarik's records confirm petitioner was to be off work as of February 11, 2015 through June 20, 2015. Dr. Sweeney kept petitioner off work from May 28, 2015 through his last visit of January 14, 2016.

The Arbitrator finds petitioner was temporarily totally disabled as of February 11, 2015 through the date of hearing on February 2, 2016 based upon the opinions of Dr. Kravarik and Dr. Sweeney, who found petitioner's condition was caused by the work accident and disabling.

The Arbitrator makes this finding despite the opinion of Dr. Casini, who did not believe petitioner was disabled from any type of work. The Arbitrator discounted the opinion of Dr. Casini as he did not know what the diagnosis of the mass was and did not know if petitioner's mass/cyst was aggravated by the work accident as he was unsure as to what it was. Dr. Casini did not have the benefit of the post-operative findings at the time of his testimony. Without the knowledge of the petitioner's actual condition, Dr. Casini's opinion on petitioner's disability is questionable.

For these reasons, the Arbitrator awards temporary total disability from February 11, 2015 through February 2, 2016, or 51 weeks of TTD @ $306.67 per week.

(WHICH SAID STENOGRAPHIC STIPULATION IS

AS FOLLOWS:)

"It is stipulated and agreed by and between the parties hereto that in the event either party files a petition to review the award of the Arbitrator within the time required by law and orders a transcript of evidence and proceedings before the Arbitrator within the limitations fixed by law and in accordance with the rules and practice of the Workers' Compensation Commission, and the reporter provided by the Workers' Compensation Commission does not complete or furnish such transcript of evidence within such limitations, that the opposite party will not raise the question of jurisdiction of the Workers' Compensation Commission to review said award of the Arbitrator upon the grounds that said transcript of evidence was not filed within the limitations fixed by law."

THE ARBITRATOR: And also the parties have been asked to initial that they have agreed to receive the

Arbitrator's decision in lieu of certified mail, to receive it via e-mail. For the Petitioner I have M, as Mary, P, as in Paul, H as Harry, and m-e-y-e-r-s, meyers hyphen flowers, f-l-o-w-e-r-s, dot com.

Does the Petitioner receive the e-mail at that address?

MR. HELLMAN: The Petitioner does, your Honor.

THE ARBITRATOR: The Respondent I have as g-g-a-l-a-n-t-e at S, like Sam, a-l-a-w-u-s dot com.

MS. GALANTE: Dot com.

THE ARBITRATOR: Let me repeat g-g-a-l-a-n-t-e, at s-a-l-a-w-u-s dot come.

Does the Respondent agree to receive the decision via e-mail in lieu of certified mail at this address?

MS. GALANTE: Yes, your Honor.

THE ARBITRATOR: Is there any objection to the introduction of Arbitrator's Exhibit No. 1?

MR. HELLMAN: No objection from Petitioner.

MS. GALANTE: No objection for Respondent.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Christopher Cates,

Petitioner,

vs. NO: 10 WC 40512

SOI/Pinckneyville Corr. Ctr.,

16IWCC0643

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

The Commission hereby strikes as hearsay those depositions admitted into evidence in error by the Arbitrator from other claims not presently pending – namely, the depositions admitted at PX13-15 and PX20-21.

All else is otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed 1/16/15, with corrections, is hereby affirmed and adopted.

16IWCC0643

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 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: OCT 5 - 2016
o: 8/8/16
TJT/pmo
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

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

CATES, CHRISTOPHER
Employee/Petitioner

Case# **10WC040512**

SOI/PINCKNEYVILLE CORR CTR
Employer/Respondent

16IWCC0643

On 1/16/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

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

0558 ASSISTANT ATTORNEY GENERAL
KYLEE J JORDAN
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

0498 STATE OF ILLINOIS
ATTORNEY GENERAL
100 W RANDOLPH ST 13TH FL
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1350 CENTRAL MANAGEMENT SYSTEMS
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 16 2015

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)

Christopher Cates
Employee/Petitioner

v.

State of Illinois/Pinckneyville Corr. Ctr.
Employer/Respondent

Case # 10 WC 40512

Consolidated cases: ____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Herrin**, on **November 13, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

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

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

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

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

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

G. [ ] What were Petitioner's earnings?

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

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

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

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

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

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

N. [ ] Is Respondent due any credit?

O. [ ] Other ____

FINDINGS

On the date of accident, **September 21, 2010**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**55,973.50**; the average weekly wage was $**1,076.91**.

On the date of accident, Petitioner was **37** years of age, *married* with **3** dependent children.

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

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

Respondent is entitled to a credit of $**any benefits paid through group** under Section 8(j) of the Act.

ORDER

Respondent shall pay the reasonable and necessary medical expenses as outlined in Petitioner's group exhibit. Respondent shall have credit for all amounts paid through its group carrier, but shall indemnify and hold Petitioner harmless from any claims regarding payment of any amount for which it is receiving this credit, pursuant to §8(j) of the Act

Respondent shall authorize and pay for any medical treatment recommended by Dr. Brown and Dr. Young, including but not limited to surgery, as provided in §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

1/12/15
Date

JAN 1 6 2015

STATE OF ILLINOIS)
) SS
COUNTY OF WILLIAMSON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

CHRISTOPHER CATES
Employee/Petitioner

v. Case # 10 WC 40512

STATE OF ILLINOIS PINCKNEYVILLE CORR. CTR.
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner's Testimony

At the time his injuries manifested, Petitioner was a 37-year-old Correctional Officer at Pinckneyville Correctional Center. (T.10-11; AX1). Petitioner testified that was employed at Pinckneyville Correctional Center as a Correctional Officer for 15 years, from 1998 until 2013, when he transferred to Du Quoin Impact Incarceration Center. (T.10-12). Prior to his employment with Respondent, the State of Illinois, Petitioner served in the U.S. Air Force. (T.10). Petitioner testified that he does not suffer from diabetes, gout, hypothyroidism or rheumatoid arthritis. (T.11).

Petitioner testified that he spent over half of his career at Pinckneyville Correctional Center working in the R5 segregation unit. (T.12). Petitioner testified that use of his arms and hands was amplified while working in segregation because all movement was controlled and chuckholes were used extensively to cuff and uncuff inmates for movement and for feeding. (T.12-13). Petitioner testified that chuckholes are steel slots in the main door opened with a Folger Adams key, which were sometimes difficult to operate and required the use of grip and both hands. (T.13-14, 17). He testified that the chuckholes stuck over time because they were subjected to food, grime, feces, urine and other things that caused them to rust. (T.14). Petitioner testified that sometimes the problem was the key rather than the locking mechanism. (T.45). When asked on cross-examination whether it was possible to have a shift where there were no problematic locks, Petitioner stated, "That would be very rare" and that he "always had locks that [gave him] trouble." (T.45-46). Petitioner testified that there was a locksmith on hand to assist with the doors and locks. (T.17, 44-45). Inmates were fed one meal per shift. (T.16). Petitioner was required to deliver food and drinks through the chuckholes and then go back and collect the trays and food through the chuckholes. (T.16-17). Petitioner testified that inmates sometimes resisted when being cuffed through the chuckholes and that he had to forcefully use his hands, wrists and arms. (T.14-15).

Petitioner testified that although the door locks in segregation (not the chuckholes) could be unlocked by the control room, the doors did not automatically swing open and had to be physically pulled open by a Correctional Officer. (T.42-43). Petitioner testified that the doors did not open easily. (T.43). Petitioner testified that the doors had a rubber seal on the bottom, which prevented water from coming out into the wing if an inmate decided to flood his cell and prevented them from flying kites across the wing. (T.43). Petitioner testified that this rubber seal is bolted on the bottom of the segregation doors and caused the doors to stick. (T.43). He stated that each door was different, but that "it would take some force for some." (T.43-44).

Outside of segregation, Petitioner worked in every assignment in the institution. (T.19). However, he testified that he spent most of his time working outside of segregation as a Wing Officer. (T.19). As a Wing Officer, Petitioner was responsible for the security of the cell house and performed wing checks, ran line movement and performed shakedowns. (T.19). Petitioner testified that the doors at the facility were made of heavy steel. (T.26-27). Wing checks were performed every 30 minutes and required Petitioner to forcefully tug on every door to ensure that every cell is locked. (T.51-52). Petitioner testified that the screen in the control room doesn't always accurately reflect whether a door is locked because some of them do not work correctly, and he testified that inmates can alter the door lock to where the door appears to be locked, but it is not. (T.52). The following testimony was elicited on cross-examination:

> Q: Would you categorize that as, like, a light tug or click in the door to see if it clanks more or less?
>
> A: No. You want to tug on it good, because an inmate can alter the door to where – stick something in it to where they can have the lock stuck and have it appear to be shut and it's not. And I've ran across that myself and I've seen other officers run across that on a count where they've tugged on the door that appeared to be compromised, and it was. (T.52).

Petitioner testified that performing shakedowns required him to go into inmate cells and check the property boxes and all of the inmate's property to ensure that contraband was not being kept and that the cell was not damaged or unsafe. (T.19-20). Petitioner testified that this required the use of his arms and hands and "a little bit of everything" when he performed lifting. (T.20). Petitioner testified that officers are required to complete shakedowns on every cell on their assigned wing each month. (T.20). Correctional Officers may be assigned one or two wings. (T.20). Officers chose how many cells he or she would shake down per day or week. (T.20, 53-54). There are 56 cells on a wing with two inmates per cell. (T.20-21). Petitioner testified that the length of time it took to complete a shakedown depended upon how much property the inmate had and how thorough the search needed to be. (T.53-54). Inmates have two property boxes, a large box where items such as flat screen TVs, clothing and commissary items, and a small property box where all their legal items are kept. (T.21). Petitioner testified that a shakedown could take anywhere from 20 to 40 minutes for one cell. (T.54). Petitioner testified that he on average shook down one cell every day. (T.53).

Petitioner mainly worked the 3 to 11 shift. (T.23). Petitioner testified that shower and medical treatment passes are ran on the 3 to 11 shift, and that the movement on the 3 to 11 shift are comparable to day shift, if not greater. (T.36).

Petitioner testified that the duties of Correctional Officers are intensified during lockdown. (T.23-24). Petitioner testified that lockdown affects inmate movement, which means that officers may not have inmate workers. (T.23). Petitioner testified that the job duties of Correctional Officers double during this time, because Correctional Officers are required to feed every cell, and all movement is cuffed movement. (T.24). Every inmate has to be individually cuffed and escorted for every pass. (T.24). Petitioner testified that although the restricted movement is normal in segregation, Segregation Officers were required to do the cleaning and other tasks that inmate porters did in addition to their normal job duties during lockdown. (T.55-56).

Petitioner testified that he has opened thousands of doors and chuckholes over his years at Pinckneyville Correctional Center. (T.15). Petitioner also testified that he worked quite a bit of overtime. (T.31-32). Petitioner testified that he reviewed Respondent's evidence, the depositions of his co-workers, the depositions of his own physician and Respondent's records reviewer, Dr. Williams. (T.32-33, 64).

Petitioner testified that his condition has gradually worsened over the four years since his injuries manifested. (T.27-28). Petitioner testified that he has a "heck of a time shutting the alarm off in the morning some mornings" due to the numbness and falling asleep during the night. (T.28). His hands make him wake during the night. (T.28). Petitioner also testified that when his claim was first filed, he received an e-mail from the State of Illinois saying that his claim was compensable, which was admitted into evidence as Petitioner's Exhibit 8. (T.29; PX8). Petitioner is also now having problems with his right elbow. (T.30). Petitioner testified that his is right hand dominant. (T.30). Petitioner testified to hobbies of bow hunting and weight lifting. (T.60-62). He testified that he tries to work out three to four times per week because Respondent's Du Quoin boot camp encourages him to stay fit. (T.61).

Testimony of Jason Thompson

Lt. Jason Thompson was present on behalf of Respondent but called by Petitioner. (T.65). Lieutenant Thompson testified that he currently serves at Pittsfield Work Camp. (T.65-66). He testified that he worked at Pinckneyville Correctional Center from 1998 to 2011. (T.66). He testified that he had the opportunity to work with Petitioner during that time, and stated that he is a good employee. (T.66). Lt. Thompson acknowledged that his Key Estimation Study is an estimate. (T.66-67). Lt. Thompson also testified that his testimony given by way of deposition was specifically regarding his Key Estimation Study, the amount of work done by Correctional Officers, and Respondent's analyses videos of the facility. (T.67-68). He testified that he did not have any idea *why* he was being asked those questions during his deposition. (T.67-68). On cross-examination by Respondent's counsel, Lt. Thompson agreed with much of Petitioner's testimony concerning the conditions of the facility, with the exception of his characterization of a wing check. (T.69-71).

Deposition of Jason Thompson (PX20)

Lieutenant Thompson also testified by way of deposition that during his time at Pinckneyville Correctional Center, he was present in x-wing style housing units 3 and 4, which held 448 inmates. (PX20, p.6). These are 112 cells in 2 wings, holding 2 inmates each. *Id.* at 6.

He saw Dr. Williams' attempt to open one key on the R3-C wing door and one handcuff key. *Id.* at 7. He testified that Dr. Williams was awkward while trying to get the hand position movements, and had trouble hitting the double lock key portion of it. *Id.* at 7.

When asked to explain the difficult double lock key portion, he testified:

> A: Basically, with your handcuff keys, you've got the keyhole, which the key portion fits in. You turn that to unlock it. (Indicating.)
>
> Q: Yes, sir.
>
> A: On either the side—either the edge side or on the opposite of the keyhole, you also have what's called a double-locking mechanism. (Indicating.) If it's a pin-type, you have a small pin that you press in with the non-key end of the key—of the cuff key. It's just like a pinpoint.
>
> Q: Yes, sir.
>
> A: And you press it in, and that double-locks the cuffs. (Indicating.) If not, you've got—it's basically a wire-type double lock, where you—also using the same end of that key, you stick it in there and you push it in, and that also double-locks the cuffs.
>
> Q: Very good. And the reason that they're double-locked is why?
>
> A: So they can't be compressed any further and they're harder to jimmy.
>
> Q: Safety reasons?
>
> A: Yes. Absolutely. *Id.* at 7-8.

Lieutenant Thompson testified that keying cells and chuckholes, opening and closing doors, cuffing and un-cuffing inmates, turning difficult keys, opening difficult doors, pulling on bars, checking cell doors, weapons training, working mandated double shifts, performing extra duties on lock down, opening and closing chuckholes, lifting property boxes, carrying trays upstairs, restraining inmates, guiding inmates through lines, and performing various amounts of paperwork were the duties of a Correctional Officer. He further agreed that there was not a single part of the job that did not involve using one's arms, hands, or elbows. *Id.* at 38. In addition, he acknowledged that these activities involved force and stress. *Id.* at 40.

Deposition of Melanie Welch (PX13)

Ms. Welch is an employee of CorVel, which is a national corporation providing services to employers, third party administrators, insurance companies, and government agencies. (PX13, p.44). When asked if she had ever done a Job Site Analysis for an injured worker, the following interchange took place:

> Q: As far as performing a job site analysis for an injured worker, have you ever done that?
>
> A: Yes.

Q: Ma'am, I took your deposition on—in the case of Darin Hathaway versus IYC, State of Illinois on June 9, 2011, and I specifically asked you on line 14 through 18 on page 23, "As far as performing job site analysis for an injured worker, have you ever done that?" Your answer under oath at that point, ma'am, was, line 16 through 17, "For the employer. The injured worker did not call us, no." Do you remember that answer, ma'am? Have you done one since June 9, 2011?

A: Since June 9, 2011. Oh, you mean requested by an injured worker.

Q: No, ma'am. My question was pretty clear, and I caught you in a lie right out of the box. Now, my question now is very simple. Have you performed a job site analysis for an injured worker since June 9?

A: Not requested by an injured worker, but when I do, like, an ergonomic assessment, I consider that to be for the injured worker, for their behalf.

Q: Well, was this done on behalf of the employees at Pinckneyville Correctional Center or was it requested by the State of Illinois?

A: It's requested by the State of Illinois.

Q: I see.

A: For the injured worker.

Q: I don't think it's very funny, ma'am.

A: Okay.

Q: I note for the record you're laughing, but I consider that a sign of disrespect for all parties involved. *Id.* at 44-45.

Ms. Welch received her training in Job Site Analysis from ErgoRehab Incorporated. *Id.* at 45-46. This certification was obtained by mail and through the Internet, and was paid for by Corvel. *Id.* at 47-48.

Ms. Welch could not remember the last time she did any work on behalf of an injured worker, did not know the age of Pinckneyville Correctional Center, did not know that during the 5 to 7 years prior to the video being shot that the facility was short staffed, and admitted that the video was edited. *Id.* at 50-51.

Ms. Welch also believed that it was a requirement that 20% of the entire staff rotate every 90 days, despite the consistent testimony from other witnesses that some Correctional Officers stay in their positions for years. *Id.* at 55. She did not take into account overtime and she mistakenly believed that the segregation unit was contained in the video that she filmed. *Id.* at 56-58. The video did not show any of the locks that would not open, did not show how hard the locks were to open, did not show any bending or breaking of keys, did not show any new keys which were hard to put into the locks, and did not show the heaviness or the weight of the wing doors. *Id.* at 58-59.

Ms. Welch testified that she had neither seen nor lifted a property box, and was completely unaware that they contained TVs, radios, books, paperwork, computers, clothing. *Id.* at 63-64. She further acknowledged that the video showed nothing about Correctional Officers having to carry crates filled with cartons of milk or juice weighing hundreds of pounds up flights of steps to feed inmates. *Id.* at 66. When asked whether it would be important in consider whether a Correctional Officer had to carry a milk carton and/or food tray and simultaneously open and close difficult chuckholes that often stick, Ms. Welch answered, "I don't know, I didn't try it." *Id.* at 67. She also believed that restraining a combative inmate at a Respondent's Pinckneyville Correctional Center would fall in the "medium" category of job requirements. *Id.* at 64.

She further acknowledged that there was nothing in the Job Site Analysis or video about keying and un-keying doors for moving of inmates through the housing units in passes run on any given day; nothing about the transfer box, writs, medical furloughs, medical and furlough bags. *Id.* at 68-69. Nothing was contained in the video about keying out passes for clothing, barber shop, and commissary, or weapons and tactical training. (RX6; RX7).

She did not videotape or observe any cell shake downs and, in fact, believed that shake downs were performed on Correctional Officers themselves when they entered the prison. *Id.* at 76. She did not video tape the Correctional Officers having to push buttons and operate toggles to open doors, which required the officers to hold down the button with their thumb and toggle the switch with their little and pinky fingers at the same time. *Id.* at 77-78. She had no idea that this happened almost 250 times in an hour and thousands of times in a day. *Id.* at 78. After going through all this information, Ms. Welch testified that whether Correctional Officers are constantly and repetitively using their arms and hands in a forceful manner depended on their post. *Id.* at 88-89.

Deposition of Robert Schuchert (PX14)

Mr. Schuchert was employed at Respondent's Correctional Center as the facility's locksmith. (PX14, p.4). He also operates an outside business called Schuchert's Lockshop in Chester, Illinois. *Id.* at 4. He began working for the State of Illinois in 1981 at Menard Psychiatric Center, and transferred to Pinckneyville Correctional Center on August 16, 1998. *Id.* at 5-6. He served as a Correctional Officer, like Petitioner, from 1998 until January 2004. Since 2004, he has been a locksmith at Pinckneyville. *Id.* at 6. Schuchert viewed the videos from Menard Correctional Center and Pinckneyville Correctional Center. *Id.* at 7. He also reviewed the Job Site Analysis. *Id.* at 7-8. He testified that while employed as a locksmith at Pinckneyville, he developed bilateral compression neuropathies and filed a Workers' Compensation Claim that was accepted by Respondent. *Id.* at 8. He was voluntarily paid for his time off and received a settlement. *Id.* at 8, 33-34. He attributed his injuries to his repetitive work at Menard and Pinckneyville Correctional Centers. *Id.* at 9-10. He testified that his problems began while working in the segregation at Menard and progressed while performing his job duties at Pinckneyville. *Id.* at 9-10. He testified that, "It got to the point where if I had a tool box full of locks I couldn't carry them with my left hand, especially from one cell house to the next. I had to keep switching hands because it hurt so bad." *Id.* at 9-10. When asked to describe the difference between the locks in the segregation unit and the general population, he stated:

> The seg unit—the difference between the locks in the seg unit and general pop over there is they have a mogul key—a bigger electronic lock in their unit over there than general pop. General pop has a Medeco lock, which is a smaller key, which is compared to your house key. The mogul keys that are over in the seg unit—they're a bigger key. I would say probably about that big on the head. The length of the key is probably about that long. (Indicating). *Id.* at 10.

He acknowledged that all Correctional/Wing Officers had to key open chuckholes, cell doors, cabinets, and medical cabinets; and diary each item that had to be keyed out, logged out, keyed back in, and logged back in. *Id.* at 11-12. The same requirements existed in medical. *Id.* at 12. When asked to describe the locks at Pinckneyville, he stated:

> They have gotten worse, naturally, through the years. When we first arrived, the inmates had their own keys to their locks, so there was a lot of wear and tear. I was trying to remember last night how long it's been since we got rid of the—we pulled the inmate keys out over there. *Id.* at 12.

He testified that approximately 7 to 8 years ago, the inmates had their own keys. *Id.* at 13. However, the keys were taken away due to the atrocious wear and tear on the locks from constant inmate traffic. *Id.* at 13. He described the current condition of the locks as fair to poor. *Id.* at 13-14. When asked to describe the locks where Petitioner has worked the last 5 years, he stated:

> . . .We had a lot of wear on the locks then, and it's been—the chuckhole locks have got a lot of wear, especially in the seg, because they get keyed all the time. You're feeding them three meals a day, plus you're transporting them in and out, if you're—if they're going to – they're going to the yard; they're going to passes, and right now, you're—in warm weather, pass ice, mail, anything else—you got to open that chuckhole. *Id.* at 13.

He acknowledged that Respondent's witness, Lieutenant Thompson, was correct when in stating that the locks and the chuckholes were very difficult to open. *Id.* at 16-17. The difficulty stemmed not only from the locks, but from the food spilled in them. *Id.* at 18. He estimated that he switched out between 2 to 5 locks per week, or at times, 4 or 5 locks will go out in a day. *Id.* at 22.

Demands of the Job Form (RX4)

Respondent submitted a "Demands of the Job" form, which is a form that is designed to quantify Petitioner's arm and hand usage in the performance of his job duties. (RX4). The form indicates that Petitioner lifts 1 to 10 pounds up to 2 hours per day, and lifts 11 to 20 pounds up to 2 hours per day. *Id.* The form indicates that Petitioner never lifts over 20 pounds. *Id.* The form indicates that Petitioner uses his hands for gross manipulation such as grasping, twisting and

handling for up to 2 hours per day, and never uses his hands for fine manipulation such as typing and good finger dexterity. *Id.* The form makes no indication whatsoever as to whether anything is done with our without carrying or intermittent rest. *Id.* The Arbitrator notes that this form is directly at odds with the Job Site Analyses performed by CorVel and Petitioner's unrebutted testimony. *Id.*

Job Site Analyses (RX5)

The CorVel Analyses indicate that 70% of the key turning is done by Wing Officers. (RX5). Both of Respondent's Job Site Analyses categorizes the strength demands Petitioner's job as "Medium" which is defined as "lifting 50 pounds maximum with frequent lifting and/or carrying up to 25 pounds. *Id.* "Frequent" is defined as 2.5 to 5.5 hours per day, 34% to 66% of a day, or 33 to 200 repetitions per day. *Id.* Petitioner also engages in "frequent" wrist turning and "frequent" finger manipulation. *Id.* The wrist turning was associated with the opening of doors and chuckholes up to 150 times per shift in the housing unit. *Id.* More keys would be turned during lockdown. *Id.* The hand-and-arm usage evaluation in the Analyses quantifies more activity than what is indicated in Respondent's "Demands of the Job" form. (RX4; RX5).

Post Description and Key Usage Estimate

Respondent submitted a Post Description for a Housing Unit Wing Officer which enumerates the job duties of a Correctional Wing Officer. (RX5). Pertinent job duties involve:

- Restricting the activity of inmates and ensuring that they do not move from wing to wing;
- Searching inmates leaving and returning to the Unit on call passes or schedule movement;
- Completing cell searches every 60 days and logging the results on a form; Officers are required to shakedown all areas of the unit;
- Completing cell condition checks when inmates are assigned to different cells, noting any irregularities on a form and completing disciplinary reports if any damage has occurred;
- Performing inmate counts and inventory counts and completing count and inventory logs;
- Monitors the issue and use of caustic/toxic substances used in the cleaning area;
- Checking I.D. Cards when passing inmate mail;
- Make constant rounds checking all doors to inmate rooms and ensure that all security doors are closed and locked at all times, except when allowing authorized persons to pass through;
- Check all windows, doors and screens in the housing units in accordance with established procedures;
- Complying with D.R.'s, A.D.'s, I.D.'s, Warden's Bulletins, or special order bulletins, and performing other duties as required or assigned, which are reasonably within the scope of the duties enumerated in the Post Description. *Id.*

The key usage estimate indicates that general population Wing Officers turn 55 large keys and 50 small keys per shift by totaling the key usage estimate under the categories of wing checks, inmate traffic, laundry, utility closet, shakedowns, property box checks, and miscellaneous wing traffic. (RX8). Petitioner testified that he did not have any reason to doubt the estimates listed by Lt. Thompson; however, he indicated that it does not appear that this estimate takes into account inmate feeds on the night shift, which is done through a chuckhole and requires use of a large key. (T.64; RX8). The estimate also contains disclaimers regarding its inadequacies and cautionary statements regarding the combing of posts and resulting usage increases:

> It must be stressed that these are estimations based on visual observations, average inmate movement experienced on the post, estimated amount of staff movement during the shifts, and the assumption that the institution is not on lockdown. Lockdown situations will increase these estimations considerably for posts that are normally open for inmate movement . . . [Emphasis Original].
>
> There are several posts, especially on the 3-11 and 11-7 shifts, in which the duties of two or more posts are combined into one post. An example of this is the 11-7 post 1250, in which the R1 A WING officer is also responsible for R1 B WING. This is a combined post. These posts are identified on the rosters in the same manner as the split posts. **A regular post can become a combined post at any time** by closing a non-mandatory post and placing the responsibility for the closed post on the mandatory post officer. [Emphasis added]. This can be done on any shift, and when it occurs, the affected post will see usage increase by the amount of usage on the closed post. (RX8).

Medical Care and Treatment

During the course of his job duties as a Correctional Officer at Pinckneyville, Petitioner began developing symptoms of paresthesia and numbness in his hands. (T.24).

Petitioner first sought treatment for his injuries with Dr. Sudeep Nair, who noted Petitioner's complaints of worsening wrist pain and numbness. (PX3, 9/14/10). Dr. Nair noted the following regarding Petitioner's symptoms and employment:

> Christopher Cates is a 37 year old male. Worsening wrist pain, numbness, works in 'segregation' at prison, has to twist several locks every day . . . *Id.*

Petitioner's medical history was negative for any contributory factors. *Id.* Physical examination showed tenderness on palpation over Guyon's canal, numbness with tingling in the median nerve distribution with Phalen's testing, and positive Tinel's sign of the median nerve in both Petitioner's right and left wrists. *Id.* Dr. Nair recommended and referred Petitioner for bilateral nerve conduction studies. *Id.* Nerve conduction studies were performed at the Orthopaedic

Center of Southern Illinois by Dr. Nemani on September 21, 2010, and showed bilateral carpal tunnel syndrome, right greater than left. (PX4). Petitioner testified that September 21, 2010, the date on which he received the results of his nerve conduction studies, was the first day he became aware of his work-related condition. (T.27).

Petitioner continued his care with Dr. David Brown, who previously treated Petitioner another problem and noted that Petitioner was returning with a new problem. (PX5). He noted that Petitioner continued to work at Pinckneyville Correctional Center as a Correctional Officer, and that Petitioner's job duties entailed turning keys, cuffing and uncuffing inmates, and opening and closing heavy doors throughout his 8 hour workday for 40 hours per week. *Id.* Dr. Brown's physical examination confirmed the existence of bilateral carpal tunnel syndrome, and he recommended that Petitioner wear wrist splints over both of his wrists at night and take anti-inflammatory medication. *Id.* Dr. Brown stated that based on Petitioner's job description as a Correctional Officer at Pinckneyville Correctional Center, combined with his own understanding of Petitioner's job and Petitioner's lack of medical problems such as diabetes, hypothyroidism or arthritis that would put him at risk for carpal tunnel syndrome; he believed that Petitioner's work as a Correctional Officer at Pinckneyville Correctional Center was an aggravating factor in Petitioner's need for treatment for his bilateral carpal tunnel syndrome. *Id.*

Petitioner was subsequently referred by Dr. Nair to Dr. Young of Southern Orthopedic Associates. (PX6, 3/19/12). Petitioner reported to Dr. Young that his symptoms has progressed since his nerve conduction studies and rated his pain as a 4 or 5 on a scale of 10 with aching, throbbing and numbness that worsened with activities such as writing. *Id.* Petitioner continued to report that his right side was worse than his left and reported that his right ring and small finger were now being affected. *Id.* Physical examination continued to confirm the existence of bilateral carpal tunnel syndrome, which Dr. Young noted was demonstrated by Petitioner's former nerve conduction studies. *Id.* Dr. Young recommended repeat nerve conduction studies performed by Dr. Newell, which showed only right carpal tunnel syndrome. (PX7).

Petitioner returned to Dr. Young on April 12, 2012, following the results of the nerve conduction studies. (PX6, 4/12/12). After reviewing Petitioner's initial nerve conduction studies, and performing another physical examination, which demonstrated positive Tinel's over the ulnar and median nerves and positive Phalen's tests bilaterally over the wrists, Dr. Young informed Petitioner that Dr. Newell's results could be a false negative, as his physical examination showed provocative signs of cubital and carpal tunnel syndromes. *Id.* Dr. Young also noted that Petitioner's complaints not only involved numbness in his index finger, but also numbness in his small finger that wakes him up at night. *Id.* Petitioner's condition had not improved with splints and anti-inflammatory medication. *Id.* Dr. Young recommended surgery, but Petitioner wished to wait. *Id.*

Respondent had Petitioner's records reviewed by Dr. James Williams, who concluded that Petitioner's job activities were neither causative nor contributory to Petitioner's bilateral carpal tunnel syndrome. (RX9). He felt that Officers "do turn a lot of keys;" but he felt that there was significant rest and recovery time between cells as they move from one to another, and did not believe that the job duties involved any significant vibration, impact or repetitive use. *Id.* He did indicate that he agreed that Petitioner's symptoms were consistent with carpal tunnel syndrome. *Id.* Dr. Williams indicated that Petitioner's carpal tunnel syndrome could be

idiopathic in nature, and cited Petitioner's age (37) and his height (5'9") and weight (210), which he noted to be an increased body mass index, as risk factors. *Id.* He also believed Petitioner's hobby of hunting could be a contributory factor in his development of carpal tunnel syndrome. *Id.* Dr. Williams also indicated that he has visited Pinckneyville Correctional, observed some of the duties of a Correctional Officer and "used keys and turned locks," and he did not feel that these activities were causative or contributory to carpal tunnel syndrome. *Id.*

Dr. Williams also testified by way of Deposition. (RX11). He testified that he reviewed the material provided to him by Respondent and Petitioner's medical records up to his treatment with Dr. Brown. *Id.* at 9. He testified that he believed that Petitioner's medical records showed that he suffered from carotid artery disease and stated that it could be a risk factor because it is a vascular-type problem. *Id.* at 16. It does not appear that Dr. Williams had access to the medical records of Dr. Young. *Id.* at 9. Dr. Williams testified that he has still not been provided with the deposition testimony of the other Correctional Officers at Respondent's Pinckneyville Correctional Center. *Id.* at 39-40.

Dr. Williams testified that he opened and closed one (1) chuckhole while visiting Respondent's facility and opened doors using a small key and a large Folger Adams key. *Id.* at 11-12. He did not see anything during his tour of Respondent's facility that he felt would be causative of contributory of Petitioner's condition. *Id.* at 19. Dr. Williams testified that at the time Petitioner saw Dr. Brown, Dr. Brown's recommendations, including surgery, were reasonable and necessary. *Id.* at 18, 21-22.

On cross-examination, Dr. Williams acknowledged that forceful and repeated gripping and pinching are risk factors for carpal tunnel syndrome. *Id.* at 38-39. He testified that repetitive motion of the fingers or repeated flexion of the flexor tendons can cause friction between the flexor tendons within the carpal tunnel and cause tenosynovitis, which is an inflammatory-type arthropathy and causal factor of carpal tunnel syndrome. *Id.* at 39. Dr. Williams acknowledged that if his causation opinion was based upon flawed information, then his causation opinion could be flawed or even change. *Id.* at 43.

Dr. Williams testified that he did not observe any of the locks and/or chuckholes malfunctioning at the facility and was unaware that Respondent kept a locksmith on staff at its facility. *Id.* at 44. When asked if conditions where Correctional Officers had to repeatedly turn the keys more than once or turn difficult keys because of the conditions of the locks would increase the pressure and force placed on the hands and arms of Officers and cause or contribute to the development of bilateral carpal tunnel syndrome, Dr. Williams' response was, "That could be a problem." *Id.* at 44-45. Dr. Williams was unaware of whether Correctional Officers forcefully pull on doors to make sure that they are secured during wing checks. *Id.* at 45. Dr. Williams testified that this activity could contribute to the development of carpal tunnel syndrome depending on how often this activity was performed. *Id.* at 45-46. Dr. Williams did not witness or perform a shakedown. *Id.* at 46. When given details concerning shakedowns, he acknowledged that these activities too could be contributory factors. *Id.* at 46-47. Dr. Williams also acknowledged that the key estimation study does not mention whether these figures refer to keying inmates out of their cells, into their cells, or both. *Id.* at 50. Dr. Williams was aware that property boxes can weigh up to 100 pounds, but was not aware of any Correctional Officers who lifted property boxes while performing cell shakedowns. *Id.* at 55-56.

Dr. Young also testified by way of deposition. (PX11). Dr. Young testified that he is a board-certified orthopedic surgeon and that 80% of his practice is related to treatment of the hand and upper extremity including carpal and cubital tunnel syndromes. (PX11, p.6). Dr. Young testified that nonoccupational risk factors for carpal tunnel syndrome were obesity, diabetes, rheumatoid arthritis, low thyroid function, trauma, smoking and excessive alcohol consumption. *Id.* at 7. Occupational risk factors included gripping or pinching forcefully or repetitively. *Id.* at 7-8. Dr. Young testified that Petitioner's medical records showed only carotid artery stenosis, which is narrowing of the carotid artery. *Id.* at 37. Dr. Young testified that this could not contribute to the development of compression neuropathy. *Id.* at 37. Dr. Young testified that hyperlipidemia was not contributory. *Id.* at 38. He testified that renal failure, if substantial, could potentially contribute because it is metabolic and material could deposit within the carpal tunnel, but he had no indication that Petitioner's condition was that significant. *Id.* at 37-38.

Dr. Young testified to taking a personal history from Petitioner, reviewing his medical records, and the results of his own personal physical examination of Petitioner. *Id.* at 8-10. After obtaining new nerve conduction studies, he believed that Petitioner still suffered from clinical bilateral carpal tunnel syndrome. *Id.* at 11. He discussed surgery with Petitioner. *Id.* at 11-12. Dr. Young testified that although not confirmed by his nerve conduction studies, Petitioner showed clinical signs of cubital tunnel syndrome. *Id.* at 16. He recommended conservative treatment and observation for Petitioner's suspected cubital tunnel syndrome and testified that Petitioner should be reevaluated if his symptoms have progressed. *Id.* at 16-17. Dr. Young testified that he does not believe Petitioner's bilateral carpal tunnel syndrome will improve without surgical intervention. *Id.* at 18. He testified that Petitioner had an excellent post-surgery prognosis. *Id.* at 18.

Dr. Young testified that he has reviewed the videos of Pinckneyville Correctional Center, the Job Site Analyses, the Post Descriptions, Petitioner's medical records, and the depositions of other staff pertaining to Pinckneyville Correctional Center, and has treated other Correctional Officers from various correctional centers, including Pinckneyville. *Id.* at 12-15. He estimated that he has treated 200 to 300 Correctional Officers over the last 5 years and has spoken to them personally about their job duties. *Id.* at 12.

Respondent objected to Petitioner's treating physician testifying as to causation under *Ghere* because no opinion or list of documents upon which his opinion was based was contained in his treatment records. *Id.* at 15, 19. The Arbitrator notes, however, that in *Homebrite Ace Hardware v. Indus. Comm'n*, the Appellate Court distinguished *Ghere*, a case in which the physician was attempting to testify regarding causal connection for a condition to which the physician rendered no treatment whatsoever, from a case where the treating physician is testifying on the causal connection between work and a condition which he or she has actually treated. *Homebrite Ace Hardware v. Indus. Comm'n*, 351 Ill.App.3d 333, 814 N.E.2d 126 (5th Dist. 2004). The Appellate Court held that there is no "bright-line" rule or presumption that undisclosed opinion testimony constitutes surprise. *Id.* at N.E.2d 132. The Court held that since the treating physician's record contained details about the claimant's treatment and neck complaints, that the employer was put on notice that the treating physician might testify as to a causal relationship between the claimant's condition and work accident. *Id.* The Arbitrator therefore overrules Respondent's objections with regard to Dr. Young's testimony on causal connection.

Dr. Young testified that he believed that there was an actual impact on Petitioner's condition from his work situation. *Id.* at 19. Dr. Young testified believed that there is additional force required to turn locks or keys which malfunction, and that this would contribute to the development of compression neuropathy. *Id.* at 23. When asked whether the frequency of motion and movements indicated in Respondent's Job Site Analyses would cause or contribute to the development of bilateral compression neuropathy, Dr. Young testified that these would be contributory factors. *Id.* at 24. Dr. Young testified that the occupational activities performed by Correctional Officers are far more hand-intensive than those performed by members of the general public. *Id.* at 25. He testified on cross-examination that despite Petitioner's potentially contributory hobbies, the amount of hand-intensive activity performed by Petitioner for Respondent alone could be enough to contribute to the development of compression neuropathy. *Id.* at 38-39, 43. He testified that he has gleaned enough information through speaking with Petitioner, his review of Respondent's evidence and caring for many correctional staff to render a causation opinion in Petitioner's case. *Id.* at 44.

CONCLUSION

Issue (C): Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent? And;

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

In a repetitive trauma case, issues of accident and causation are intertwined. *Elizabeth Boettcher v. Spectrum Property Group and First Merit Venture*, 99 I.I.C. 0961. "The word 'accident' is not a technical legal term, and has been held to mean anything that happens without design, or an event which is unforeseen by the person to whom it happens...Compensation may be allowed where a workman's existing physical structure, whatever it may be, gives way under the stress of his usual labor." *Laclede Steel. Co. v. Industrial Comm.*, 6 Ill.2d 296 at 300, 128 N.E.2d 718, 720 (1955) citing *Baggot Co. v. Industrial Comm.*, 290 Ill. 530, 125 N.E. 254 (1919). Under Illinois law an injury need not be the sole factor, or even the primary factor of an injury, as long as it is **a** causative factor. *Sisbro, Inc. v. Indus. Comm'n*, 207 Ill.2d 193, 205, 797 N.E.2d 665 (Ill. 2003) [Emphasis added]. Even when other non-occupational factors contribute to the condition of ill-being, "[*A*] 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*, 309 Ill.App.3d 1037, 723 N.E.2d 846 (3rd Dist. 2000). Allowing a claimant to recover under such circumstances is a corollary of the principle that employment need not be the sole or primary cause of a claimant's condition. *Land & Lakes Co. v. Indus. Comm'n*, 834 N.E.2d 583 (2d Dist. 2005). Employers are to take their employees as they find them. *A.C.& S. v. Industrial Comm'n*, 710 N.E.2d 837 (Ill. App. 1st Dist. 1999) citing *General Electric Co. v. Industrial Comm'n*, 433 N.E.2d 671, 672 (1982). The Supreme Court in *Durand v. Indus. Comm'n* noted that the purpose of the Illinois Workers' Compensation Act is best served by allowing compensation where an injury is gradual but linked to the employee's work. *Durand v. Indus. Comm'n*, 862 N.E.2d 918, 925 (Ill. 2006).

In the repetitive trauma case of *Fierke*, the Appellate Court specifically applied the foregoing legal standard of causation specifically to a repetitive trauma case and noted that non-

employment related factors that contribute to a compensable injury do not break the causal connection between the employment and a claimant's condition of ill-being. *Fierke*, N.E.2d at 849. The Court specifically stated, "The fact that other incidents, whether work related or not, may have aggravated a claimant's condition is irrelevant." *Id.*

The Appellate Court's decision in *Edward Hines Precision Components v. Indus. Comm'n* highlights that there is no standard threshold which a claimant must meet in order for his or her job to classify as sufficiently "repetitive" to establish causal connection. *Edward Hines*, 365 Ill.App.3d 186, 825 N.E.2d 773, 292 Ill.Dec. 185 (Ill.App.2d Dist. 2005). In fact, the Court expressly stated, "There is no legal requirement that a certain percentage of the workday be spent on a task in order to support a finding of repetitive trauma." *Id.* at N.E.2d 780. Similarly, the Commission recently noted in *Dorhesca Randell v. St. Alexius Medical Center*, 13 I.W.C.C. 0135 (2013), a repetitive trauma claim, a claimant must show that work activities are a cause of his or her condition; the claimant does not have to establish that the work activities are the sole or primary cause, and there is no requirement that a claimant must spend a certain amount of time each day on a specific task before a finding of repetitive trauma can be made. *Randell* citing *All Steel, Inc. v. Indus. Comm'n*, 582 N.E.2d 240 (1991) and *Edward Hines supra.* The Appellate Court in *Darling v. Indus. Comm'n* even stipulated that quantitative evidence of the exact nature of repetitive work duties is not required to establish repetitive trauma injury in reversing a denial of benefits, stating that demanding such evidence was improper. *Darling v. Industrial Comm'n*, 176 Ill.App.3d 186, 195, 530 N.E.2d 1135, 1142 (1st Dist. 1988).

In 2009, the Appellate Court issued a favorable decision in a repetitive case to a claimant in which the claimant's work was "varied" but also "repetitive" or "intensive" in that he used his hands, albeit for different task, for at least five (5) hours out of an eight (8) hour work day. *City of Springfield v. Illinois Workers' Comp. Comm'n*, 388 Ill.App.3d 297, 901 N.E.2d 1066, 327 Ill.Dec. 333 (Ill.App. 4th Dist., 2009). As was noted by the Commission and reiterated in the Appellate Court decision in *City of Springfield v. Illinois Workers' Compensation Comm'n*, "while [claimant's] duties may not have been 'repetitive' in a sense that the same thing was done over and over again as on an assembly line, the Commission finds that his duties required an intensive use of his hands and arms and his injuries were certainly cumulative." *Id.* Based upon the aforementioned law, Petitioner can establish a claim for repetitive trauma even though she worked various assignments and has an underlying condition. Petitioner's job duties involve the performance of tasks distinctly related to his employment which pose risks to which the public is not equally exposed. This risk is both qualitative and quantitative. This is buttressed by Respondent's own Job Site Analysis, despite its limitations in accuracy and detail.

The independent analyses performed by Respondent, despite omitting some of Petitioner's job duties, clearly demonstrate that Petitioner frequently or repetitively uses his hands throughout his work day for at least 5 hours per day, similar to the claimant in *City of Springfield*. (RX5). The CorVel Analyses indicate that 70% of the key turning is done by Wing Officers. (RX5). Both of Respondent's Job Site Analyses categorizes the strength demands Petitioner's job as "Medium" which is defined as "lifting 50 pounds maximum with frequent lifting and/or carrying up to 25 pounds. *Id.* "Frequent" is defined as 2.5 to 5.5 hours per day, 34% to 66% of a day, or 33 to 200 repetitions per day. *Id.* Petitioner also engages in "frequent" wrist turning and "frequent" finger manipulation. *Id.* The wrist turning was associated with the

opening of doors and chuckholes up to 150 times per shift in the housing unit. *Id.* More keys would be turned during lockdown. *Id.* Petitioner testified that he spent the majority of his time in segregation, which involved more key turning than working on a wing, and the majority of his time outside of segregation working as a Wing Officer. (T.12, 19).

Dr. Williams rendered his causation opinion based on his perception that Petitioner's job did not involve any impact or repetition. (RX9). Dr. Williams acknowledged that if his causation opinion was based upon flawed information, then his causation opinion could be flawed or even change. (RX11, p.43). Dr. Williams testified that he did not observe any of the locks and/or chuckholes malfunctioning at the facility and was unaware that Respondent kept a locksmith on staff at its facility. *Id.* at 44. When asked if conditions where Correctional Officers had to repeatedly turn the keys more than once or turn difficult keys because of the conditions of the locks would increase the pressure and force placed on the hands and arms of Officers and cause or contribute to the development of bilateral carpal tunnel syndrome, Dr. Williams' response was, "That could be a problem." *Id.* at 44-45. The deposition testimony of the locksmith, Robert Schuchert, confirms that such conditions did in fact exist. (PX14). The Arbitrator notes that the locksmith would be in a best position to testify as to the condition of the doors and locks at the facility. Additionally, Lt. Thompson testified in his deposition that there was not a single part of a Correctional Officer's job that did not involve using one's arms, hands, or elbows, and that these activities involved force and stress. (RX17, p.38, 40).

Dr. Williams did not witness or perform a shakedown. *Id.* at 46. When given details concerning shakedowns, he acknowledged that these activities too could be contributory factors. *Id.* at 46-47. Dr. Williams was unaware of whether Correctional Officers forcefully pull on doors to make sure that they are secured during wing checks. *Id.* at 45. Dr. Williams testified that this activity could contribute to the development of carpal tunnel syndrome depending on how often this activity was performed. *Id.* at 45-46. Petitioner testified that wing checks were performed every 30 minutes and required him to forcefully tug on every door to ensure that every cell is locked. (T.51-52). This means that Petitioner was pulling on 56 doors every 30 minutes, in addition to his key turning and lifting activities referenced in the Job Site Analyses. (T.20, 51-52). Therefore, Dr. Young's testimony that the activities performed by Petitioner would cause or aggravate the development of compression neuropathy is persuasive. (PX11).

The Commission has also found the at the job duties of a Correctional Officer at Pinckneyville Correctional Center aggravate and contribute to the development of repetitive injuries. *Dustin Bowles v. Pinckneyville Corr. Ctr.*, 14 I.W.C.C. 0842 (2014); *Samuel Burns v. Pinckneyville Corr. Ctr.*, 14 I.W.C.C. 0482 (2014); *Chris Walter v. Pinckneyville Corr. Ctr.*, 13 I.W.C.C. 0634 (2013); *Craig Briley v. Pinckneyville Corr. Ctr.*, 13 I.W.C.C. 0519 (2013).

Even though Petitioner has non-occupational contributory factors, non-work related contributing factors do not sever the causal link between Petitioner's employment and his resulting injury. As the *Fierke* Court noted, employment need only be *a* factor in the total condition of ill-being. *Fierke supra*. The Arbitrator finds it significant that Petitioner's condition is more severe on his dominant side. (PX4). In *Samuel Burns v. Pinckneyville Corr. Ctr.*, 14 I.W.C.C. 0482 (2014), the Commission held that intensive hobbies performed in addition to employment do not negate the contributory effects of employment or sever the causal chain between injury and contributing job duties. *Samuel Burns v. Pinckneyville Corr. Ctr.*, 14 I.W.C.C. 0482 (2014).

Based upon the foregoing, the Arbitrator finds the causation opinion of Dr. Young to be credible and finds that Petitioner met his burden of proof in establishing that he sustained accidental injuries that arose out of and in the course of his employment with Respondent which are causally related to his current condition of ill-being.

Issue (D): **What was the date of the accident?**
Issue (E): **Was timely notice of the accident given to Respondent?**

Repetitive-trauma injuries occupy an odd niche between accidental injury, compensable under the Act, and occupational disease, compensable under the Workers' Occupational Diseases Act. *A.C. & S. v. Indus. Comm'n*, 304 Ill. App. 3d 875, 879, 710 N.E.2d 837, 840 (Ill. App. 1st Dist., 1999). In choosing to cover such injuries as accidental injuries, as noted by the Appellate Court in *A.C. & S.*, the Supreme Court **deliberately** modified the standards for determining the date of injury for repetitive trauma cases in order provide protection for injured workers. *A.C. & S. v. Industrial Commission*, 304 Ill.App.3d 875, 710 N.E.2d 837, 840-841 (Ill. App. 1st Dist., 1999). Even though carpal tunnel syndrome is not treated as an occupational disease in Illinois, we still look to the Occupational Diseases Act for guidance. *Id.*

The Workers' Compensation Act is a humane law of a remedial nature that should be liberally construed to achieve its purpose. *Hagene v. Derek Polling Const.*, 388 Ill. App. 3d 380, 902 N.E.2d 1269 (2009). Hence, the Supreme Court has established a flexible but fair standard for determining manifestation dates. *Durand v. Industrial Commission*, 224 Ill.2d 53, 862 N.E.2d 918 (2007). Although the date on which the employee becomes aware that he has a condition related to work was the first method for determining a manifestation date, it is not the only permissible means for alleging or proving manifestation. The manifestation date can be set as: **(a)** the date the employee actually became aware of the physical condition and its relation to work through medical consultation; **(b)** the date the employee requires medical treatment; **(c)** the date on which the employee can no longer perform work activities; or **(d)** when a reasonable person would have plainly recognized the injury and its relation to work. *Durand v. Industrial Commission*, 224 Ill.2d 53, 862 N.E.2d 918 (2007), *see also Peoria County Belwood Nursing Home v. Industrial Commission*, 115 Ill.2d 524, 505 N.E.2d 1026 (1987); *Oscar Mayer & Co. v. Industrial Commission*, 176 Ill.App.3d 607, 531 N.E.2d 174 (3rd Dist. 1988); *Three "D" Discount Store v. Industrial Commission*, 198 Ill.App.3d 43, 556 N.E.2d 261 (4th Dist. 1989).

Although a claimant is aware of symptoms and carries a suspicion that these are work-related, the Supreme Court has stated, "The 'fact of injury' is not synonymous with the 'fact of discovery'" *Durand*, N.E.2d at 927. In short, claimants are not charged with filing a claim as soon as they believe they *may* have a work-related condition, nor are they penalized for failing to realize a condition is work-related when the employer feels that he or she should have. In fact, the Supreme Court stated that to rely solely on a claimant's testimony concerning symptoms, without accurate knowledge of the cause of those symptoms, would essentially be asking them to "rely on 'expert' medical testimony from a layperson." *Id.* at 929. The Court likewise noted that the claimants would have had difficulty proving injury with a sketchy and equivocal understanding of same. *Id.* at 930. The standard that "the 'fact of injury' is not synonymous with the 'fact of discovery'" has since become a safety measure employed by all Courts to ensure that the employers do "penalize an employee who diligently worked through" his or her symptoms. *Durand v. Indus. Comm'n*, 862 N.E.2d at 927, 930.

In *Oscar Mayer*, the Court embraced the "date of collapse" method of determination (setting the manifestation date on the date of surgery, or the date the employee could no longer work), allowing compensation to be awarded to a claimant despite his full knowledge that his condition was work-related well before he filed a claim because the claimant diligently served his employer until he could no longer do so without intervention for his repetitive injuries. *Oscar Mayer supra.* The Court noted that no prejudice can occur in employing such a method, since it is not until the employee actually misses work for his injuries that the employer becomes adversely affected; and the notice provisions were not impugned as this flexible and fair provision in no way interfered with an employer's ability to effectively investigate the claim. In *Three "D" Discount Store v. Industrial Commission*, 198 Ill.App.3d 43, 556 N.E.2d 261 (4th Dist. 1989), the Appellate Court held that even though the claimant had previously sought treatment and received a diagnosis for his condition, his injuries manifested on the date that he was advised by a physician that his condition was work-related. *Three "D" Discount Store v. Industrial Commission*, 198 Ill.App.3d 43, 556 N.E.2d 261 (4th Dist. 1989).

The law allows Petitioner to select a manifestation date that coincides with discovery of injury and its relation to work after medical consultation. See *Steven Beal v. Town of Normal*, 06 IL.W.C. 25261, 10 I.W.C.C. 0380 (2010); *see also White v Worker's Compensation Commission*, 374 Ill.App.3d 907, 873 N.E.2d 388, 392-393 (4th Dist. 2007) (holding Petitioner could select accident date); *A.C. & S. v. Industrial Commission*, 304 Ill.App.3d 875, 710 N.E.2d 837, 841-842 (1st Dist. 1999).

Petitioner claimed his injuries manifestation on September 21, 2010, the date he received the results of his nerve conduction studies, as that was the first day he became aware that he suffered from a work related problem. (T.27). Petitioner testified that although he had symptoms for approximately a year prior to his manifestation date, he did not know what was wrong with him at that time. (T.59-60). The Arbitrator therefore finds that Petitioner met his burden of proof in establishing that his injuries manifested on September 21, 2010. Petitioner completed and submitted a Notice of Injury to Respondent on September 29, 2010. (T.27; RX2). Therefore, Petitioner provided timely notice of his accidental injuries under the Act.

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

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

Upon a claimant's establishment of a causal nexus between injury and illness, employers are responsible for the employees' medical care reasonably required in order to diagnose, relieve, or cure the effects of the claimant's injury. *Plantation Mfg. Co. v. Indus. Comm'n.* 294 Ill.App.3d 705, 691 N.E.2d 13 (2000); *F & B Mfg. Co. v. Indus. Comm'n*, 325 Ill.App.3d 527, 758 N.E.2d 18 (1st Dist. 2001).

Causal connection has been resolved in Petitioner's favor, and Respondent's records reviewer, Dr. Williams, agreed with Petitioner's diagnosis and the reasonableness of his treatment and recommendations for future treatment. (RX9; RX10, p.18). Respondent is therefore ordered to pay the medical expenses contained in Petitioner's group exhibit and shall have credit for any amounts paid through its group carrier. Respondent shall indemnify and hold

Petitioner harmless from any claims from these medical providers arising out of the expenses for which it claims credit.

Respondent shall further authorize and pay for the treatment recommended by Dr. Brown and Dr. Young, including but not limited to surgery.

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

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

FRANK MIONI,

Petitioner,

16IWCC0644

vs.

NO: 13 WC 6168

F.E. MORAN FIRE PROTECTION,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §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 accident, notice, causation, temporary total disability, credit pursuant to §8(j) of the Act, and medical expenses both current and prospective, and being advised of the facts and law, reverses the Decision of the Arbitrator, finds that Petitioner did not sustain his burden of proving a work-related accident on January 22, 2013, and denies compensation.

Findings of fact and Conclusions of Law

1. Petitioner testified he has worked for Respondent since June of 2009. He is a sprinkler fitter, a member of the union for 15 years, and job foreman. As a job foreman he is "entrusted to make decisions for the contractor as far as safety, job changes," and oversees the work of other employees. As sprinkler fitter he uses various hand tools and some heavy equipment. He has to move threading machines, which weigh about 250 lbs, around a job site.

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2. Petitioner was working for Respondent on January 22, 2013 installing a hose valve. He was working alone, which happens about 50% of the time depending on the particular job. He had to pick up some pipe from another building. Walking back to his work location he slipped and fell. He put his right hand back to break his fall and felt a jerk in his shoulder and pain. He did not seek treatment because this was his last day of work "for a couple of days" because of a lack of work and he hoped the pain would go away. He finished working that day. Petitioner testified he had not injured or had treatment for his right shoulder previously.

3. When he was scheduled to return to work he called off work. He called Scot Acred, his acting superintendent, to report his injury, medical treatment, and five-pound lifting restriction put on him. He left a voice-mail message; it was normal for "them" not to answer phone calls. He first saw Dr. Dragisic, his principal care physician, on January 29, 2013. He prescribed medication and a CT, which he had on January 30th. Dr. Dragisic then prescribed physical therapy.

4. Dr. Dragisic referred Petitioner to Dr. Perez-Sanz, whom he saw on April 12, 2013. He recommended epidural steroid injections, wanted an MRI, and instructed Petitioner to stay off work. After the MRI, Dr. Perez-Sanz continued physical therapy and placed the five-pound restriction on him. Respondent was not able to accommodate that restriction.

5. On June 10, 2013, Dr. Perez-Sanz recommended surgery which he performed on July 2, 2013. After more physical therapy, Dr. Perez-Sanz prescribed work hardening, which Petitioner began on November 11, 2013. He was scheduled to see Dr. Perez-Sanz again on January 6, 2014, but was told he could not see him until he paid his outstanding balance. Respondent had not paid for medical services thus far. The bills went to the union, but Petitioner had co-payments. Petitioner continued to treat with Dr. Dragisic, who continued prescriptions and kept him off work. Petitioner's last day of work hardening was February 18th, just the week prior to the hearing. He doesn't have another appointment scheduled with Dr. Perez-Sanz.

6. Petitioner also testified that currently, his right shoulder was still painful "susceptible to weather." Overhead lifting causes pain and sleeping on his right side was "not an option" because of pain and "it just locks up." Petitioner had previous surgery on his right shoulder in 1988. He went through rehab at that time and worked full duty for 25 years since. Petitioner was currently 54 years old and did not have any problem with, or having any treatment for, his shoulder at the time of this accident.

7. On cross examination, Petitioner testified he did not talk to Mr. Acred personally when he left the voice mail about his injury, but did on February 15th when Mr. Acred called Petitioner. He did not physically take his five-pound lifting restriction in to Respondent but he did mention it in the voice mail. To his knowledge nobody witnessed the accident. He continued working the day of the accident but had not worked since.

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8. Petitioner also testified that at the time of the accident he was holding the pipes with his left hand on his left shoulder. He slipped on ice, his left foot slipping first, and he fell backwards. He was wearing Timberland work boots, which was what he usually wore. He also injured his left elbow but he did not receive treatment for the left elbow.

9. While Petitioner first saw his doctor on January 29th, he called for an appointment on January 25th. His pain increased from a 4/10, immediately after the accident, to an 8/10 the day after and remained at that level. He did not call Mr. Acred again by January 25th even though he did not receive a call back. On January 29th, he told Dr. Dragisic that he slipped and fell at work, and if he did not record that in his notes that was his failure.

10. Petitioner could drive his car, but not his motorcycle "right away." He is a member of a golf league, but was not able to play from the time he initially saw his doctor to his surgery. He also had to give up bowling. He could not lift heavy boxes, but could open doorknobs "underhanded." Petitioner agreed that about six to seven months prior to the accident he complained to Dr. Dragisic about pain in his shoulder.

11. Petitioner agreed that as foreman, he is familiar with Respondent's safety policies and accident reporting requirements. He was aware that as foreman he was supposed to file a written report within 24 hours. However, he was not aware that as a foreman he was to "carry around job accident reports with" him. He has never run a safety meeting or attended a safety meeting run by Mr. Acred. In addition, employees did not discuss safety at "weekly tool box meetings."

12. On redirect examination, Petitioner testified he would not disagree if the medical records actually indicated he complained to Dr. Dragisic about shoulder pain about nine months prior to the accident. At that time he was installing a heavy pipe and it slipped out of his grip and hit him on the shoulder. He actually went to Dr. Dragisic for a wart on his foot and mentioned the shoulder. Dr. Dragisic gave him Ibuprofen and the pain went away; there was no other treatment. It was very common for him to suffer bumps and bruises in his job. He does not report every sprain, bump, or bruise. He did not report any pain level when he first saw Dr. Dragisic and was not aware of the 1-10 pain scale; if one was noted in the treatment note it was based on interpretation.

13. Scott Acred was called by Respondent, for which he worked for 18 years. He has been field superintendent for six years. He scheduled manpower shifts, deliveries, and use the tools. In January of 2013 Petitioner was field foreman and was responsible for running the jobsite and "the daily work at hand." Mr. Acred notified the foremen that they had to report accidents immediately and fill out accident reports. They would turn the reports in to him or the safety department. Mr. Acred became aware that Petitioner was reporting an accident when he was called into the president's office, sometime at the end of February. Petitioner never reported an accident within 24 hours, and the witness did not receive a voice-mail message from him. Mr. Acred checks his messages.

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14. After the accident, Petitioner continued to work for "just a short time," finishing up the job. Petitioner never presented Mr. Acred with a restricted duty note. Respondent has a policy of accommodating restricted duty if it can.

15. On cross examination, Mr. Acred testified he began his career as a union sprinkler fitter. He was field foreman prior to becoming field superintendent. He has gotten various types of minor injuries in his jobs. He did not report such minor injuries. Bumps and bruises happen in the job, which is in the construction business, but it is not a daily occurrence. As foreman, Petitioner would have been Respondent's representative on the job site, and was paid additional compensation for that responsibility.

16. Jeff Smith was called by Respondent, for which he worked for 14 years. He started as an apprentice, became foreman, and was now a superintendent. In January of 2013, he was a foreman and worked with Petitioner, who was also a foreman. Accidents are to be reported "usually immediately, but within that day, an eight hour period." Foremen must file a written report within 24 hours with the superintendent.

17. Mr. Smith testified he had the opportunity to observe Petitioner in June 2013 at the local union hall. He saw Petitioner riding a motorcycle. He did not appear to be in any distress. They greeted and shook hands. Respondent provides light duty work to injured employees.

18. On cross examination, Mr. Smith also testified that a foreman is Respondent's representative at the job site and was responsible to ensure that other employees do their jobs. Mr. Smith worked his entire career for Respondent. He would not report a bump or bruise but he would "absolutely" report a strain or sprain. He hurt his back once and it felt a little sore, so he called right away and asked what they wanted him to do. He was given "a form to follow the policy," which he did. There were employees who were injured and later laid off, but "not necessarily right after" a doctor's release. Released employees would be told there was no work for them "when times were slow."

19. On a later hearing date Mr. Smith was recalled by Respondent and testified that after his previous testimony he "went to the end of the hall and sat at a table down there" with Mr. Acred. Petitioner approached them and asked the witness why he brought up the motorcycle incident. He replied that he simply told the truth. Petitioner then indicted that his lawyer's relative was Tom Collins, whom the witness believed was the current president of the union local, and "he's got your names down on the list. He has got your names down, so don't worry about it. It will be taken care of."

20. On cross examination, Mr. Smith testified he was being paid his normal hourly rate during his testimony. He did not receive a subpoena. Petitioner did not threaten him prior to his testimony.

21. Scott Acred was also recalled by Respondent and testified that after his initial testimony he was waiting at the end of the hall with Mr. Smith. Petitioner approached them and asked Mr. Smith why he had brought up the motorcycle. He then asked them if they knew who his lawyer was related to. The witness did not respond, but Petitioner continued that his lawyer had their names and knew who they were.

22. On cross examination, Mr. Acred testified he was being paid during his testimony and was not out any out-of-pocket expenses. The local union hall is not a hiring hall and the witness did not go to the union to get a job. He contacts contractors on his own, but he would call the hall for suggestions about possible clients.

23. Petitioner was recalled in rebuttal. He agreed that when he left the previous hearing there was a discussion between the other witnesses and him. Petitioner stopped to get a drink of water and Mr. Smith and Mr. Acred approached him. They told Petitioner "listen, we're sorry we testified but we have family to worry about and houses." Petitioner responded "what about my family? What about my house?" Petitioner believed he then said something to the effect, "don't ever confuse us as being friends or union brothers." He may have said something else; he "was pretty upset at the time." However, he never mentioned that his lawyer knew someone in the hall and "never threatened anyone." Petitioner has never held any position of authority at the hall, which is not a hiring hall and simply provides an administrative function. The name Tom Collins never came up in their conversation.

24. On cross examination, Petitioner testified the union can assist a sprinkler fitter by referring them to out-of-town contractors looking for help.

25. On re-direct examination, Petitioner testified the business manager for the union was Dennis Fleming. Prior to that it was Kevin Connelley, and prior to that it was John Zubricks. Tom Collins retired from the union 15 years ago.

26. On re-cross examination, Petitioner testified he believed Tom Collins was Vice President. Thereafter, Petitioner's lawyer interjected questions and Petitioner testified that Tom Collins was Vice President of the Examining Board. That position is voluntary and not a leadership or paid position.

27. The medical records show that on April 23, 2012, Petitioner presented to Dr. Dragisic for a checkup. He complained of right shoulder pain and "something on the bottom of his foot," which was diagnosed to be a plantar wart.

28. On January 29, 2013, Petitioner presented to Dr. Dragisic for a "checkup" complaining of right shoulder/elbow pain and cramps in the back. Dr. Dragisic diagnosed unspecified shoulder bursae and tendon disorder, adhesive capsulitis, and unspecified enthesopathy of the elbow. Dr. Dragisic had "positive" findings and prescribed Hydrocortisone lotion and physical therapy for the shoulder disorder.

29. On February 19, 2013, Petitioner presented for physical therapy for right shoulder degenerative joint disease on referral from Dr. Dragisic. He had reported a sports injury in 1988 but no pain after it healed until he tripped while carrying pipe on January 22, 2013 injuring the right shoulder. This appears to be the first reference of the alleged accident in the medical records. He reported 4/10 pain. Later that month, Dr. Dragisic referred Petitioner to Dr. Perez-Sanz, an orthopedic surgeon.

30. On May 6, 2013, Petitioner presented to Dr. Perez-Sanz after he received an injection at Dr. Perez-Sanz' previous office. Petitioner reported significant immediate relief and continued to be better than before. Dr. Perez-Sanz noted right shoulder arthroscopy in 1988, after which Petitioner had done very well with occasional pain until his work injury on January 22, 2013. The MR scan had significant artifact but Dr. Perez-Sanz thought it showed degenerative changes. X-rays showed osteophyte formation. Dr. Perez-Sanz began gentle physical therapy and put a restriction of five-pound occasional lifting.

31. About a month later, Petitioner returned to Dr. Perez-Sanz and reported "some deterioration from the injection" but still felt better. He did not believe he could work or perform activities and wanted to proceed with surgery. Dr. Perez-Sanz noted the imaging showed mild degenerative changes but no clear evidence of a rotator cuff tear, though he again noted the significant artifact. The plan was for arthroscopic examination, probable debridement, and possible staple removal/decompression/tear repair.

32. On July 2, 2013, Dr. Perez-Sanz performed examination under anesthesia, arthroscopic decompression, and debridement of the right shoulder for impingement with anterior laxity and some degenerative changes.

33. Petitioner progressed after surgery and postoperative physical therapy. Dr. Perez-Sanz' treatment note of September 11, 2013 noted that Petitioner remained delighted with his continued improvement. He still had problems with endurance and overhead activities, which was not unexpected. Dr. Perez-Sanz advanced physical therapy and restricted Petitioner to 10-pound occasional lifting and occasional overhead activity.

34. On September 23, 2013, Petitioner returned to Dr. Dragisic and reported that it was the first time he could raise his arm over his head for three years.

35. Petitioner completed extensive physical therapy including work hardening. By July 6, 2014, he was rated to be able to work at a very heavy physical demand level.

36. Dr. Dragisic testified by deposition that he is board certified in family medicine. Petitioner has been a patient of his for quite a while. According to his records, on April 23, 2012, Petitioner came in for a checkup and complained of right shoulder pain and something on his foot. Dr. Dragisic examined him and the only abnormality documented in his notes was a plantar wart.

37. Petitioner's next visit was on January 29, 2013. Petitioner again complained of right shoulder pain as well as elbow pain. After examination, Dr. Dragisic noted "positive, positive, positive," which he guessed was shorthand for positive impingement. There was no indication in his previous record of such impingement. Even though it appears otherwise in his notes, the hydrocortisone cream was not prescribed for Petitioner's shoulder; the only thing he prescribed relative to the shoulder was an MRI. However, because Petitioner had metal in his shoulder a CT was performed instead. The CT showed arthritis but no tear was apparent. Dr. Dragisic prescribed physical therapy.

38. Dr. Dragisic also testified he had "somewhat" of a recollection that he discussed with Petitioner "a work injury," but he could be 100% certain. He explained that his office was relatively new in using electronic records and the fact that it is not in there does not mean that he did not mention it; "because obviously on the therapy it is."

39. Petitioner continued to have pain in his right shoulder as well as impingement signs. On February 25, 2013, he referred Petitioner to Dr. Perez-Sanz, who specializes in shoulders. Dr. Dragisic worked with him for 20 years and he greatly trusts his judgment. Dr. Dragisic was then shown the first treatment note by Dr. Perez-Sanz from May 6, 2013 in which he indicated Petitioner reported falling at work on January 22, 2013.

40. Dr. Perez-Sanz eventually performed surgery. His operative report noted a postoperative diagnosis of degenerative changes. When asked whether he believed Petitioner's work activities as a sprinkler fitter contributed to his degenerative condition, Dr. Dragisic answered: "I'll put it this way: I have several pipefitters as my patients, and several of them over the years end up having arthritis in their shoulder/shoulders." The activities specified in Petitioner's job description "can cause degenerative changes in any joint." Petitioner's job is repetitive and Dr. Dragisic sees a lot of repetitive type of injuries. Pipefitting could cause strain on the shoulders.

41. On cross examination, Dr. Dragisic testified he does not perform shoulder surgery. His recollection was that Petitioner suffered an acute injury prior to his January 29, 2013 visit. There was no indication in his first or second treatment note regarding the mechanism of injury or whether it was work related.

42. On redirect examination, Dr. Dragisic testified it was fair to categorize his previous testimony as indicating that he recalled Petitioner talking about a work injury, but that comment did not make it into his notes. Petitioner's job as sprinkler fitter can contribute to arthritis due to repetitive action.

43. Respondent's Section 12 medical examiner, Dr. Hennessy, testified he is a board certified orthopedic surgeon and a certified independent medical examiner. He performed a review of the records and issued a report in the instant case at Respondent's request.

44. There was a reported accident date of January 22, 2013. Petitioner first saw Dr. Dragisic who noted positive impingement signs in the right shoulder and elbow tendonitis. He diagnosed impingement post previous rotator cuff repair. In the first five treatment notes of Dr. Dragisic there is no mention of any workplace injury. The first indication of any workplace accident was in the initial physical therapy visit on February 19, 2013.

45. Dr. Hennessy testified that in his practice, the notation of trauma is important because in orthopedic injuries it connotes whether a condition is acute or chronic and the mechanism of accident could show how a joint is injured. Therefore, that information is important for a diagnosis.

46. Dr. Hennessy also testified that the findings noted in the operative report, the spur arthritis, and fraying are all degenerative, chronic conditions. Dr. Hennessy noted that Petitioner denied pain prior to the accident. Nevertheless, he opined that Petitioner's condition was not related to any of his work activities on January 22, 2013. The findings of the MRI showed no acute rotator cuff tear and that was confirmed during surgery. The pathology found in the MRI and surgery was not consistent with a fall or traumatic event. In addition, the records of Dr. Dragisic indicate Petitioner had a "routine degenerative process that can flare at times in middle-aged men and women." The fact that Petitioner complained of right shoulder pain in April of 2012 further supports his conclusion that he had a chronic condition and not related to "a sentinel event" on January 22, 2013.

47. On cross examination, Dr. Hennessy agreed that if he had additional information, that could affect his opinion on causation. He was unaware that Dr. Dragisic gave a deposition. He did not personally review the CT films, MRI films, or intraoperative photographs. He also did not discuss the circumstance of the injury with Petitioner. Dr. Hennessy indicated that while the treatment note in April 2012 identified right shoulder pain prior to the instant accident, he agreed the note did not list any treatment that was rendered. It was silent on the issue of impingement sign or adhesive capsulitis.

48. Dr. Hennessy also reviewed Dr. Dragisic's notes from 2006 and agreed that there was no mention of right shoulder pain in those previous notes. Dr. Hennessy indicated that Petitioner had a chronic condition that could wax and wane. When asked "it waxed once in seven years?" he responded "it's just like gout, you get your first attack, you may not have an attack for seven years, but as time goes on, you get more and more attacks."

49. Dr. Hennessy agreed that a patient can have an asymptomatic degenerative condition in a shoulder and fall on that shoulder thereby requiring treatment and surgery such as the surgery Petitioner had. If Petitioner had reported the fall at his initial visit to Dr. Dragisic on January 29, 2013, that would potentially change his opinion regarding causation. Dr. Hennessy thought it unlikely that Petitioner's work activities as a sprinkler fitter caused his condition, because he did not complain of intermittent pain until the alleged traumatic event. However, it was more likely than not that "some of his degenerative changes are from his work."

50. Dr. Hennessy had no problem with the treatment provided Petitioner. As of February of 2013 Petitioner could not work full duty because he had shoulder pain and overhead work was limited.

In finding Petitioner proved a work-related accident, the Arbitrator accepted the testimony of Petitioner and found it forthright, even though he characterized his behavior in the courtroom as childish and noted that he had some anger issues with another witness. The Arbitrator did not find the issue of whether he left a voice-mail message to Mr. Acred determinative because he accepted Petitioner's "testimony regarding the actual facts of the accident as alleged along with how he as a long time tradesman on a busy construction site, handles such initial physical insults on a job site at the time they occur." Respondent argues the Arbitrator erred because Petitioner was not credible. It cites that his accident was unwitnessed, the accident occurred on his last day of work, Petitioner did not seek medical attention for a week, the medical records do not make any mention of an accident until the physical therapy records of February 19, 2013, Petitioner did not comply with company policy about reporting accidents even though he was a foreman, and Petitioner threatened Respondent's witnesses.

The Commission agrees with both the Arbitrator and Respondent that the critical issue here is Petitioner's fundamental credibility. Apparently, the Arbitrator found Petitioner credible despite his misgivings about his behavior. Initially, the Commission notes that it acts as the original trier of fact as does the Arbitrator. Therefore the Commission is not bound by the Arbitrator's assessment of the relative credibility of witnesses. In this matter, the Commission finds serious discrepancies between Petitioner's testimony and the medical record as well as internal inconsistencies within his testimony. Therefore, the Commission does not find his testimony credible. The Commission considers Petitioner's apparent failure to report the accident/injury to be more problematic than the Arbitrator apparently did. Especially being a foreman, Petitioner had specific knowledge of proper procedures to be followed. Although there was timely statutory notice, the lack of compliance with procedures certainly affects the credulity of his testimony.

Petitioner's testimony is somewhat vague about when he exactly allegedly made the call to Mr. Acred. However, he testified he allegedly made the call when he was supposed to return to work. He also testified that he did not call Mr. Acred again after Mr. Acred had not yet returned his call by January 25. Therefore, Petitioner's testimony indicates he called Mr. Acred prior to January 25th and therefore prior to his initial doctor appointment on January 29, 2013. Nevertheless, he testified that in his voice-mail message he informed Mr. Acred of his five-pound restriction. There would not have been any such medical restriction at that time. In addition, as a foreman, Petitioner should have been aware of the importance of notifying Respondent about the accident quickly, even if he did not see the need to report it immediately. It appears unlikely that he would not have called Mr. Acred after he did not return the call. Finally, Petitioner's testimony about leaving a voice-mail message was specifically contradicted by Mr. Acred. Therefore, the Commission is not convinced that Petitioner actually called Mr. Acred and left him a voice-mail message regarding his alleged accident.

In addition, the Commission cites Petitioner's testimony regarding the encounter with the other witnesses after their testimony. Although that encounter is not explicitly relevant to the issues addressed here, Petitioner's testimony about that incident is clearly relevant regarding the determination of his overall credibility. Petitioner basically claimed that the witnesses apologized for their testimony but he told them not to worry because they were still "union brothers." However, he then admitted he could have said "something else" as well because he "was pretty upset." Petitioner's testimony about the encounter is internally inconsistent, simply does not make sense intuitively, and is completely contradicted by the credible testimony of the other witnesses involved in the incident.

Dr. Dragisic's testimony that he had a recollection that Petitioner mentioned a work accident and his explanation of why there was no mention of it in his records, while conceivable, is not very persuasive, especially considering that his testimony about Petitioner's report of a work accident was equivocal at best. Dr. Dragisic testified that he thought he remembered something about Petitioner mentioning a work accident, but he was not 100% certain. In this regard it is noteworthy that his initial January 29, 2013 treatment note indicated that Petitioner presented for a "checkup" without any indication in the record about any acute injury or condition. However, at that time Dr. Dragisic found impingement in the right shoulder, after which Petitioner probably understood the need for substantial prospective treatment.

Also of interest is Dr. Dragisic's treatment note of September 23, 2013. In that note, he noted that Petitioner reported that it was the first time he could raise his arm over his head for three years. That notation certainly suggests that Petitioner had significant problems with his shoulder prior to the alleged accident. So the record strongly suggests that Petitioner had ongoing problems prior to the alleged accident of January 22, 2013 and the need for substantial treatment was confirmed by Dr. Dragisic's findings of January 29th. The Commission also finds relevant the fact that nowhere in the medical records does any doctor refer to Petitioner's shoulder condition as anything but degenerative; there is no indication whatsoever that Petitioner's pathology was acute or traumatic in nature.

Accordingly, because Petitioner did not report his accident in a manner prescribed by company policy of which as foreman he was clearly aware, because there is no indication in the record that he made any mention of an alleged work accident until his initial physical therapy session almost a month after the alleged accident, because there is no indication in the medical records that Petitioner's pathology was anything but degenerative in nature, and because of discrepancies and inconsistencies in Petitioner's testimony, the Commission concludes that Petitioner's testimony was not credible. Therefore, the Commission finds that Petitioner did not sustain his burden of proving he suffered a work-related accident on January 22, 2013 and the Commission denies compensation. Because the Commission's finding that Petitioner did not prove a compensable accident is dispositive of the instant claim, all other issues are moot and will not addressed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator issued on August, 12, 2015 is hereby reversed and compensation is denied.

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: OCT 5 - 2016

Ruth W. White

RWW/dw
O-9/13/16
46

Joshua D. Luskin

DISSENT

I respectfully dissent from the majority opinion in this matter. I would have found that Petitioner did prove he sustained an accident on January 22, 2013 causing the current condition of ill-being of his right shoulder and affirmed the Decision of the Arbitrator.

The Commission is certainly correct that it stands as an initial trier of fact and is not bound by the Arbitrator's determination of the credibility of witnesses. Nevertheless, simply because the Commission may overrule the Arbitrator's determination of Petitioner's credibility, does not mean that it necessarily should in this instance. Here, the Arbitrator was cognizant of some discrepancies in Petitioner's testimony as well as issues regarding his behavior. He clearly noted the inappropriateness of Petitioner's apparent behavior regarding other witnesses. Nevertheless, as conceded by the majority, that encounter was completely irrelevant to the fundamental issues regarding accident and causation. Despite his reservations about Petitioner's actions, the Arbitrator specifically found Petitioner credible regarding the fundamental bases of his claim. In this case, I do not believe that the discrepancies noted by the majority rise to the level for the Commission to substitute its determination of credibility over that of the Arbitrator who actually observed the witnesses.

It does appear that Petitioner did not report his accident immediately as required under company policy. Nevertheless, as pointed out by the Arbitrator, there was testimony that not every minor injury is reported as required by that policy. In addition, there is no dispute that Respondent had actual notice of the alleged accident well within 45-day time limit specified by the Act. Finally, Respondent could not show any prejudice from any delay in Petitioner's reporting of the alleged accident. There was no evidence of the accident at the scene to preserve and there were no witnesses to interrogate.

For the reasons stated above, I would have affirmed the Decision of the Arbitrator. Therefore, I respectfully dissent from the decision of the majority.

CJD/dw
O-9/13/16
49

Charles J. DeVriendt

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

Ken Barhoumeh,

Petitioner,

16IWCC0645

vs.

NO: 10 WC 40045
12 WC 5993
13 WC 1783

City of Chicago,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causal connection, prospective medical treatment, TTD and penalties and fees and being advised of the facts and law, affirms and clarifies the Decisions of the Arbitrator, which are attached hereto and made a part hereof. The Commission further remands these cases 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).

Petitioner's three cases were consolidated for hearing on August 27, 2015 and the Arbitrator issued three Decisions. The Arbitrator's findings, conclusions, and orders were set forth in the Decision in case number 10 WC 40045. The Arbitrator found that Petitioner, a 56-year-old public way inspector, failed to prove that the current condition of ill-being of his right knee and left ankle are causally related to his employment by Respondent. The Arbitrator did not order Respondent to pay any TTD benefits beyond what Respondent paid voluntarily. We hereby clarify the Arbitrator's award with respect to the specific periods of temporary total disability.

Related to the October 10, 2010 accident (10 WC 40045), we find that Petitioner is entitled to temporary total disability benefits from October 10, 2010 through May 10, 2011. Corresponding to the second accident on February 5, 2012, we find that Petitioner is entitled to temporary total disability benefits from February 5, 2012 through July 14, 2012. Finally, as to the third accident on December 21, 2012, we find that Petitioner is entitled to TTD benefits from December 21, 2012 through September 24, 2014. In total, Petitioner is entitled to 145 weeks of TTD at the rate of $826.67 per week which amounts to $119,867.15. Respondent shall have credit for $157,972.27 paid in temporary total disability benefits. All else is otherwise affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $826.67 per week for a period of 145 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 shall be responsible for only those medical bills which it has voluntarily paid regarding Petitioner's left ankle and Petitioner's right knee and none additional with respect to those body parts.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's claims for prospective medical treatment regarding the left ankle and the right knee are denied.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's claims for penalties and attorneys' fees are denied.

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

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

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. Respondent shall have credit for $157,972.27 paid in temporary total disability benefits.

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

DATED: OCT 5 - 2016
RWW/plv
o-9/13/16
46

Ruth W. White

Joshua D. Luskin

Charles J. DeVriendt

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

16IWCC0645

BARHOUMEH, KEN
Employee/Petitioner

Case# **10WC040045**

12WC005993
13WC001783

CITY OF CHICAGO
Employer/Respondent

On 12/22/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.51% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in 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 LAW FIRM
PATRICK ANDERSON
111 W WASHINGTON ST SUITE 1425
CHICAGO, IL 60602

0766 HENNESSY & ROACH PC
CHRISTOPHER JARCHOW
140 S DEARBORN ST 7TH FL
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16IWCC0645

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)

Ken Barhoumeh
Employee/Petitioner

Case # **10** WC **40045**

v.

Consolidated cases: **12 WC 5993,13 WC 1783**

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 **Milton Black**, Arbitrator of the Commission, in the city of **Chicago**, on **August 27, 2015 and September 21, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☐ What were Petitioner's earnings?

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

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

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

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

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

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

N. ☐ Is Respondent due any credit?

O. ☐ Other _____

FINDINGS

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

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

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

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

Petitioner's current condition of ill-being regarding his left ankle and his right knee *is not* causally related to the accident.

In the year preceding the injury, Petitioner earned $**64,480.00**; the average weekly wage was $**1,240.00**.

On the date of accident, Petitioner was **56** years of age, *married* with **no** dependent children.

Respondent *has* paid all reasonable and necessary charges for all reasonable and necessary medical services regarding Petitioner's left ankle and Petitioner's right knee.

Respondent shall be given a credit of $**157,972.27** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**157,972.27**.

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

ORDER

Respondent shall be liable for only that temporary total disability which it has voluntarily paid regarding Petitioner's left ankle and Petitioner's right knee and none additional with respect to those body parts.

Respondent shall be responsible for only those medical bills which it has voluntarily paid regarding Petitioner's left ankle and Petitioner's right knee and none additional with respect to those body parts.

Petitioner's claims for prospective medical treatment regarding the left ankle in the right knee are denied.

Petitioner's claims for penalties and attorneys' fees are denied.

Respondent shall have a credit for all amounts paid to or on behalf of Petitioner on account of said accidental injuries.

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

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

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

Signature of Arbitrator

December 20, 2015
Date

ICArbDec19(b)

DEC 2 2 2015

FINDINGS OF FACT

Petitioner testified that on the October 10, 2010 he was employed as a public way inspector for the City of Chicago. Petitioner testified that on October 10, 2010 he was at the site where a trench approximately 10 to 15 feet deep was covered by thin plywood. Petitioner testified that as he was walking on the property he fell through the plywood and into the trench. Petitioner testified that he felt pain and that he had no knee pain or ankle pain prior to that date.

Petitioner sought treatment on October 10, 2010 at Our Lady of the Resurrection Medical Center. Petitioner gave a history of falling into a ditch and injuring his right shoulder, right knee and right ankle (PX3, p6).

Petitioner began medical treatment at MercyWorks on October 12, 2010. Dr. Anish Pithadia recommended pain medications, dispensed a right knee sleeve, and prescribed light duty restrictions of a sitting job only (PX1, p12).

Petitioner saw his primary care physician, Dr. Omar Alsamman on October 13, 2010 and reported pain in his right shoulder, right hip, right knee, right ankle, and back. Dr. Alsamman recommended physical therapy and to remain off work for two weeks (PX6, pp359-360). Petitioner underwent physical therapy 3 times per week (PX6, pp353-358).

On October 28, 2010, Petitioner underwent a right knee MRI at Resurrection Medical Center. It showed a complex tear of the posterior horn of the medial meniscus extruded medially bowing the medial collateral ligament (PX1, pp48-49).

On November 1, 2010, Petitioner returned to Mercy Works and was seen by Dr. Japhlet Aranas, who diagnosed a meniscal tear in the right knee and referred Petitioner to Dr. Alan McCall at Northwest Orthopedic and Sports Medicine (PX1, p14).

On November 4, 2010, Petitioner was seen by Dr. McCall who administered a right knee steroid injection, recommended physical therapy, and kept Petitioner off work (PX1, pp54-55). On December 2, 2010 Dr. McCall referred petitioner to Dr. Christopher Mahr at Northwest Orthopedic and Sports Medicine for a surgical consult (PX1, p67).

On November 4, 2010, Petitioner began treatment with Dr. Mahr. Petitioner had multiple pain complaints, including his right knee. The medical impression included right knee effusion (PX5, p28). Dr. Mahr noted that the right knee MRI demonstrated fragmentation of the medial meniscus (PX5, p28). Dr. Mahr performed a right knee arthroscopy and partial meniscectomy on December 15, 2010 (PX1, pp76-77).

On December 18, 2010, Petitioner followed up on crutches with Dr. Alsamman . Dr. Alsamman recommended physical therapy and continued Petitioner's pain medications (PX6, p325).

On December 21, 2010, Petitioner followed up with Dr. Mahr. Petitioner was prescribed and underwent physical therapy and was given a right shoulder injection (PX5, p32; PX6 pp317-20).

On December 29, 2010, Petitioner followed up at Mercy Works. He was examined by Dr. Pithadia, who recommended that Petitioner remain off work (PX1, p15).

On January 31, 2011, Petitioner underwent a right shoulder arthroscopy, subacromial decompression, and rotator cuff repair (PX5, pp38-39).

On February 23, 2011, Petitioner followed up at Mercy Works. He was examined by Dr. Pithadia, who noted that Petitioner's right knee "catches" sometimes. Dr. Pithadia recommended that Petitioner remain off work (PX1, p16).

Petitioner retuned to Dr. Mahr on March 24, 2011. Petitioner complained of right ankle pain. Petitioner stated that his right shoulder was mostly improved with only occasional pain with slight burning sensation at night. Petitioner was assessed with right ankle pain that has been persistent since his original injury that has not improved with conservative treatment (PX5, p49).

On April 6, 2011, Petitioner underwent a right ankle MRI for which was interpreted as showing distal Achilles tendinosis (PX5; pp50-51)

Petitioner retuned to Dr. Mahr on April 26, 2011, at which time Petitioner underwent a right ankle injection (PX5, p56).

Petitioner was evaluated at Respondent's request on May 10, 2011 by Dr. Scott Kale. Dr. Kale reviewed medical records. Dr. Kale opined that Petitioner was at maximum medical improvement and could return to work immediately (PX5, pp57-60). Dr. Kale diagnosed "well-healed right shoulder, well-healed right knee, mild low back strain, possible at most mild right ankle strain, intermittent headaches and completely normal functioning of daily activities" (PX5, p59).

Petitioner returned to MercyWorks on May 11, 2011. Notes from this visit indicate Petitioner underwent a cortisone injection to his right ankle on April 25, 2011. Petitioner had continued complaints of stomach pain, headaches, and blurred vision subsequent to his shoulder surgery. Dr. Pathadia's notes indicate Petitioner was to continue treatment with Dr. Mahr. Petitioner was kept off duty (PX1, p17).

Petitioner returned to Dr. Mahr on May 12, 2011 and complained of lateral sided ankle pain. Dr. Mahr charted "He, I believe, has had an independent medical exam". Petitioner complained of low back pain radiating into his right leg. It was noted that Petitioner's right ankle pain may be a component of lumbar radiculopathy. Dr. Mahr reviewed Petitioner's MRI of the lumbar spine, which showed degenerative changes, moderate spinal stenosis at L3, L4 and L4, L5 with lateral recess narrowing at L5, S1 (PX5, p61).

Petitioner was examined by Dr. William Davidson on September 22, 2011 for a neurological consultation. Dr. Davidson ordered a brain MRI and MRA and authored a report to Dr. Mahr (PX6, pp2, 4-6). Petitioner is reevaluated by Dr. Davidson on October 27, 2011. Dr. Davidson reported that "his MRA and MRA were absolutely normal" (PX6, p11).

Petitioner was evaluated at Respondent's request by Dr. Jay Levin on October 17, 2011. Dr. Levin's evidence deposition was entered into evidence without objection. However, the first 36 pages of the deposition transcript were not included (RX1).

Petitioner continued to treat with Dr. Alsamman through November 14, 2011(PX6, p248).

Petitioner continued to treat with Dr. Mahr through January 24, 2012 (PX5, pp61-75, 90).

Petitioner testified that he was forced returned to work on September 23, 2011 and that he worked from September 30, 2011 to February 5, 2012 as a public works inspector.

Petitioner testified that he was involved in a second work injury on February 5, 2012. Petitioner testified that he was driving a City vehicle to an inspection site when he was rear ended by another driver. Petitioner was treated and released from the emergency room of South Shore Hospital (PX13). Petitioner testified that he had a lot of pain to his low back and right side and that his head was bleeding. Petitioner testified that he followed up with Dr. Alsamman and with Dr. Mahr. Both Dr. Alsamman and Dr. Mahr noted low back pain (PX5, p97; PX6, p219). Petitioner began neck and back physical therapy (PX6, p199). On March 5, 2012, Petitioner began treatment with Dr. Iyad Alkhouri, a psychiatrist (PX12, pp24-26). Petitioner testified that he continued to treat with Dr. Mahr through June 2012. Petitioner testified that the lost time dates of February 6, 2012 to July 14, 2012 "sounds right". Petitioner testified that he returned to work with the "same restrictions".

Petitioner was evaluated at Respondent's request by Dr. Karen Levin on October 24, 2012. Dr. Levin reviewed medical records. Dr. Levin opined that the symptoms were significantly out of proportion to either injury and were lasting way too long. Dr. Levin opined that Petitioner was at maximum medical improvement from a neurological standpoint. Dr. Levin opined that Petitioner can be at work full duty from a neurological standpoint (RX6).

Petitioner testified that he was involved in a third work injury on December 21, 2012. Petitioner testified that he was working as a public works inspector, at a prescheduled meeting under Wacker Drive, when he walked out of his car into uneven ground. Petitioner testified that he noticed immediate left ankle pain. Petitioner testified that he received medical treatment from MercyWorks, Dr. Alsamman, and Dr. Mahr. Petitioner testified that he has been taken off work by Dr. Mahr from December 27, 2012 to the present. Petitioner testified that he received temporary total disability on and off through April 20, 2015. Petitioner testified that Dr. Mahr has recommended left ankle surgery. Petitioner testified that Dr. Mahr has also recommended right knee replacement surgery. Petitioner testified that neither surgery has been authorized. Petitioner testified that he will undergo the surgeries if they are authorized. Petitioner testified that he has received ongoing medical treatment from Dr. Alsamman, and Dr. Mahr.

Dr. Mahr testified at an evidence deposition. Dr. Mahr testified that the arthroscopic right knee surgery was related to the October 10, 2010 accident (PX16, pp19-20). Dr. Mahr testified that Petitioner would need total knee replacement surgery due to the work injury and the arthroscopic surgery (PX16, pp20-21). Dr. Mahr testified that all of the treatment he rendered to Petitioner's right knee was reasonable, necessary, and causally related to the October 10, 2010 accident (PX16, pp27-28).

Petitioner was evaluated at Respondent's request on February 24, 2014 by Dr. Bryan Neal. Dr. Neal reviewed medical records. Dr. Neal opined that there is no causal connection to Petitioner's current right knee condition (RX2, pp25-29) and that there is no causal connection to Petitioner's current left ankle condition (RX2, pp-29-32).

CONCLUSIONS OF LAW

In support of the Arbitrator's decision with respect to F (causal connection), the Arbitrator finds as follows:

The Arbitrator concludes that Petitioner has failed to prove that his claimed current condition of ill-being regarding his left ankle and his right knee is causally related to the October 10, 2010 accident. The Arbitrator is persuaded by the combined opinions and conclusions of Dr. Scott Kale, of Dr. Karen Levin, and of Dr. Bryan Neal. The Arbitrator agrees that Petitioner has reached maximum medical improvement.

The Arbitrator finds that Petitioner was at maximum medical improvement as of May 10, 2011 relative to the right knee, the date of Dr. Kale's persuasive report. The Arbitrator finds that Petitioner was at maximum medical improvement relative to the right knee and the left ankle as of September 24, 2014, the date of Dr. Neal's persuasive report.

The Arbitrator finds that Petitioner was not persuasive in what he testified to nor in the way that he testified. Petitioner was not entirely responsive or direct in his answers when he testified.

In support of the Arbitrator's decision with respect to J (medical), the Arbitrator finds as follows:

Based upon the Arbitrator's decision regarding causal connection, Respondent shall be responsible for only those medical bills which it has voluntarily paid regarding Petitioner's left ankle and Petitioner's right knee and none additional with respect to those body parts.

In support of the Arbitrator's decision with respect to K (prospective medical), the Arbitrator finds as follows:

Based upon the Arbitrator's decision regarding causal connection, Petitioner's claims for prospective medical treatment for the right knee and for the left ankle are denied.

In support of the Arbitrator's decision with respect to K (temporary total compensation), the Arbitrator finds as follows:

Based upon the Arbitrator's decision regarding causal connection, Respondent shall be liable for only that temporary total disability which it has voluntarily paid regarding Petitioner's left ankle and Petitioner's right knee and none additional with respect to those body parts.

In support of the Arbitrator's decision with respect to M (penalties and attorney's fees), the Arbitrator finds as follows:

Respondent was reasonable in placing its reliance upon its persuasive independent medical examiners. Therefore, Petitioner's claim for penalties and attorney's fees is denied.

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

16IWCC064

BARHOUMEH, KEN
Employee/Petitioner

Case# **12WC005993**

10WC040045
13WC001783

CITY OF CHICAGO
Employer/Respondent

On 12/22/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.51% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in 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 LAW FIRM
PATRICK ANDERSON
111 W WASHINGTON ST SUITE 1425
CHICAGO, IL 60602

0766 HENNESSY & ROACH PC
CHRISTOPHER JARCHOW
140 S DEARBORN ST 7TH FL
CHICAGO, IL 60603

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Ken Barhoumeh
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # **12 WC 5993**

Consolidated cases: **10WC40045, 13WC1783**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Milton Black**, Arbitrator of the Commission, in the city of **Chicago**, on **August 27, 2015 and September 21, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☐ What were Petitioner's earnings?

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

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

J. ☒ Were the 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 ______

16IWCC0645

FINDINGS

On the date of accident, **February 5, 2012**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

Petitioner's current condition of ill-being regarding his left ankle and his right knee *is not* causally related to the accident.

In the year preceding the injury, Petitioner earned $**64,480.00**; the average weekly wage was $**1,240.00.**

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

Respondent *has* paid all reasonable and necessary charges for all reasonable and necessary medical services regarding Petitioner's left ankle and Petitioner's right knee.

Respondent shall be given a credit of $**157,972.27** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**157,972.27**.

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

ORDER

The findings, conclusions, and orders which are recited in case number 10 WC 40045 are incorporated and adopted herein as though fully restated.

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

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

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

Milton Black

Signature of Arbitrator

December 20, 2015

Date

ICArbDec19(b)

DEC 2 2 2015

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

16IWCC0645

BARHOUMEH, KEN
Employee/Petitioner

Case# **13WC001783**

10WC040045
12WC005993

CITY OF CHICAGO
Employer/Respondent

On 12/22/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.51% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in 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 LAW FIRM
PATRICK ANDERSON
111 W WASHINGTON ST SUITE 1425
CHICAGO, IL 60602

0766 HENNESSY & ROACH PC
CHRISTOPHER JARCHOW
140 S DEARBORN ST 7TH FL
CHICAGO, IL 60603

16IWCC0645

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)

Ken Barhoumeh
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # **13 WC 1783**

Consolidated cases: **10WC40045, 12WC5993**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Milton Black**, Arbitrator of the Commission, in the city of **Chicago**, on **August 27, 2015 and September 21, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☐ What were Petitioner's earnings?

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

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

J. ☒ Were the 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 21, 2012**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

Petitioner's current condition of ill-being regarding his left ankle and his right knee ***is not*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**64,480.00**; the average weekly wage was $**1,240.00.**

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

Respondent ***has*** paid all reasonable and necessary charges for all reasonable and necessary medical services regarding Petitioner's left ankle and Petitioner's right knee.

Respondent shall be given a credit of $**157,972.27** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**157,972.27**.

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

ORDER

The findings, conclusions, and orders which are recited in case number 10 WC 40045 are incorporated and adopted herein as though fully restated.

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.

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

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

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

Milton Black

Signature of Arbitrator

December 20, 2015
Date

ICArbDec19(b)

DEC 2 2 2015

STATE OF ILLINOIS	)	☐ Injured Workers' Benefit Fund (§4(d))
	) SS.	☐ Rate Adjustment Fund (§8(g))
COUNTY OF COOK	)	☐ Second Injury Fund (§8(e)18)
		☐ PTD/Fatal denied
		☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Joseph Shabez,
Petitioner,

vs. NO: 09 WC 27207

Pace Bus,
Respondent.

16IWCC0646

DECISION AND OPINION ON REMAND

This matter comes before the Commission pursuant to Opinion and Order of the Circuit Court of Cook County Judge Kay Marie Hanlon dated March 30, 2016. In her January 15, 2015 decision, Arbitrator Simpson found Petitioner failed to prove he sustained an accident arising out of and in the course of his employment or, more specifically, that he was exposed to any occupational hazard arising out of his employment and resulting in disease and disablement pursuant to the Occupational Diseases Act on April 8, 2009 and denied his claim. Petitioner filed a timely review and in its Decision and Opinion on Review dated September 22, 2015, the Commission affirmed and adopted Arbitrator Simpson's decision. Petitioner appealed the Commission's Decision and Opinion on Review to the Circuit Court of Cook County. In her Opinion and Order dated March 30, 2016, Judge Hanlon reversed the Commission's Decision and Opinion on Review and remanded with instructions to address all the issues before it consistent with the standards of law discussed. Judge Hanlon noted, "As the Commission misapplied existing Illinois law, it follows that its conclusions may be erroneous. However, the Court will not itself step into the shoes of the Commission. It is the province of the Commission to weigh the evidence, resolve conflicts in evidence and draw reasonable inferences from the evidence. *Beattie*, 276 Ill.App.3d at 449." On Remand upon due consideration of the Circuit Court Order, the Commission re-affirms the Arbitrator's decision, finding that Petitioner failed to prove he was exposed to any occupational hazard arising out of his employment and resulting in disease and disablement pursuant to the Occupational Diseases Act on April 8, 2009 and denies his claim for the reasons set forth below.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

1. Petitioner, a 59 year old mechanic, testified at the July 2, 2013 arbitration hearing that he started working for Respondent in November 1979 at the northwest division facility in Des Plaines (Tr 13-14). His job at that time was a fueler, now called service worker (Tr 14). At that time Petitioner worked a 4:00 p.m. to 12:30 a.m. shift. When the buses would come off their runs, the drivers would park them. Petitioner would get a bus, fuel it, air it out, wash it and then park it in the garage for the next day (Tr 14-15). The garage where the buses were cleaned, fueled and parked held 64 buses (Tr 15). When he started, Petitioner had Sunday and Monday off; that changed as he gained seniority and he chose Friday and Saturday off (Tr 16). There was another facility for servicing the buses, a maintenance garage (Tr 16). In this maintenance garage, there were 8 to 10 maintenance bays. In between the parking garage and the maintenance garage there was a wash rack (Tr 17). In the wash rack, buses were swept out, aired out and washed (Tr 17). After being washed, the buses were fueled at a separate space (Tr 17). Sometimes Petitioner would help clean-up the shop or whatever they wanted him to do (Tr 18). If something broke down on the bus, it would have to be repaired, such as the air conditioning (Tr 18). He also had to make service calls only if a bus needed to be switched out; he left the facility to do that once or twice a week (Tr 18).

In 1984, Petitioner became a mechanic helper (Tr 19). He started doing brake jobs and changing radius rods, shocks and tires (Tr 19). His shift changed to 12:00 a.m. to 8:30 a.m. (Tr 19). Respondent sent him to attend courses to get training, but no special certification (Tr 20). Petitioner had a commercial drivers' license (Tr 20). About 15 years ago in 1998, the parking garage and maintenance garage were updated and renovated (Tr 21). There were no exhaust hoses in the old parking garage or the new parking garage (Tr 22). There were no exhaust hoses in the old maintenance garage (Tr 22). There were exhaust hoses in the new maintenance garage (Tr 22). There was no ventilation system in the old parking garage or the old maintenance garage (Tr 23). On Sunday nights, Petitioner had to go to the old parking facility and check the anti-freeze on the buses, start them up and let them run; this was done year-round and not just in the winter (Tr 23-24). In the winter, the buses would run from like midnight to when they started pulling out in the morning at 4:00 a.m. (Tr 24). All the buses were diesel engines (Tr 24). During the rest of the year, the buses were run for a shorter period of time, maybe 2 hours (Tr 24-25). The buses were run because on the weekends, the buses were not used and the batteries would wear down and sometimes anti-freeze would leak, so they wanted to double check to make sure the buses would run in the morning (Tr 25). In the parking garage, all 64 buses would be running at the same time (Tr 25). During his shift (midnight to 8:30 a.m.), Petitioner would spend 4 to 5 hours in the old parking garage where the 64 buses were warming up (Tr 26). During those 4 to 5 hours, there was no ventilation or exhaust hoses attached to the running buses (Tr 26). There were 4 doors in the old parking garage that would have been able to be opened for ventilation purposes (Tr 26). Those doors were open most of the time, unless it was real, real cold outside, then only one or two doors would be opened (Tr 26). The doors would be all the way opened (Tr 26). Even with the parking garage doors open, diesel exhaust would build up in the parking garage while the buses were running (Tr 27). During the 4 to 5 hours the buses were warming up, Petitioner would be checking anti-freeze and going row by row starting them all up (Tr 28). There were no workstations in the parking garage (Tr 28).

For the remainder of his shift, Petitioner would go back to the old maintenance garage and work on buses, changing tires or changing a headlight or fixing a fare box; whatever the driver had noted needed to be done was done, along with general maintenance (Tr 29-30). On any given shift, Petitioner would spend 4 hours performing general maintenance on the buses in the maintenance garage (Tr 31). In the old maintenance garage, there were doors that could be left open for ventilation purposes (Tr 31). Those doors would not be opened in the winter time and there would not be any ventilation (Tr 32-34). There would be no windows or doors opened generally in the winter time and there were no windows to open (Tr 34). Petitioner described what the fumes would be like during those hours in the winter in the old maintenance garage: if there were one or two buses running, the smoke would be coming out of the exhaust; they were old buses with old engines that would burn more diesel fuel (Tr 35). At any given time, one or two buses would be running in the 8 to 10 bays (Tr 35). In the old maintenance garage, the buses were backed into the bays (Tr 35). The work benches were at the back of the bus (Tr 35). The engines were located at the back of the buses where the exhaust fumes would come from (Tr 36). Where the exhaust was coming out of the bus was where all his work equipment was (Tr 36).

The wash rack was in between the maintenance garage and parking garage and was covered. It had an open door at each end for the bus to go through (Tr 36). In the winter time the doors would go up and down automatically. The bus to be cleaned would be shut down, but it would be smoky in there from the bus before (Tr 37). As a mechanics helper in the old garage system, Petitioner spent 6 hours per shift around diesel exhaust fumes (Tr 38). There was some portion of his shift where he would have a respite from the diesel exhaust fumes; during those times he would sometimes be doing a brake job, changing a tire or maybe nobody would have a bus running (Tr 38-39). Winter duties would be performed from the beginning of December to the end of February (Tr 39). Petitioner worked the midnight shift for about 3 years, then the shift hours were changed. Petitioner worked the 8:00 a.m. to 4:30 p.m. shift for a while. Then he worked the 6:30 a.m. until 3:00 p.m. shift. Petitioner worked days for about 15 to 20 years (Tr 40).

On the day shift as a mechanics helper, on any given work day Petitioner would be doing brake jobs, changing shocks, radius rods, windows, inspecting the buses and changing AC condensers in the old GM buses (Tr 41). His entire day shift would be spent in the old maintenance garage and he did not do any washing or fueling (Tr 41-42). The buses would be running if he was working on the air conditioning or to check the heat (Tr 42). When working the day shift and spending the majority of his work time in the old maintenance garage, Petitioner would spend 6 hours around diesel exhaust fumes, but it all depended on what some of the other guys were doing on their buses (Tr 43). It was common for the buses to remain running for certain repairs (Tr 43). It was on a daily basis that buses were running for repairs (Tr 43-44). During these 6 hours that he spent in the old maintenance garage, there were no ventilation fans or hoses present to remove diesel exhaust fumes from the building (Tr 44).

Approximately 15 years ago, the garages were renovated (Tr 44). In the parking garage, there were still 64 buses that would park there (Tr 44). The renovation included installation of exhaust fans placed in the roof. The exhaust fans would suck the air out of the garage, but it

would not take all the smoke out (Tr 48). It is Petitioner's testimony that there remained exhaust exposure in the parking building even after the ventilation fans were installed (Tr 48). The wash rack was expanded to 2 lanes, but it remained covered with doors on both sides (Tr 49). There were no fans or hoses installed in the wash racks (Tr 49). In the newly renovated maintenance garage, there were 10 repair bays. In the new maintenance garage, there was room made for repairs to be done outside of a bay if there was an overflow situation (Tr 49). The new maintenance garage was covered and if the 10 bays were full, they would pull buses in and repairs would be done to those buses right there to get it out of the way (Tr 49-50). About 6 extra buses could fit in this additional space for overflow (Tr 50). The new maintenance garage had exhaust hoses, but no ventilation fans (Tr 50). Petitioner described how the hoses worked: he would cycle them down, unwind them and put them on the exhaust pipe on the bus and then hit the on/off button to get the hose to start sucking out the exhaust fumes (Tr 50). Eight of the 10 bays had hoses (Tr 51). There were no hoses for when the overflow space was used for repairs (Tr 51). Sometimes the hoses would not work; sometimes the guys would forget the hose was attached to the bus and back out the bus and rip the hose; sometimes the on/off buttons would not work (Tr 52). The additional overflow space was used every day (Tr 52). Petitioner estimated that with the addition of the exhaust hoses, his exposure to diesel exhaust fumes decreased to 4 hours per shift (Tr 52). The exposure was continuing because during the day, they would bring buses in onto the overflow and leave them running because they would fix those buses right away and pull them out (Tr 52). There were no hours during an average workday where Petitioner was not exposed to diesel exhaust fumes (Tr 53). He worked 8 hours a day in the new maintenance garage (Tr 53). There would be some days where there would be no buses running (Tr 53). In an average workweek, there were no buses running one or two days (Tr 54). Petitioner generally worked 6 days a week; the 6th day was overtime that he chose to work; his job duties were the same on the 6th day as they were on the other 5 workdays (Tr 54). There remained garage doors in the new maintenance garage that could be opened for ventilation purposes (Tr 55). Those doors did not always remain open (Tr 55). Those doors were sometimes closed for security. Those doors were not opened in the winter for security and to keep the heat in (Tr 55). There were approximately 10 mechanics working per shift (Tr 55).

After being a mechanic's helper, Petitioner was promoted to a mechanic position in 1986 or 1987 (Tr 56). He performed the duties of a mechanic's helper and mechanic working in the old garage (Tr 56). His job duties were similar in these positions (Tr 56). The mechanic position required additional education and training certification (Tr 56). Petitioner bid for the mechanic position based on seniority (Tr 56-57). He was working as a mechanic when the new garage was built (Tr 57). Every workday Petitioner was performing repairs in the new maintenance garage with a bus running and exhaust fumes being emitted (Tr 57). He would use the exhaust hoses when they were available (Tr 57). Petitioner continued to work in this capacity until May 2009 (Tr 57). The exhaust hoses would break and would tear; he and others would try and fix them, but sometimes they could not be fixed; then the on/off buttons would not work (Tr 58). The exhaust hoses were not all operational when Petitioner stopped working in May 2009 (Tr 58). Then when he was diagnosed with bladder cancer, two weeks prior to his surgery, Respondent had a company come out and fix all the switches and the hoses (Tr 58). Petitioner and his co-workers always complained of the functioning of the exhaust hoses (Tr 59). Petitioner

complained to his foreman Joseph Luster and the superintendent of maintenance Rick McCormick (Tr 59). He did not know if there were any complaints ever made outside of the Pace system (Tr 59). Petitioner continued on the 6:30 a.m. to 3:00 p.m. shift in the new maintenance garage (Tr 59). In the new facility with the parking and maintenance garage, there were job duties that necessitated his presence in the parking garage for the 64 buses two to three times a week (Tr 59-60). If a bus driver was having a problem with a bus and wanted a mechanic to check it, Petitioner would see what was going on with it before the bus would be brought into the new maintenance garage (Tr 60-61). When he would go into the parking garage at that time, the buses would be running and he would be exposed to diesel exhaust fumes (Tr 61). This continued until Petitioner ceased working for Respondent in May 2009 (Tr 61).

Petitioner identified Px2 as a paystub from Respondent for him. Px2 shows an hourly rate of $24.44 and gross pay for 40 hours of $977.60 (Tr 62). Px2 reflects a pay period from May 17, 2009 to May 30, 2009 (Tr 62). Px2 was his last pay stub before he ceased working for Respondent (Tr 62). Petitioner may have had a raise in the year prior to May 2009 of 25 cents an hour (Tr 63). Any time after 40 hours was considered overtime (Tr 64). Petitioner volunteered for overtime (Tr 64). Respondent started giving out masks when they got the buses with the lifts for the wheelchairs. The mechanics were given masks to assist with the lubricant application to the chains on the handicap ramps (Tr 65). The masks were not intended to be worn for exhaust fumes as well. There were fumes from the lubricant and wearing the masks was not mandatory (Tr 65). Petitioner could not remember when Respondent got the buses with the handicap ramps, but believed it was 10 years ago, after the new garage was constructed (Tr 66). An AC recharge did not have to be done in a maintenance bay and were often done in the overflow bay (Tr 67). The bus for an AC recharge would have to be running. Petitioner would do AC recharges a couple times a week in the summer (Tr 67). When the AC recharges are done on the overflow area, no exhaust hoses are attached (Tr 67). For an AC recharge, the bus runs for 3 hours, during which time Petitioner was exposed to diesel exhaust fumes from the bus (Tr 68). This continued as a procedure up until he stopped his employment with Respondent in May 2009 (Tr 68). In April and May 2009, they were getting the buses ready for the summer and AC recharges were being done at that time (Tr 68). Respondent wanted the doors to the new maintenance garage closed in the winter for security purposes (Tr 69). When it was real hot outside the doors could be open if there was something in front of the doors, like a bus blocking the doors (Tr 70). Even when the doors were open, Petitioner was instructed to put some sort of blockade in front to prevent any thefts (Tr 70).

Petitioner would get a lunchbreak, which he could take in the TV room, the lunchroom or at a picnic table in the shop. His lunchbreak was a half hour (Tr 71). If he was at the picnic table, Petitioner would be exposed to exhaust fumes if somebody brought a bus into the garage. Buses were not worked on during lunchtime as everyone took lunch at the same time (Tr 71).

Dr. Collins was his primary care physician for a long time and before 2009. Petitioner would see Dr. Collins for routine check-ups (Tr 72). On January 28, 2009, Petitioner saw Dr. Collins for a complaint of blood in his urine, called hematuria (Tr 72). Dr. Collins recommended testing. After the results of the testing, Dr. Collins referred Petitioner to Dr. Dybal at Northwest

Suburban Urology Associates (Tr 73). Petitioner first saw Dr. Dybal on February 18, 2009 (Tr 73). Dr. Dybal asked what he did for a living and he told him he was a mechanic. Petitioner did not remember if Dr. Dybal had him undergo a kidney ultrasound (Tr 73). On February 27, 2009, Dr. Dybal performed a cysto urethroscopy to conduct a biopsy of Petitioner's bladder (Tr 74). On March 10, 2009, Dr. Dybal performed a second procedure to remove a bladder tumor, which was sent for testing (Tr 74). Petitioner followed-up with Dr. Dybal on April 8, 2009 and was informed his diagnosis was bladder cancer (Tr 75). The next day (April 9, 2009), Petitioner went to work and told Rick McCormick, superintendent of maintenance, his diagnosis of bladder cancer (Tr 75). Also on April 9, 2009, Petitioner underwent a DOT physical at Respondent's company clinic and informed the company physician that he had been diagnosed with bladder cancer the previous day (Tr 76). On April 8, 2009, Dr. Dybal wanted Petitioner to have additional testing for other cancers. Test results had shown an elevated PSA and enlarged prostate (Tr 76). Twelve core samples were taken from his prostate and were biopsied. On April 22, 2009, Dr. Dybal informed Petitioner that only 1 out of the 12 core samples had a positive cancer result from this biopsy (Tr 77). Dr. Dybal recommended he see Dr. Flanigan at Loyola University Medical Center for a consultation regarding surgery for the bladder cancer (Tr 77). Petitioner saw Dr. Flanigan on May 11, 2009 and surgery was scheduled for May 26, 2009. Petitioner informed Superintendent Rick McCormick of the surgery date and that he was going to be off work (Tr 78-79). Petitioner arranged with Respondent some sort of leave to attend the surgery (Tr 79). Petitioner also informed the Safety Department of everything that was going on, as requested (Tr 79). Petitioner requested workers' compensation information from either Mr. McCormick or the Safety Department and was provided with that information (Tr 79-80). Petitioner could not recall if he contacted the workers' compensation insurance carrier.

Petitioner completed the workers' compensation insurance forms with the Safety Department prior to going off work for surgery (Tr 80). Between May 11, 2009 and May 26, 2009, Petitioner knew he would be off work for the surgery and afterwards (Tr 82). Petitioner informed Mr. McCormick and the Safety Department about his need to be off work for the upcoming surgery (Tr 82). Petitioner could not recall a specific date when he had this conversation (Tr 82). Petitioner assumed he had this conversation shortly following the time he was given for his surgery date so he could make arrangements to be off work for this serious procedure (Tr 82). During this time, Petitioner spoke with Mike Strauss in the Safety Department, who gave him forms to complete and he did so (Tr 83). Petitioner told Rick McCormick that he thought his condition was work related and that it was from the diesel exhaust (Tr 83-84). This was in a latter conversation with Mr. McCormick, after the April 9, 2009 conversation with him; this latter conversation was after he was scheduled for surgery, but before he went off work for surgery (Tr 84). Petitioner was not given copies of the papers that he filled out in the Safety Department (Tr 84). He could not remember what the forms were titled that he had filled out in the Safety Department (Tr 85). Shortly after requesting information regarding workers' compensation, Petitioner filled out an Application for Adjustment of Claim on May 14, 2009 (Tr 85). This was within days of receiving his surgery date (Tr 85). At that time, Petitioner believed his condition was related to his work (Tr 85).

Petitioner kept working in February and March 2009 (Tr 85). It was not until he saw Dr. Dybal on April 8, 2009 that Petitioner was given the results of his bladder biopsy (Tr 86). Petitioner was not aware that he was going to need to be missing any time from work until he saw Dr. Flanigan on May 11, 2009 (Tr 86).

On May 26, 2009, Dr. Flanigan performed surgery consisting of a radical cystectomy with orthotopic neobladder, bilateral pelvic node dissection, prostatectomy and urinary diversion (Tr 87). Dr. Flanigan removed his bladder and had taken part of his colon and made a bladder out of it and diverted everything so he could still urinate and also removed his prostate and some lymph nodes (Tr 87-88). Petitioner was hospitalized from May 26, 2009 through June 3, 2009 (Tr 88). Petitioner returned to the emergency room on June 10, 2009 and was admitted for treatment of an infection and was released on June 14, 2009 (Tr 88). When Petitioner had seen Dr. Collins in January 2009, the bleeding in his urine had been going on for about a month to a month and a half before (Tr 89). There would be blood and then it would stop for a day or two; Petitioner thought he had a hernia and that he should be looked at, so he made an appointment to see Dr. Collins (Tr 89). He did not have blood in his urine before that (Tr 89). Petitioner had never been treated for urinary tract infection in the past and never received antibiotics for that condition (Tr 90).

Petitioner followed-up with Dr. Flanigan on June 22, 2009 and he informed him that chemotherapy treatment was not required at that time (Tr 90-91). Dr. Flanigan informed him that biopsies of the removed prostate were done and it was cancer (Tr 91). On July 15, 2009, Petitioner complained to Dr. Flanigan of post-operative infection complications (Tr 91). He remained authorized off work by Dr. Flanigan (Tr 91). The infection had started to affect his kidneys and Petitioner was prescribed medications. He was not prescribed physical therapy (Tr 92). He recovered on his own at home (Tr 92). On December 3, 2009, Dr. Flanigan recommended additional testing and continued him off work because he was still having problems and getting sick a lot, getting chills and dehydrating (Tr 93). In January 2010, there was concern that the bladder cancer had returned (Tr 94). A bladder biopsy was done in February 2010. On July 1, 2010, Dr. Flanigan did another cystectomy to take that biopsy. The biopsy showed that the bladder had E.coli in it (Tr 94). Petitioner was given a special medication for this E. coli infection and he will have to take this medication for the rest of his life (Tr 95). Dr. Flanigan did not release him to return to work (Tr 95). Petitioner continued to follow-up with Dr. Flanigan from July 2010 through July 2011 (Tr 95). As of November 1, 2011, Petitioner was granted Medicare benefits. Medicare was not paying for his treatment. The medical bills were paid by Blue Cross/Blue Shield, Petitioner's health insurance from work. Petitioner was still paying for health insurance (Tr 96). In December 2009, Petitioner was awarded Social Security Disability (Tr 97). Petitioner did not retire from Respondent and is still there because he did not want to lose his health insurance (Tr 97). Petitioner is on some sort of leave at this point (Tr 97). Petitioner's employment relationship has not terminated (Tr 97). Blue Cross/Blue Shield remains his primary health insurance, with Medicare as a secondary payer (Tr 98).

Petitioner returned to Dr. Flanigan in January 2012. At that time there was concern that the cancer had returned (Tr 98). He underwent a PET scan on January 31, 2012 and was notified that the cancer from his bladder had metastasized to his colon (Tr 98). Dr. Eberhardt did surgery to remove the affected part of his colon (Tr 99). When Petitioner followed-up with Dr. Flanigan in April 2012, he ordered more biopsies in his pelvic area (Tr 99). These biopsies showed cancer in the lymph nodes and a tumor on the pelvic bone in the pelvic area (Tr 99-100). Petitioner followed-up with Dr. Flanigan on June 18, 2012 and received those results. On July 18, 2012, Petitioner began chemotherapy treatment with Dr. Gainer. Petitioner underwent radiation as well, but not at the same time (Tr 100). He underwent chemotherapy series first, then radiation (Tr 100). Chemotherapy treatments have continued to the present time. Chemotherapy is to treat a metastases of his bladder cancer to his lymph nodes and pelvic area (Tr 101). He has a follow-up scheduled with Dr. Flanigan in September 2013. Petitioner has chemotherapy with Dr. Gainer the day after this hearing (Tr 101). Dr. Gainer is out of Loyola University Medical Center as well (Tr 101).

Petitioner served in the military from October 21, 1968 to May 24, 1970 and is a veteran of the Vietnam War. During this time, he was exposed to Agent Orange, a herbicide used by the U.S. military during the war (Tr 102). On May 6, 2009, Petitioner filed for service connection benefits with the Department of Veteran Affairs for his bladder and prostate cancer (Tr 102). Petitioner was shown Px1, a decision document of the Department of Veteran Affairs dated September 26, 2009 regarding his service connection application for bladder cancer and prostate cancer. The decision by the Department of Veteran Affairs denied a service connection for high grade uretheral carcinoma claimed as bladder cancer (Tr 103). The Department of Veteran Affairs denied that his exposure to Agent Orange was connected to his diagnosis of bladder cancer (Tr 103). Petitioner thought he appealed this Decision, but he did not remember (Tr 105). It is his understanding that the Department of Veteran Affairs denied that his bladder and prostate cancer conditions were related to any exposure he may have received to Agent Orange (Tr 108). The Department of Veteran Affairs did not issue him any service benefits (Tr 109). Petitioner filed both with the Department of Veteran Affairs and for workers' compensation benefits because he did not know what was going to happen to him, he did not understand and everything was coming at him at the same time (Tr 109). The Application for Adjustment of Claim was filed after he received the diagnosis of bladder cancer (Tr 110). No one assisted him in making application for benefits to the Department of Veteran Affairs. Petitioner did not remember if the VFW assisted him in making that application (Tr 110). Petitioner was exposed to diesel exhaust fumes up until the time of his departure from Respondent in May of 2009 (Tr 110-111). He was exposed to diesel exhaust fumes on a daily basis for approximately 4 hours per day (Tr 111). This exposure continued even with the addition of the exhaust hoses and ventilation systems in the new garage (Tr 111). He informed Dr. Dybal of his diesel exhaust exposure at work (Tr 111).

2. On cross-examination, Petitioner testified he did not know exactly when he was having blood in his urine, maybe January or February 2009 (Tr 115). Petitioner denied having blood in his urine for 10 years before he saw Dr. Dybal (Tr 115-116). When he saw Dr. Collins on May 29, 2007, Petitioner complained of a few traces of blood in his urine (Tr 116). When he

saw Dr. Dybal in February 2009, Petitioner wanted to be truthful, be accurate and give him the best medical picture he could about his background (Tr 117). Petitioner acknowledged he did not report to Dr. Dybal that he had seen a urologist some 10 years before (Tr 118). About the end of January or beginning of February 2009, Petitioner was alarmed and concerned when his underwear was full of blood all the time (Tr 118). In April 2009, Dr. Dybal informed Petitioner of his diagnosis and that chances are it could be from his work as a mechanic (Tr 119-122). Also present in the room when Dr. Dybal informed him of that were his daughter Sandy Wallace and her fiancée Joyce Semanchek (Tr 122-123). Petitioner did not remember the exact date Dr. Dybal told him this bladder and prostate cancer could be work related (Tr 125-126). The conversation took place before Petitioner signed the Application for Adjustment of Claim on May 14, 2009 (Tr 126-127). After the Application was signed, Petitioner had no more conversations with Dr. Dybal about his opinions regarding his work and his diagnosis of bladder and prostate cancer (Tr 127). Dr. Dybal told Petitioner just one time in or around April or May 2009 that there might be a connection (Tr 127). Petitioner's attorneys did not ask him to deliver any information to Dr. Dybal or obtain information from him (Tr 127). Petitioner did not know why it took Dr. Dybal years to produce a one paragraph letter stating that there might be a connection between diesel and his condition of bladder and prostate cancer (Tr 128).

Petitioner testified that Dr. Flanigan said his bladder and prostate cancer could be from his job, but he did not know when Dr. Flanigan said that. Petitioner did not have a report from Dr. Flanigan stating that (Tr 128). He did not know if his attorneys have a report from Dr. Flanigan (Tr 128). It is Petitioner's recollection that Dr. Flanigan said that his work duties might or could have caused his prostate and bladder cancer (Tr 129). He could not remember when Dr. Flanigan said that. Maybe Dr. Flanigan said that twice, but he did not remember (Tr 129). Petitioner testified that Dr. Collins told him that there might be a connection between his bladder and prostate cancer and his work. Dr. Collins told him this when he was bleeding. He did not remember if Dr. Collins said that more than once (Tr 129). Petitioner did not ever ask Dr. Collins to write him a report to state that (Tr 129). He did not know if his attorneys asked Dr. Collins to write a report asking for that opinion (Tr 130).

Petitioner spent maybe a half hour telling Dr. Dybal about his work when he first met him (Tr 131). Dr. Collins already knew about his job as he was his primary care physician and would see him regularly (Tr 132). Dr. Collins knew Petitioner was a mechanic working with Pace Bus (Tr 132). Petitioner never specifically talked about his job duties and responsibilities with Dr. Collins (Tr 132). He just told Dr. Flanigan that he was a Pace mechanic and nothing more (Tr 132). Petitioner underwent chemotherapy for 5 months, then radiation for 2 weeks solid, then chemotherapy every 3 weeks up to the date of this hearing. He has chemotherapy scheduled for the day after this hearing (Tr 133-135). He then stated he started doing chemotherapy maybe 9 months ago. He was doing chemotherapy every week (Tr 135). Petitioner was cancer free until it got into the colon, then Dr. Eberhardt did surgery on the colon on February 13, 2012 (Tr 136). Dr. Flanigan had ordered tests to make sure the cancer was gone and then cancer was found in his colon (Tr 137). He was doing all right for approximately a year before that (Tr 137). For the year and a half before February 12, 2012, Petitioner was living. Dr. Flanigan had authorized him off work for the year and a half before February 12, 2012 (Tr 137).

During that time, he was going for check-ups all the time as he had kidney problems and infections; he had to get up every 2-3 hours in the middle of the night to urinate (Tr 138). Petitioner does not need any assistive devices to walk or get around (Tr 138). He drives his automobile. He took a Metra train to get to the hearing site and walked from Union Station.

From October 1968 to May 1970, Petitioner was a vet in the Vietnam War (Tr 139). He was in the Army on the ground during that period of time. He was a combat troop. During that period, it is his belief and understanding that he came into contact with Agent Orange. Petitioner could not remember if that contact was on multiple and repeated occasions (Tr 140). In Vietnam, Petitioner did not smoke cigarettes or drink. He did not ever smoke cigarettes. Petitioner lived with his parents for 18 years and his father smoked maybe one pack a day. Petitioner's father was a regular cigarette smoker inside and outside the house (Tr 141). During his working periods of time, Petitioner worked with 9 or 10 other co-employees. There was no smoking in the shop/garage or break rooms (Tr 142-143). Some co-employees smoked. For the last 20 years, Petitioner golfed as a regular recreational activity (Tr 143). He was honorably discharged (Tr 144). When Petitioner applied for VA benefits claiming he was exposed to Agent Orange, he also applied for benefits because of PTSD (Tr 144). He was helped with these applications by either the VFW or DAV. Dr. Whitelock, his primary care physician at that time, supported his claim for PTSD. Dr. Whitelock was with the VA at Hines Hospital (Tr 145-146). He still sees Dr. Whitelock from time to time and last saw him a month ago (Tr 146). Petitioner has not seen Dr. Whitelock for his bladder cancer or prostate cancer, but did inform him of his medical condition (Tr 148). Petitioner was discharged from the Army in 1970. He began working for Respondent in 1979. In between, he worked different cash jobs; he was finding himself after getting out of the jungle (Tr 149-150). He was a painter on a crew for a while. He worked at General Telephone in a print shop putting phone books together (Tr 151). The print shop was in Des Plaines and called General Telephone Directory Company. It was a factory setting, a plant floor; the machines were not running where he was at; where he worked was clean and had all kinds of windows (Tr 152-153). He then went to work for Respondent.

When he began working at Respondent in 1979, his job was a fueler at the old garage (Tr 153). There were 8 to 10 bay doors in the old garage and the doors were 12 to 13 feet wide and 15 to 20 feet high (Tr 154). The doors were on one side of the garage. The old parking garage held 64 buses. It was one giant facility and completely covered. The old parking garage had 4 double garage doors on each side of the building, each double garage door was about 25 to 30 feet wide and 15 to 20 feet high (Tr 155). His job as a fueler was a union job with ATU local 1028. This became the Teamsters about 8 years ago, local 731 (Tr 156). Buses were fueled outside of the building (Tr 157). After the buses were fueled and cleaned, they were parked in the parking garage (Tr 157). The buses were running as they were being fueled, which was standard operating procedure (Tr 157-158). All the buses had exhausts on the top of the bus (Tr 158). The top of the bus was 9 feet high back in 1979 (Tr 158). Petitioner is 5'10' to 6' tall. He would also sweep out the inside of the bus or blow out the bus with an air hose (Tr 158-159). While doing so, he was typically not exposed to any air, other than the air that was inside the bus (Tr 159). When parking the bus in the garage, Petitioner would drive the bus. While driving the bus, he was not exposed to outside air, only the air inside the bus (Tr 159). He worked the fueler

position for about 5 years, into 1984. For the first 3 years of those 5 years, Petitioner worked from 4:00 p.m. to 12:30 a.m. shift (Tr 160). During his work as a fueler, it was also his responsibility in the old garage to keep the buses running all the time. Most of the buses were back to the garage from the street by 9:00 p.m. (Tr 161). For the first 5 hours of his shift, the buses were doing their street routes (Tr 161-162). Most of the buses were doing their rush hour routes from 4:00 p.m. to 6:00 p.m. (Tr 162). The buses start coming in about 7:00 p.m. and a lot of buses are back at the garage by that time (Tr 162). When the buses arrived at the garage, they are already running. The time he spent in the maintenance garage at that period of time as a fueler was just to do odds and ends (Tr 163).

Petitioner became a mechanics helper in 1984 (Tr 163). In that period of time he did essentially the same things as a fueler and from time to time he would help out with the brakes, tires and shocks (Tr 163-164). The buses are not running while the brakes, tires and shocks are being done (Tr 164). All the buses that Petitioner ever worked on from 1979 until May 2009 had the exhausts on top of the bus (Tr 164). None of the buses he ever worked on were blowing exhaust in his face or his body and everything was vented on top (Tr 164). Petitioner is claiming he was exposed to bus exhaust fumes (Tr 165). A bus could be started from the outside by reaching through the driver's window (Tr 166). The buses would be parked in the parking garage and the engines turned off (Tr 167). From 4:00 p.m. to 9:00 p.m., there may have been 40 buses parked in the parking garage (Tr 167). The drivers drive the buses into the parking garage and turn the engines off (Tr 168). When Petitioner would go to get a bus is when he would start the bus. If it did not start, Petitioner would get the battery charger and charge the battery so it could be started later. The double sized garage doors in the parking garage would be open probably 6 months out of the year (Tr 168). The wash rack was an enclosed facility. The buses were normally running when he was washing them (Tr 168). One bus was washed at a time in the wash rack (Tr 168). There was a bay door in front and in back. Six to nine months a year, a bay door was open, unless they were worried about security because of the fare boxes (Tr 169).

Petitioner became a full-time mechanic in 1986 or 1987 (Tr 169). As a mechanic, he worked on brakes, shocks and everything else. The work Petitioner was performing as a mechanic was principally done with the bus engine off, but sometimes there would be buses on the apron that would be running (Tr 170). Petitioner's job duties and responsibilities were substantially the same and no different than his colleagues and co-workers as a mechanic on the floor (Tr 170). Petitioner started receiving Social Security Disability benefits in December 2009 (Tr 171). He did not know what doctors supported him for his claim for Social Security Disability benefits; he just went to social security and applied for it and no attorney helped him with that; he reported his medical condition and the doctors he was seeing at that time (Tr 171-172). Petitioner did not apply for short-term disability benefits or long-term disability benefits through Respondent or his union (Tr 173-174).

The new parking and new maintenance facility is approximately 15 years old and it might be older (Tr 174). The new parking garage has the same size double doors (Tr 175). Those doors would be closed during extreme weather. Most of the time those doors would be open in

nice weather (Tr 175-176). There are 2 bay doors in the new maintenance facility and the doors are the same size as the doors of the new parking garage (Tr 176). A bus does not have to back out because there is another set of bay doors straight ahead. There are two sets of giant bay doors on either side of the mechanic building (Tr 176). During good weather those doors were open, but there was something in front of the doors for security; that did not prevent the doors from being closed (Tr 176-177). A lot of times it was just easier to have the door closed so he would not have to put anything in front of the doors (Tr 177). Petitioner never asked his doctors for a report or note saying that his bladder and prostate cancer is work related (Tr 178). He did not know who was the first person that solicited or asked the doctors for such a note and he did not remember (Tr 178). Petitioner and his attorneys never worked together to try to get one of these doctors to come forward and try to establish an entitlement to benefits (Tr 179). Petitioner's last paystub covered the pay period from May 17, 2009 through May 30, 2009 (Tr 179). His hourly rate might have been 20 cents less for the 52 week period before that (Tr 179). It is fair to say Petitioner did not know what he was paid; he just knows what his last pay stub shows (Tr 180).

Petitioner's mother is still alive, but has health issues such as old age and being overweight, no diabetes as far as he knows, no cancer or OCD. Petitioner's father is alive and has health issues such as old age. His mother is 83 years old and his father is 89 years old. Petitioner had a brother and 3 sisters, none of whom were diagnosed with cancer. None of his siblings or parents have any medical history of cancer or disease processes that he knows of (Tr 182).

3. On re-direct examination, Petitioner testified he worked as a fueler from 1979 until approximately 1984, about 5 years (Tr 182). At that time, his shift started at 4:00 p.m. The buses would not really start to come back in from their routes until closer to 6:00 p.m. or 7:00 p.m. During the time when most of the buses were out on their routes, as a fueler Petitioner would do odds and ends in the shop until the buses came in (Tr 183). There were still buses present at that time being worked on and repaired (Tr 183). During the hours from approximately 4:00 p.m. to 7:00 p.m. when he was doing those things, Petitioner was being exposed to exhaust fumes from buses running at that time (Tr 183). Petitioner had testified on cross-examination that most of the work he performed when he was a full mechanic was with the engine off. During that time the other mechanics could have had buses running (Tr 183-184). There were also still repairs, such as AC recharging, that he and others did with the buses running (Tr 184). On July 1, 2010, Dr. Flanigan placed Petitioner on anti-infection medication for E-coli that he has to take for the rest of his life (Tr 184). At that time Petitioner had complained of frequent urination. He also had some pain in his kidneys (Tr 185). The infection was causing the kidney problems and he had to catheterize himself (Tr 185). At the present time, Petitioner does not have to catheterize himself (Tr 186). He had to catheterize himself for approximately 2 months. From July 2010 through January 2012, Petitioner was seeing Dr. Flanigan every 3 or 6 months (Tr 187). Every time he saw Dr. Flanigan, Petitioner would undergo urinary testing (Tr 187). Dr. Flanigan continued to have Petitioner remain off work (Tr 188). Petitioner opined he needed to be off work due to having lost a lot of weight, his lack of strength and not sleeping because he had to get up every 2 to 3 hours to empty his bladder.

Petitioner did not feel he was physically capable of his work (Tr 188). To perform his job at Respondent, Petitioner would have to perform significant, heavy lifting (Tr 188-189). He would have to lift tires and generators; a generator weighed 120 pounds (Tr 189). Petitioner will have the neobladder for the rest of his life (Tr 189). Petitioner has to empty the neobladder and he does not need special facilities in order to do that (Tr 189).

4. On re-cross examination, Respondent's attorney informed Petitioner that on January 13, 2011, Dr. Flanigan noted that Petitioner denied fatigue, denied shortness of breath and denied any weight loss. Petitioner stated he gets tired and Dr. Flanigan was going from his last appointment before January 13, 2011 that he had no weight loss (Tr 190-191). When he started with Dr. Flanigan, Petitioner weighed 235 pounds. The week before this hearing he weighed 196 pounds. He lost 40 pounds with this cancer (Tr 191). The doors are open in the spring, unless they are worried about security again. It is not correct that when he was working on AC it allowed him to be outside (Tr 192). Buses were worked on inside the building. The venting is on top and the exhaust is on top and the doors could be open (Tr 192).

On re-direct examination, Petitioner testified that when the door is open, often there is a bus parked in front of the door (Tr 193). The bus occupies half the width of the door and about half the height of the door (Tr 193-194).

5. At the January 10, 2014 arbitration hearing, the parties stipulated that Petitioner's average weekly wage was $977.60 (Tr 5). Proofs were closed at that hearing following admission of the documentary evidence.

6. According to Dr. Collins' records from Alexian Brothers, Px3, Petitioner was seen on May 17, 2006 and assessed with hematuria. The plan was noted as culture and urinalysis. Petitioner was seen on May 29, 2007 and assed with hematuria, among other things. The plan was culture, urinalysis, prostate cancer screen and colon cancer screen.

On January 28, 2009, Dr. Collins noted that Petitioner was there for hypertension follow-up. On examination, Dr. Collins noted blood in Petitioner's urine was present, as was frequency and impotence. Nocturia was not present. Petitioner complained of intermittent back pain, a dull ache he rated at 4/10. Dr. Collins assessed hematuria. The plan was noted as culture, urinalysis, prostate cancer screen and colon cancer screen. Dr. Collins prescribed Flomax. A Physician Notification of Planned Surgery dated February 23, 2009 indicated Petitioner was scheduled for a flexible cystoscopy by Dr. Dybal on February 27, 2009.

7. Northwest Suburban Urology records, Px5, indicate Petitioner saw Dr. Dybal for a urologic consultation on February 18, 2009. In his report of that date, Dr. Dybal noted that the reason for this consultation was gross hematuria. Dr. Dybal noted the following history: "Mr. Shabez is a 59 year-old white male who two months ago began developing gross hematuria. It tends to be mostly at the end of urination. It is occurring with almost each urination. He does have associated blood clots." Recent urine culture was negative. "He also has exposures to diesel fuel and solvents at work. He did see a urologist for hematuria some ten years ago. He is

unsure of any of the results." Lab results showed urine by dipstick and microscopy with too numerous to count red blood cells. Dr. Dybal assessed: 1) gross hematuria; 2) enlargement of the prostate. Urine was collected for culture and testing. Renal ultrasound followed by flexible cystoscopy were scheduled.

A Diagnostic Report dated February 19, 2009 indicated Cytologic Diagnosis was positive for malignancy of a high-grade urothelial carcinoma and/or carcinoma in situ. Mild acute inflammation was also noted. A kidney ultrasound examination was also performed on February 19, 2009 with findings noted of no gross abnormality being seen.

On February 27, 2009, Dr. Dybal performed a flexible cystourethroscopy. The Operative Report noted a pre-operative diagnosis of gross hematuria. Dr. Dybal noted that the pan cystoscopy of the bladder revealed a large 5cm bladder tumor with fresh and old clot. It was noted that Petitioner was to return for outpatient transurethral resection of bladder tumor. A Physician Notification of Planned Surgery dated March 3, 2009 to Dr. Collins indicated Petitioner was scheduled for a cystoscopy/ transurethral resection of bladder tumor by Dr. Dybal on March 10, 2009. (Px3).

8. Dr. Dybal saw Petitioner on March 10, 2009 and noted his bladder tumor and that urine cytology was positive for malignancy. The FISH analysis was also abnormal. Petitioner's NMP22 was positive. Renal ultrasound was noted as unremarkable. Petitioner presented for cystoscopy and transurethral resection of bladder tumor. In his March 10, 2009 Operative Report, Dr. Dybal noted a pre-operative diagnosis of bladder tumor. The procedure was noted as cystoscopy and transurethral resection of bladder tumor. The report indicates the tumor was resected in its entirety into deep muscle tissue. The March 12, 2009 Pathology Report indicated that the tumor was best classified as urothelial (transitional cell) carcinoma. (Px5).

9. Petitioner saw Dr. Dybal on April 8, 2009 and reported he was urinating markedly better now without any complaints of hematuria. Dr. Dybal noted Petitioner had an elevated PSA for his age at 3.9 ng/ml. Dr. Dybal's impression was 1) pathologic T2 transitional cell carcinoma of the bladder, high grade; 2) elevated PSA; 3) enlargement of the prostate. The plan was to institute metastatic evaluation. Dr. Dybal ordered a CT scan of the abdomen and pelvis. Dr. Dybal noted that Petitioner will need to be seen at a tertiary care facility for consideration of radical cystectomy with urinary diversion. He also scheduled a transrectal ultrasound of the prostate with biopsy for the elevated PSA. (Px5).

10. Alexian Brothers Occupational Health records, Px4, indicate Petitioner was seen on April 9, 2009 for a commercial driver fitness determination. The Medical Examination Report for Commercial Driver Fitness Determination dated April 9, 2009 noted Petitioner reported: "Was diagnosed yesterday with bladder cancer."

11. On April 14, 2009, a prostate needle biopsy under ultrasound guidance was done. The Urology Pathology Report dated April 15, 2009 indicated that out of the 12 biopsies, 11 were benign and 1 was focal high grade prostatic intraepithelial neoplasia. A CT scan of the

abdomen and pelvis was performed on April 17, 2009. It was noted under abdomen findings that a tiny calculus measuring about 1mm was seen in the mid kidneys region of both kidneys. There was no evidence of obstructive uropathy. Otherwise the kidneys appeared normal. There were normal appearing liver, spleen, pancreas and adrenal glands. Pelvis findings were noted as the appendix appeared normal and the rectum and sigmoid colon were unremarkable. There was thickening of the bladder wall with a nodularity at the lateral aspect on the right side, compatible with the clinical diagnosis of bladder cancer. The nodule measured approximately 13mm X 8mm. The prostate appeared mildly enlarged measuring about 5.2cm in diameter. There was no adenopathy or pelvic mass. Dr. Dybal saw Petitioner on April 22, 2009 and noted the prostate biopsy results. Dr. Dybal noted Petitioner would require a radical cystoprostatectomy. Dr. Dybal's impression was: 1) high grade PIN of the prostate; 2) high grade pathologic T2 bladder cancer; 3) enlargement of the prostate; 4) elevated PSA. Petitioner was to continue prescribed Flomax. Dr. Dybal referred Petitioner to Dr. Flannigan at Loyola. (Px5).

Petitioner saw Dr. Collins for hypertension follow-up on April 25, 2009. In his physical examination, Dr. Collins noted that blood in the urine, frequency and impotence were present. Nocturia was not present. In his April 29, 2009 physical examination, Dr. Collins noted that Petitioner's prostate was enlarged, soft, 1+ and not nodular. Dr. Collins' assessment was bladder cancer and prostate cancer, among other things. Dr. Collins referred Petitioner to urology, general surgery. (Px3).

12. Department of Veterans Affairs records, Px1, indicate Petitioner filed a claim on May 6, 2009 alleging service connection for bladder cancer and prostate cancer due to herbicide exposure (Agent Orange).

13. Loyola University Medical Center, Px7, indicate Petitioner saw Dr. Flanigan on May 11, 2009. Dr. Flanigan noted that Petitioner was referred for consultation for newly diagnosed muscle invasive bladder cancer. Dr. Flanigan noted that Petitioner's urologic history began in February 2009 during which time he started having intermittent painless gross hematuria. This lead to a cysto/URBT on March 10, 2009 for a 5cm tumor on the right side of the bladder dome. The pathology was T2G3 UCC. Petitioner was also noted to have an elevated PSA of 3.9 and subsequently had a PNB on April 14, 2009. This was negative for prostate cancer, but Petitioner did have a focus of HGPIN at the left apex. Dr. Flanigan noted Petitioner was taking Flomax for his LUTS. Dr. Flanigan noted he had a viable FOS, but otherwise his urinary ROS was negative. Dr. Flanigan noted Petitioner had never smoked and that he was currently a diesel mechanic. Dr. Flanigan noted Petitioner's family history was negative for prostate cancer or other urologic disease. On examination, Dr. Flanigan found Petitioner was generally normal. Dr. Flanigan's assessment was muscle invasive bladder cancer. Dr. Flanigan counseled Petitioner on his options of radical cystectomy with diversion versus XRT. Dr. Flanigan informed Petitioner that failure rates were higher for XRT and that this modality was usually reserved for poor surgical candidates. Dr. Flanigan noted Petitioner was interested in radical cystectomy with diversion and was leaning towards a neobladder.

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Dr. Flanigan performed surgery on May 26, 2009. In his Operative Report, Dr. Flanigan noted the procedure he performed of radical cystectomy with creation of orthotopic neobladder, bilateral pelvic node dissection and prostatectomy. Petitioner was discharged on June 3, 2009. However, on June 10, 2009, Petitioner was seen at the emergency room for post-operative fever. It was noted that he had an uneventful post-operative course until 24 hours prior when developed elevated temperature and shaking chills. He had nausea, vomiting and fevers since the day before this visit. He had no chest or abdominal pain. Urine and blood samples were sent to the laboratory. The Foley catheter was found to be plugged and was flushed. Petitioner was admitted and was subsequently discharged on June 14, 2009. The Discharge Summary indicated that the urine culture was returned showing pansensitive E.Coli. Petitioner was given medications and he remained afebrile throughout his hospital stay and was discharged home. He was shown and demonstrated Foley flushing.

Petitioner returned to Dr. Flanigan on June 22, 2009 for removal of uretheral catheter and bladder training. Dr. Flanigan noted Petitioner had a 13 pound weight loss. He was positive for E. coli resistant to Cipro and was switched to Bactrim as catheters were removed. Dr. Flanigan checked with pathology and there was no prostate cancer noted on his specimen. Petitioner reported feeling tired and weak. His appetite and energy level were fair. Petitioner reported a pain scale 6-7/10 on his left flank and he took hydrocodone for this. Petitioner saw Dr. Flanigan on July 15, 2009 for complaints of intermittent bilateral back/flank pain and persistent incontinence after recent neobladder. Dr. Flanigan thought Petitioner was emptying well. Petitioner was to continue Kegel exercises and Dr. Flanigan would consider pelvic floor therapy if Petitioner felt he was not making progress.

Dr. Flanigan saw Petitioner on August 27, 2009 for complaints of chills 4 days before associated with fatigue, back pain and foul smelling urine. Petitioner denied dysuria and hematuria and denied fever and flank pain. Petitioner felt he was voiding completely. Petitioner reported nocturia 7-8 times a night with incontinence. Dr. Flanigan prescribed Ampicillin for enterococcus urinary tract infection. He was to return in 3 months.

14. The Department of Veterans Affairs Rating Board issued its Decision on September 26, 2009 wherein Petitioner was denied service connection for bladder cancer and prostate cancer due to herbicide exposure (Agent Orange). (Px1).

15. Dr. Flanigan noted on October 29, 2009 that Petitioner had been treated for 5 urinary tract infections, 4 E.coli and 1 VRE. He noted Petitioner usually complained of left flank pain, but not always with fever. Petitioner was started on Urex 3 weeks ago following the last UTI. Dr. Flanigan noted that initially Petitioner did not catheterize/ irrigate, but now did so daily. He was voiding every 4 hours, 4 times per day, and continued Kegels. Petitioner reported he did have left flank pain the day before and foul odor in his urine. It was Dr. Flanigan's assessment that Petitioner was clinically well now. He was to stop daily IC with irrigations and follow-up in 3 months.

On January 15, 2010, Petitioner was seen for urine cytology. Cytologic examination was negative for malignancy. Dr. Flanigan noted on February 23, 2010 that Petitioner had been admitted for a possible bladder stone on neobaldder and narrowing of the ureters with secondary malignant neoplasm of bone and bone marrow. Petitioner underwent pouchoscopy, neobaldder barbotage with general anesthesia this day. His neobladder was found to be free of any intrinsic abnormality except for some additional mucous which was adherent to the bladder. Petitioner was discharged this day.

Petitioner followed-up with Dr. Flanigan on July 1, 2010. Recurrent urinary tract infection was noted and Petitioner was taking Bactrim. His last UTI was noted on April 20, 2010 as E. coli. Petitioner had his usual complaints of left flank pain, not always with fever. He was voiding every 4 hours. It was noted he was dry if awake, but wore 2-3 pads per day for safety as he leaked if he napped in a chair. He used 3-4 pads a night. A CT of the abdomen and pelvis was performed on October 4, 2010. The impression was no suggestion of recurrent or metastatic disease. (Px7).

16. Hines VA Hospital records, Px9, indicate Petitioner saw Dr. Whitelock on November 1, 2010 for a new patient visit. Dr. Whitelock noted that overall Petitioner was doing well. He noted Petitioner's bladder cancer and treatment, neobladder, recurrent infections, prostate cancer and prostate removal during bladder resection. Dr. Whitelock noted under Social History that Petitioner was usually a mechanic for Pace exposed to diesel fuel exhaust, solvents and asbestos. He noted Petitioner served in the Army from 1968-1970 and his Vietnam exposures were Agent Orange and loud noises/artillery. Dr. Whitelock noted that Petitioner did not use tobacco. Dr. Whitelock noted that Petitioner needed prescribed medications, which he gave.

On December 1, 2010, Dr. Whitelock noted that laboratory and CXR results were received and reviewed for the upcoming Agent Orange Registry on December 7, 2010. Dr. Whitelock noted that the overall pattern of the u/a suggested more of a chronic process with a low grade response.

17. Petitioner saw Dr. Flanigan for a follow-up on January 13, 2011. Dr. Flanigan noted his last UTI was October 22, 2010 and was E. coli. Petitioner was on Tofranil for complaints of nighttime leaking, which had improved. Dr. Flanigan noted Petitioner wore 1-2 pads at night, down from 3-4. Petitioner denied weight loss, bone pain, shortness of breath or fatigue. Petitioner complained of constant right mid abdominal discomfort for last 3 weeks. Dr. Flanigan noted that Petitioner got his medications from the VA. Dr. Flanigan assessed that clinically Petitioner was generally doing well. He noted that Petitioner had some mild abdominal pain in his right lower quadrant that he could not associate with any physical examination findings. There was no discomfort at the area of known ventral hernia. Petitioner was to follow-up in 6 months. (Px7).

18. In a To Whom It May Concern letter dated January 19, 2011, Dr. Collins noted that Petitioner had been a patient for nearly 5 years. He noted Petitioner was diagnosed with bladder cancer 2 years ago. Dr. Collins opined, "The possible association of hydrocarbons (diesel

exhaust) has been well known to me before seeing your meta-analysis. I feel that there is probably a causal relationship between his bladder cancer and his exposure to diesel exhaust while working for Pace Bus. However, I would defer to the experts such as (urology and or hematology oncology) in the matter of causality." (Px3).

19. Petitioner saw Dr. Whitelock on February 10, 2011 and reported some vertigo symptoms present for several days, worse with position changes. Petitioner reported he had this in the past. Dr. Whitelock noted that a CT scan was done. Petitioner reported the neobladder was emptied regularly. Petitioner was to watch for fevers. Dr. Whitelock prescribed medications and noted there were no contraindications for colonoscopy. (Px9).

20. Dr. Flanigan saw Petitioner on July 14, 2011 for a follow-up. Petitioner denied weight loss, bone pain and shortness of breath. He did have some fatigue, but was not sure if this was from lack of sleep from getting up to void to avoid accidents, or recently discovered low T. He denied erections, tried Viagra, but this gave him chest pain. Discussed possibly going to VA ED clinic for treatment. (Px7). On July 20, 2011, Dr. Whitelock at Hines VA Hospital prescribed medications. (Px9).

21. Petitioner was seen at Loyola University Medical Center emergency room on December 26, 2011. His girlfriend reported that Petitioner was normal during the day and after they had sex, he had come out of the bathroom and seemed disorientated. Petitioner denied behavioral changes. His neurological examination was intact. He was admitted to Neurology and a cardiac monitor was applied and EKG done. The ER doctor's impression was acute anterograde amnesia and if the episode improved in less than 24 hours and no other causes were found, then his impression was Transient Global amnesia. A head MRI and EEG were done. Petitioner was discharged on December 27, 2011.

Petitioner underwent CT scan of his chest, abdomen and pelvis on January 12, 2012. The radiologist's impression was that there were newly enlarged lymph nodes in the periaortic region and right pelvis which were suspicious for metastatic disease.

Dr. Flanigan noted on January 26, 2012 the Petitioner was seen that day. Dr. Flanigan's assessment was that Petitioner was doing okay clinically. He noted Petitioner had passed a stone recently and he was awaiting analysis. Dr. Flanigan noted CT scan results and ordered a PET scan. Dr. Flanigan also noted he should also have colonoscopy and referred him to Dr. Eberhardt.

Petitioner underwent a whole body PET scan on January 31, 2012. The radiologist's impression was that the scan was abnormal with increased FDG activity within two pelvic soft tissue masses and in a periaortic lymph node, consistent with recurrence of the disease/ metastasis. The focal uptake in the rectum/sigmoid colon was concerning for a second primary malignancy. It was noted Petitioner was to have a colonoscopy. Petitioner was also seen this day in Neurology by Dr. Golombievski, who noted Petitioner had no further episodes. Dr. Golombievski's assessment was episode of TGA resolved. Follow-up was in 3 months.

A colonoscopy was done on February 13, 2012. The impression was noted as a 2cm pedunculated rectal polyp was resected with snare cautery. Pathology of the polyp indicated that it was benign.

Petitioner saw Dr. Flanigan on March 1, 2012. Dr. Flanigan noted the main concern remained the nodal tissue which was more likely to represent metastatic bladder cancer, not rectal cancer, and Petitioner was to follow-up with Dr. Eberhardt to decide on future treatment for these adenomas. A right pelvic mass biopsy was done.

In his March 30, 2012 Operative Report, Dr. Eberhardt noted a pre-operative finding of adenocarcinoma of the polyp area. Dr. Eberhardt performed a transanal endoscopic microsurgical resection of rectal polypectomy site. Petitioner was discharged on April 1, 2012. The April 4, 2012 Pathology Report indicated there was no evidence of adenomatous changes or malignancy identified.

Petitioner saw Dr. Flanigan on April 5, 2012. Dr. Flanigan noted that pathology from March 30, 2012 was noted as negative for malignancy. Petitioner reported he was voiding well on his own every 3-4 hours. Dr. Flanigan noted Petitioner did have CT-guided FNA of the enlarged right iliac nodes on March 20, 2012, which came back indeterminate with atypical cells and a repeat biopsy was recommended.

Petitioner followed-up with Dr. Eberhardt on April 9, 2012. Petitioner reported doing well and feeling good. Pathology was discussed. Dr. Eberhardt noted Petitioner did not need further treatment for this particular lesion, but needed a surveillance colon scope in one year. (Px7).

Petitioner saw Dr. Whitelock at Hines VA Hospital on April 19, 2012 for a scheduled visit. Dr. Whitelock noted that the primary focus was PTSD/anxiety flare-up related to new questions of cancer. Dr. Whitelock prescribed medications. (Px9).

22. Petitioner followed-up with Dr. Flanigan on May 11, 2012. Dr. Flanigan noted that Petitioner was to undergo a repeat biopsy, however, the lymph nodes were found to be decreased in size on further imaging and it was decided not to proceed with biopsy. Petitioner reported he has had significant pain at the right groin biopsy site, worsening over the past week, and rated at 8/10. There was no left extremity swelling. Pain was worse with ambulation and radiated to the right buttock. Dr. Flanigan's assessment was acute worsening of the right groin pain and was significantly diaphoretic, which subsided with time to comfortable disposition.

On May 14, 2012, Petitioner reported to Dr. Flanigan he had 3 additional episodes of diaphoresis, severe pain and on Saturday it was followed by vomiting. Petitioner denied any chest pain and shortness of breath. It was noted that Petitioner was following-up this day after a CT scan of his pelvis revealed increased size of right pelvic soft tissue mass 3.0cm X 2.5cm, previously 2.2cm X 2.1cm. Dr. Flanigan recommended a renal ultrasound and whole body bone scan.

A whole body bone scan was done on May 14, 2012. The radiologist's impression was: 1) findings consistent with known neobladder; 2) mild thoracolumbar scoliosis and degenerative changes; 3) no evidence for osseous metastatic disease. A renal ultrasound was performed on May 17, 2012 and the impression was noted as expected appearance of the neobladder and normal kidneys.

Petitioner followed-up with Dr. Flanigan on May 31, 2012. Dr. Flanigan noted the results of the whole body bone scan and renal ultrasound. Dr. Flanigan's assessment was that although his right inguinal pain was better, Petitioner had also developed some weakness in raising his right leg when lying down. Dr. Flanigan noted that given the enlarged mass that was previously biopsied and atypical, a repeat biopsy was ordered as the etiology of this mass needed to be determined. Dr. Flanigan noted Petitioner's 13 pound weight loss over 10 weeks.

On June 12, 2012, Petitioner underwent a CT-guided pelvic lymph node biopsy. Dr. Flanigan saw Petitioner on June 18, 2012 and noted that the biopsy pathology was positive, consistent with metastatic urothelial cell carcinoma. Dr. Flanigan referred Petitioner to Dr. Gaynor as soon as possible for consideration of chemotherapy. Petitioner was to follow-up in 3 months if he decided to proceed with chemotherapy. (Px7).

23. Petitioner saw Dr. Gaynor on July 7, 2012. Dr. Gaynor noted the above information. Petitioner reported right groin pain radiating to his hip and pain down the back of his leg to the knee level. His right ankle was also painful and his right great toe was numb. Petitioner was taking prescribed medications for pain. He had lost 7 pounds since the biopsy due to a decreased appetite. He denied shortness of breath or bone pain. Dr. Gaynor assessed Petitioner was a candidate for chemotherapy and prescribed same. Petitioner was to repeat diagnostic scans for baseline findings.

On July 10, 2012, Petitioner underwent a CT scan of his pelvis and abdomen. The radiologist's impression was: 1) interval increase in size of pelvic thick-walled cystic lesion which was previously biopsied; adjacent fluid tracking and erosion of S1 vertebral body was new since the prior exam; superimposed infectious process also could not be excluded; 2) interval enlargement of para-aortic lymph node and development of a paracaval lymph node; 3) nonspecific small bilateral renal cortical hypodensities; lesions on the left kidney were not definitely present on prior study; 4) remainder of study was stable. Petitioner saw Dr. Merchut in neurology on July 13, 2012, who noted that Petitioner's current neurologic findings were most likely related to the recurrent tumor.

Petitioner saw Dr. Gaynor on July 18, 2012 and he noted the above information. Petitioner was there to begin chemotherapy. He had no new complaints and there were no symptoms to suggest progression of disease. Petitioner's K level was very low and Dr. Gaynor would have him replete K stores prior to the start of chemotherapy. Chemotherapy was delayed until the following week. Petitioner began chemotherapy on July 25, 2012. (Px7).

24. In a letter to Petitioner's attorney dated July 26, 2012, Px6, DepExPx1, Dr. Dybal noted: "He [Petitioner] first saw me in consultation on February 18, 2009 for gross hematuria (visible blood in the urine). During the course of this consultation, risk factors for hematuria were addressed. He is without a history of kidney stones, hematological disorders, urinary tract infections, tuberculosis, genitourinary tract trauma. He also has never smoked. His only risk factor is exposure to diesel fumes and the use of solvents at work. He was using aspirin and ibuprofen at that time. He underwent a renal ultrasound which was unremarkable. He then underwent a diagnostic cystoscopy which showed a 5cm papillary tumor with clot. He subsequently underwent transurethral resection of this bladder tumor. Note that his pre-operative urine cytology, FISH analysis and NMP-22 were all positive for malignancy. On March 10, 2009, he underwent a transurethral resection of this large bladder tumor. His pathology was returned showing bladder cancer, pathologic T2 (tumor invading muscularis propria). This was also a high grade tumor. He was seen in follow-up and the pathology was discussed with him in detail. He subsequently sought treatment at Loyola University Medical Center by Dr. Flanigan. I have no further medical information after that. My professional opinion is his only risk factors for developing bladder cancer is his chronic exposure at work to diesel fumes as well as the use of solvents. This is well documented in the literature not only in the review article that you provided me, but also in standard urologic text books including Campbell's Urology."

25. On August 1, 2012, Dr. Gaynor continued chemotherapy. Petitioner reported to Dr. Gaynor on August 8, 2012 that her was feeling very tired. Dr. Gaynor held chemotherapy this day given his count and the way he was feeling. Petitioner was to have a count check the next week and chemotherapy in 2 weeks. On August 22, 2012, Petitioner reported to Dr. Gaynor that he was doing well, had a good appetite and his energy level was significantly improved. He was to proceed with chemotherapy.

On August 29, 2012, Petitioner reported to Dr. Gaynor that he was feeling very tired. He did not feel well for 4 days post-treatment and had decreased appetite. Chemotherapy was held and Petitioner was to follow-up in 3 weeks for the next cycle. Dr. Gaynor resumed chemotherapy on September 5, 2012. On September 19, 2012, Petitioner reported feeling reasonably well, but was fatigued. He had intermittent pain radiating down his right leg. Petitioner denied shortness of breath or unexplained weight loss. Chemotherapy was given this day. Dr. Gaynor noted on September 26, 2012 that Petitioner tolerated cycle 3, Day 1 without problems. He was to continue chemotherapy.

On October 3, 2012, Dr. Gaynor noted Petitioner complained of fatigue and persistent radiating pain down his right leg. He was going away for a reunion. Chemotherapy was withheld this day and Petitioner was to return the next week for blood work only. Petitioner complained to Dr. Gaynor on October 17, 2012 of the same, including a frozen right toe and occasional right groin pain. Dr. Gaynor noted that Petitioner underwent a CT scan, which showed improvement in paraaortic and pelvic nodes, but the pelvic mass was slightly more prominent with erosion of the right iliac bone. Dr. Gaynor recommended Petitioner see Dr. Harkenrider for his opinion regarding palliative radiation therapy to this area. Dr. Gaynor

ordered a repeat whole body bone scan. Dr. Gaynor noted he would probably change chemotherapy when it was further pursued.

Petitioner saw Dr. Harkenrider on October 19, 2012. Dr. Harkenrider noted Petitioner's bladder cancer and his treatment to that date. His consultation was regarding palliative radiotherapy. Dr. Harkenrider's plan was palliative radiotherapy (RT) to lymph nodes and sacral mass with the goal of reducing his pain. Petitioner agreed and consented. (Px7).

26. When Petitioner saw Dr. Whitelock at Hines VA Hospital on October 29, 2012, he reported a recurrence of bladder cancer. He was doing chemotherapy and currently radiation therapy. The location was now the pelvis and around the aorta. There was some involvement of the pelvis and that was why the treatment change. Dr. Whitelock noted Petitioner had lost a lot a weight during this time. Petitioner reported he had a bony butt and used a cushion for driving and one at home. It was noted he used the VA mostly for obtaining prescribed medications. (Px9).

27. Petitioner was seen at Loyola University Medical Center emergency room on October 31, 2012 for complaints of general weakness, dehydration and nausea with vomiting. It was noted that Petitioner was on radiation therapy for sacral mass causing radicular right leg pain. Petitioner was admitted. He was also found to have an E. coli urinary tract infection. He was discharged on November 3, 2012 and was to continue outpatient RT and follow-up with Dr. Gaynor. Dr. Harkenrider noted on November 5, 2012 that Petitioner received radiotherapy.

On November 13, 2012, Dr. Gaynor noted Petitioner had completed the course of palliative radiotherapy. Dr. Gaynor noted Petitioner was hospitalized for gastroenteritis and had recovered. Petitioner reported he felt fatigued, but otherwise was without complaints. His pelvic pain was much better and he had some intermittent discomfort in his right groin. Dr. Gaynor noted that Petitioner needed time to recover from RT before resuming chemotherapy. Petitioner was to resume chemotherapy after the holidays. A recent bone scan was unremarkable.

Petitioner saw Dr. Harkenrider on December 17, 2012 for follow-up of RT. Petitioner had reported increased pain in his right buttocks radiating down the posterior aspect right leg with numbness in the right great toe. Petitioner reported his pain had worsened over the previous month, worse at night, and he took Norco for this. Dr. Harkenrider noted that an October 2012 CT scan showed interval enlargement of right pelvic lymph nodes with invasion of the sacrum, but decreased size of other lymph nodes. Dr. Harkenrider noted Petitioner had completed palliative RT and now his pain had improved in the sacrum, now just with occasional pain. Petitioner reported increasing right lateral inguinal pain and he took 4 Norcos a day for this. He denied radicular pain at this time. He still had paresthesias of the right great toe. Petitioner reported decreased strength throughout the right lower extremity. Dr. Harkenrider's assessment was painful sacral bony metastasis. The plan was re-initiation of chemotherapy.

On January 9, 2013, Petitioner complained to Dr. Gaynor of pain in the left hip and groin area and no pain with ambulation. The pain at times seemed to radiate deep into the posterior pelvis. Petitioner denied shortness of breath or unexplained weight loss. Dr. Gaynor ordered x-rays of the hip and pelvic bone and a bone scan. Dr. Gaynor suspected the pain was related to his pelvic mass. Dr. Gaynor noted that Petitioner would start chemotherapy unless the bone scan and x-rays suggested bone metastasis. Dr. Gaynor noted on January 16, 2013 that recent work-up was negative for a new source of pain. Petitioner preferred to start chemotherapy this day and chemotherapy resumed. On February 6, 2013, Dr. Gaynor noted that Petitioner wanted to postpone chemotherapy due to lack of sleep. Chemotherapy was resumed on February 12, 2012. On March 12, 2012, Dr. Gaynor noted Petitioner reported he felt well. He had just returned from Las Vegas. Petitioner's appetite and energy level were adequate and there were no new reported symptoms. Petitioner was to proceed with cycle 3.

Petitioner saw Dr. Flanigan on March 14, 2013 and reported he was voiding well on his own every 3-4 hours. He was not treating for ED. Dr. Flanigan assessed that mechanically everything was working okay. Dr. Flanigan noted that Petitioner did have more nocturia, but this he felt was primarily related to being tired from the chemotherpy. Petitioner was to follow-up with Dr. Gaynor.

On March 27, 2013, Petitioner reported to Dr. Gaynor that he was feeling well. Petitioner did have intermittent aching in his posterior right pelvis and left leg cramping. His appetite and energy level were adequate. Petitioner was to proceed with cycle 4.

Dr. Gaynor noted on April 2, 2013 that Petitioner received chemotherapy.
On April 23, 2013, Dr. Gaynor noted Petitioner reported he did not feel well following his last chemotherapy. He was feeling very weak. Petitioner had a viral gastroenteritis the previous week and he felt better from that, except for his poor energy level. Scans were rescheduled. Petitioner was to return in 2 weeks to resume chemotherapy, presuming no progression was seen on the scans. Dr. Gaynor noted on May 8, 2013 that Petitioner was there to receive cycle 5. Petitioner reported he felt much better, but was experiencing some tingling in his toes. There were no new systemic complaints. Petitioner proceeded with cycle 5 of chemotherapy this day.

Dr. Gaynor noted on May 29, 2013 that Petitioner was there to receive cycle 6. Petitioner reported he was not feeling well this day. Dr. Gaynor noted Petitioner had 2 episodes of nausea and vomiting recently related to eating spicy foods and he felt tired as a result of this. He had some epigastric discomfort and the same toe discomfort. Chemotherapy was withheld for 1 week. On June 5, 2013, Petitioner reported that he felt better, but he did have pain in the right posterior sacral area. The pain did not radiate and he had the same toe tingling. Petitioner proceeded with cycle 6 chemotherapy this day. He was to be seen in 3 weeks with laboratory results for the next chemotherapy dose.

Petitioner saw Dr. Harkenrider on June 17, 2013 for radiation oncology follow-up. Dr. Harkenrider noted Petitioner had 6 cycles of carbo/taxol, the last cycle on June 5, 2013. Petitioner reported tolerable right sacral pain, but increased right inguinal pain. He took 1-2

Norcos per day, down from 4-5 a few months ago. Petitioner denied F/C, N/V, weight loss, headaches, abdominal pain and dysuria. He had fatigue, alopecia and constipation. Dr. Harkenrider assessed that since RT, Petitioner has had significant pain relief in the right sacral area. Dr. Harkenrider noted that a recent CT scan in April 2013 revealed decrease in size of right sacral mass from 3.5cm X 2.5cm from previous 4.6cm X 2.6cm with some erosion into sacrum. Petitioner tolerated 6 cycles of carbo/taxol well. Petitioner reported plans for further chemotherapy. Dr. Harkenrider noted that clinically Petitioner was doing well with pain control with Norco. Petitioner was to continue with Dr. Gaynor and follow-up in 3 months.

Petitioner saw Dr. Flanigan on June 21, 2013 and reported he felt his night time incontinence was worse of late. He wore 3 Depends at night. He voided every 3-4 hours and did not use pads during the day. Dr. Flanigan noted he would check his urine for C&S. Petitioner was to continue chemotherapy with Dr. Gaynor and follow-up in 3 months.

On June 26, 2013, Petitioner saw Dr. Gaynor in anticipation of cycle 7. Petitioner reported feeling relatively well at this time. His appetite was good and energy level was adequate. He had intermittent nausea and vomiting and the same tingling in toes. He denied shortness of breath or unexplained weight loss. Dr. Gaynor's plan was to have Petitioner have chemotherapy on July 3, 2013 if parameters were met and to have CBC that day and those counts should be used to determine if chemotherapy is given. On July 3, 2013, Dr. Gaynor noted that Petitioner's CBC met parameters and chemotherapy was given. (Px7).

28. On October 18, 2013, Petitioner saw Dr. Whitelock of Hines VA Hospital. Dr. Whitelock noted that Petitioner had a nephrostomy tube left side due to obstruction for the last 3 months. Petitioner was hospitalized twice in August 2013, the first time was to place the tube and second time he was not feeling well with poor potassium intake. Dr. Whitelock noted Petitioner was off chemotherapy for 1 month and would start again the next week. Tumor burden was stable. (Px9).

29. In his September 11, 2013 deposition, Px6, Dr. Dybal testified he is an urologist and general surgeon. He diagnoses and treats diseases of the urinary tract system, including the bladder. Dr. Dybal recited from his records, which are already noted above. On February 18, 2009, Petitioner reported he had been having blood in his urine for 2 months (Dp 7). Dr. Dybal opined that Petitioner's exposure to diesel exhaust was his only risk factor based on his history that would have caused his bladder cancer (Dp 8). Dr. Dybal was shown DepExPx1, the July 26, 2012 letter to Petitioner's attorney that he wrote, which is already noted above. Dr. Dybal recited his opinion from that letter. Dr. Dybal testified that Campbell's Urology is considered among urologists to be the definitive textbook for urology. It is in this textbook that he became aware of the risk factors for the development of bladder cancer.

Dr. Dybal was shown DepExPx2, a Meta-Analysis of Bladder Cancer and Diesel Exhaust Exposure article. This article was published in Epidemiology, January 2001, Volume 12, No. 1, pages 125 to 130. Under Discussion the following is noted: "This review suggests a small increase in the occurrence of bladder cancer among workers exposed to diesel exhaust." "In

conclusion, our review suggested some evidence of a modest increased RR (relative risk) of bladder cancer among workers exposed to diesel exhaust." Dr. Dybal testified that bladder infection is more strongly associated with squamous cell cancer than the transitional cell cancer that Petitioner had (Dp 12). Chronic infection of the bladder such as actinomycosis would put somebody at risk for bladder cancer, not routine bladder infections (Dp 13). There is no history that Petitioner had anything nearly that serious (Dp 13). Dr. Dybal had no idea the cause of the hematuria that Petitioner had in his past history (Dp 13-14). It was Dr. Dybal's understanding that Petitioner had daily exposure to diesel exhaust, which he considered to be chronic (Dp 14). Any hydrocarbon-based solvent is also a known risk for developing bladder cancer. It is known that in about 40% of patients who undergo a radical cystoprostatectomy for their bladder cancer will also have prostate cancer (Dp 17-18). Petitioner's PSA was elevated. Dr. Dybal testified Petitioner did not have prostate cancer, instead he had prostatic intraepithelial neoplasia or PIN. Most experts argue over the significance. This can be associated with prostate cancer and may potentially be a precursor to prostate cancer. It may be an entity all to itself to which the significance is not known. In April 2009, the actual diagnosis of prostate cancer was not made (Dp 18). Dr. Dybal last saw Petitioner on April 22, 2009.

On cross-examination, Dr. Dybal testified that Petitioner did not give him a list of the solvents he used at work (Dp 19). Petitioner just said he was exposed to solvents and did not list brand names of the solvents (Dp 19). Dr. Dybal was asked if it is known how much a person needs to be exposed to diesel fumes or solvents in order to cause bladder cancer. Dr. Dybal testified that studies have never been done and would never be done to sign up human volunteers to expose them to chemicals to see who develops cancer and at what level of exposure as that would be inhumane (Dp 20).

Respondent's attorney showed Dr. Dybal DepExRx1, a June 12, 2012 International Agency for Research on Cancer Press Release, which he had not seen this before. Under Evaluation the following is noted: "The scientific evidence was reviewed thoroughly by the Working Group and overall it was concluded that there was sufficient evidence in humans for the carcinogenicity of diesel exhaust. The Working Group found that diesel exhaust is a cause of lung cancer (sufficient evidence) and also noted a positive association (limited evidence) with an increased risk of bladder cancer." Dr. Dybal noted that the Press Release noted that bladder cancer is a problem in highly exposed workers, but that the general public is not at risk (Dp 21-22). The Press Release says that for lung cancer there is sufficient evidence and limited evidence for bladder cancer and for Dr. Dybal, that is enough (Dp 22). A painter working with oil-based paints is at risk, but latex paints should not be (Dp 23). Print shop work or working around printing equipment would possibly be at risk, depending on the type of inks and dyes used (Dp 23). Dr. Dybal indicated smoking can be linked to bladder cancer and opined there is probably a loose correlation between second-hand smoke exposure and bladder cancer, but this has not been fully studied (Dp 23). Dr. Dybal opined that if Petitioner were exposed to second-hand smoke every day for 18 years until he moved out of his home, this possibly would increase his chance for bladder cancer (Dp 27). Dr. Dybal opined that there has been some correlation between Agent Orange exposure and bladder cancer and prostate cancer (Dp 27).

On re-direct examination, Dr. Dybal opined that the Press Release did not change his opinions and actually strengthened and supported his opinions (Dp 28). Dr. Dybal opined that if the Department of Veterans Affairs was to disclaim the association between Agent Orange and bladder cancer, that would affect his opinion in that regard (Dp 28). On re-cross examination, Dr. Dybal opined that if Petitioner was exposed to second-hand smoke as a child, this would play an exceedingly remote factor in his bladder cancer (Dp 29).

30. In her June 18, 2013 report, Rx1, Dr. Conibear indicated Respondent requested she perform a review of Petitioner's medical records from 2006 through the present. Dr. Conibear reviewed the medical records of Dr. Collins and Dr. Dybal. Dr. Conibear noted that papillary urothelial (transitional cell) carcinoma of the bladder is the most common type of bladder cancer. She did not interview Petitioner. Dr. Conibear noted Petitioner's employment with Respondent and his job duties. Dr. Conibear noted that according to the medical records, nothing is known about where Petitioner worked or what he did prior to starting with Respondent in November 1979. He was in the military stationed in Vietnam, but his job duties and exposure history are unknown. Dr. Conibear noted that Appendix D dated April 5, 2007 described the required use of an exhaust hose system on the bus exhaust pipe at the Pace facility. Dr. Conibear opined that to the extent this equipment was used, Petitioner's exposure to diesel exhaust would have been greatly reduced. Dr. Conibear noted Dr. Dybal's opinion that Petitioner's only risk factor for bladder cancer was his exposure to diesel exhaust and solvents while at work for Pace. The risk factors Dr. Dybal ruled out were history of kidney stones, hematological disorders, urinary tract infections, TB and genitourinary tract trauma. Dr. Conibear noted that Dr. Dybal did not comment on the extent of the diesel exhaust exposure that Petitioner experienced during his work at the Pace bus barn nor did he further identify what solvents Petitioner used during his employment that would present a risk of bladder cancer. Dr. Conibear noted, "Risk factors not addressed by Dr. Dybal but are established as such by the epidemiological literature include drinking water disinfection by-products and occupational exposures in the first ten years of Mr. Shabez's working life. Mr. Shabez gave a history of hematuria for a prolonged period prior to the bladder cancer diagnosis which may have been due to infection, a known risk factor for bladder cancer. Mr. Shabez gave a history of 'bladder stones' in his medical history taken by Dr. Dybal. All of these have been identified as having elevated risk of bladder cancer."

Dr. Conibear noted, "About one half of the bladder cancers diagnosed in the United States are attributed to cigarette smoking. Very few of the other half are associated with known risk factors. Thus the lack of known risk factors alone cannot reasonably be used to conclude that some other specific exposure was causally related. Most bladder cancers in non-smokers remain unexplained as to cause." Dr. Conibear noted that Dr. Dybal did not address the issue of intensity of Petitioner's exposure to diesel exhaust. Dr. Conibear opined that this has been shown to be an important factor in bladder cancer causation according to the epidemiologic literature. Under Questions, Dr. Conibear noted: "1) Is there a widely held medically accepted body of literature on the causal connection of bladder cancer and diesel exhaust? The current consensus is that the epidemiologic studies are inconclusive and there is limited evidence of an association. To the extent to which there is evidence of an association, it is likely in the highest exposure groups. Each case needs to be considered individually in terms of risk factors in

determining causation. According to the literature on exposure to diesel exhaust, Mr. Shabez's job would be classified in the intermediate exposure group. 2) If there is no medical causal connection relationship based upon a reasonable degree of occupational, medical, and orthopedic certainty, please identify what factors/medical literature you rely on for such an opinion? Yes, REF 1 and 2 both contain extensive reviews of the epidemiologic literature and have exhaustive bibliographies of the same. The 2012 IARC review, summarized in Exhibit E is not yet published." Dr. Conibear attached the 58th chapter on Bladder Cancer from Cancer Epidemiology and Prevention, 3rd Edition. She also attached an IARC Report on Carcinogens Background Document for Diesel Exhaust Particulates, which stated, "Most reviewers have concluded that the evidence does not clearly support a relationship of DE (diesel exhaust) exposure and bladder cancer."

31. In her November 5, 2013 deposition, Px3, Dr. Conibear recited what was contained in her CV, which had been admitted into evidence as Px2. Dr. Conibear practices in occupational medicine, anything work related or regulatory driven, OSHA compliance and EPA (Dp 6). Dr. Conibear testified that at Respondent's request, she reviewed Petitioner's medical records and wrote a report, which is already noted above. Dr. Conibear concluded that bladder cancer is not associated with diesel exhaust exposure (Dp 9). Dr. Conibear opined that Petitioner's bladder cancer was not caused by his employment with Pace and exposure to diesel exhaust (Dp 11-12).

On cross-examination, Dr. Conibear acknowledged she did not visit the Pace garage where Petitioner worked (Dp 30). Dr. Conibear did not know if air samples were taken at the Pace garage. She did not know how many windows or doors were in the Pace maintenance garage (Dp 30). She did not know how many buses could be serviced in that garage at any given time. Dr. Conibear noted that the parking garage was not mentioned in the cover letter sent by Respondent's attorney (Dp 31). Dr. Conibear was not aware of how many buses were running in the parking facility at any given time (Dp 31). She did not know when the ventilation system was installed in the maintenance garage (Dp 31). Dr. Conibear was not aware Petitioner worked for Respondent for approximately 15 years without any ventilation system (Dp 31). She was not aware of how well the ventilation system functioned after installation (Dp 31). Dr. Conibear acknowledged that according to the textbook Cancer Epidemiology and Prevention, bladder infection is more strongly associated with squamous cell cancer and Petitioner does not have squamous cell cancer (Dp 33). Petitioner has transitional cell cancer (Dp 33). Dr. Conibear acknowledged there is nothing in her file to indicate Petitioner drank tap water (Dp 34). There is no data in her file to indicate Petitioner was exposed to parasitic infection, radiation or chemical exposure risk factors (Dp 37). Dr. Conibear testified Petitioner's job would be classified in the intermediate exposure group (Dp 41). Dr. Conibear opined that diesel engine exhaust causes lung cancer in humans (Dp 48). Dr. Conibear opined she did not believe that there is an association between Petitioner's employment with Respondent and his development of bladder cancer (Dp 61).

32. The following medical expenses were admitted into evidence by Petitioner:
-Px3: Alexian Brothers, Dr. Collins: no outstanding balance owed;
-Px4: Alexian Brothers Occupational Health: no outstanding balance owed;

-Px5: Northwest Suburban Urology, Dr. Dybal: no outstanding balance owed;
-Px8: Loyola University Medical Center: no outstanding balance owed on most bills.
The following are the outstanding balances owed to this facility: 3-28-12: $138.60;
4-2-13: $7,187.04; 4-29-13: $9,344.30; 5-8-13 & 5-29-13: $6,756.94; 6-5-13: $5,585.65;
7-31-13: $70.00; 10-23-13: $1,080.00; 11-13-13: $8,823.00; 11-22-13: $283.00;
11-26-13: $8,221.00.
-Px9: Hines VA Hospital, Dr. Whitelock: The following are the outstanding balances owed to this facility: 11-1-10: $51.00 Rx, $167.84 clinic, $97.10 Dr.; 12-1-10: $314.56 x-ray, $62.24 Dr., $802.11 lab; 2-10-11: $159.41 clinic; 7-20-11: $209.78 clinic; 1-11-12: $168.85 clinic; 3-13-12: $223.63 clinic; 4-19-12: $223.63 clinic; 10-29-12: $223.63 clinic, $176.08 Dr., $212.74 lab; 2-14-13: $222.68 clinic, $184.41 Dr., $407.15 lab; 4-15-13: $222.68 clinic, $184.41 Dr., $370.30 lab.
The total of the outstanding balances owed is $52,173.76.

Petitioner also submitted aerial photographs of Pace garages and these were admitted as Px11. The Commission notes that these photographs were poor quality in the transcript and in the exhibit.

The Arbitrator found Petitioner failed to prove he sustained an accident arising out of and in the course of his employment or, more specifically, that he was exposed to any occupational hazard arising out of his employment and resulting in disease and disablement pursuant to the Occupational Diseases Act on April 8, 2009 and denied his claim. The Commission affirmed and adopted the Arbitrator's Decision based on the preponderance of evidence. Petitioner testified that he was exposed to diesel fumes from 6 hours to 4 hours throughout his employment with Respondent, however, for the majority of that time, the doors to the maintenance garage and parking garage were open, allowing air to circulate. There were no air samples taken at the Pace garages, so the concentration of diesel exhaust at the facilities is unknown. The intensity of Petitioner's exposure to diesel exhaust is unknown. Every article placed into evidence that addresses bladder cancer cited studies that found there was an increased risk of bladder cancer for those people exposed to higher levels of diesel engine exhaust. Petitioner did not testify as to the extent of the diesel exhaust exposure he experienced during his employment nor did he identify what solvents he used that would present a risk of bladder cancer. To the extent to which there is evidence of an association between bladder cancer and diesel exhaust, it is likely in the highest exposure groups. Petitioner's job would be classified in the intermediate exposure group. The evidence does not clearly support a relationship between diesel exhaust exposure and bladder cancer. For the above reasons, the Commission re-affirms the Arbitrator's decision.

IT IS THEREFORE ORDERED BY THE COMMISSION that since Petitioner failed to prove he was exposed to any occupational hazard arising out of his employment and resulting in disease and disablement pursuant to the Occupational Diseases Act on April 8, 2009, his claim is hereby denied.

16IWCC0646

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

DATED: OCT 5 - 2016
MB/maw
o07/07/16
43

Mario Basurto

Stephen J. Mathis

David L. Gore

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Maricruz Lopez,
Petitioner,

vs. NO: 12 WC 11027

16IWCC0647

Debbie's Customized Staffing,
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 causation, current and prospective medical benefits 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 found two clerical errors in the Arbitrator's decision. One, the Arbitrator erroneously awarded temporary total disability commencing on March 12, 2012, which was two days prior to the March 14, 2012 date of accident. The parties stipulated and the evidence supports the fact that Petitioner's temporary total disability should have begun on March 15, 2012. Two, the Arbitrator identified Dr. Levin as the independent medical evaluator when this doctor was actually Dr. Vender.

Having reviewed the evidence submitted at arbitration, the Commission finds the evidence supports the fact that Petitioner is entitled to temporary total disability benefits from

March 15, 2012 through March 20, 2013. Upon reviewing the evidence in the record the Commission finds that there is clear evidence that Petitioner was not complying with the treatment plan set forth by Dr. Fernandez. She voluntarily removed herself from Respondent's employment and she did not look for work on her own. More specifically, on January 8, 2013, Dr. Fernandez indicated that he would see Petitioner again in four weeks and at that time he would likely release Petitioner to full duty work. On February 20, 2013, Petitioner was discharged from physical therapy due to poor attendance and a complete lapse in attendance from mid November to mid December. On March 19, 2013, Dr. Fernandez sent a note indicating that Petitioner has missed her last appointment and indicating that she should set a new appointment. On the June 25, 2013, Petitioner was asked on the patient form approximately when last she visited Dr. Fernandez's office and Petitioner indicated it was February 1, 2013. The medical bill and records indicates that Petitioner's last visit was on January 8, 2013. Additionally, Petitioner told Dr. Fernandez that she left her employer's employment on her own on March 20, 2013. When Petitioner asked about leaving work on/around March of 2013, she said her impression was that she did not have any more work. During this time period, Petitioner had a restriction of limited force less than 5-10 pounds, limit repetitive use/use of tools to less than 5-10 pounds for her right hand. When Petitioner was asked if she looked for work on her own she said she had looked for work, but she has not kept a list/log of the jobs she applied for. When asked specifically at the August 11, 2015 arbitration hearing when she last looked for work, Petitioner testified she could not recall the last time that she applied for a job, but it was over a year ago. Based on the above, the Commission finds that Petitioner failed to prove she was entitled to temporary total disability benefits after March 20, 2013.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $220.00 per week for a period of 52-6/7 weeks, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall authorize, approve and pay for the MRI arthrogram as ordered by Dr. Fernandez and any such related medical care under §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.

16IWCC0647

No bond is due and owing. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: OCT 6 - 2016

MB/jm

O: 9/22/16

43

Mario Basurto

David L. Gore

Stephen Mathis

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

LOPEZ, MARICRUZ
Employee/Petitioner

Case# **12WC011027**

16IWCC0647

DEBBIES CUSTOMIZED STAFFING ET AL
Employer/Respondent

On 10/19/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0222 GOLDBERG WEISMAN & CAIRO
RAUL RODRIGUEZ
ONE E WACKER DR 39TH FL
CHICAGO, IL 60614

1739 STONE & JOHNSON CHARTERED
BRIAN KAPLAN
111 W WASHINGTON ST SUITE 1800
CHICAGO, IL 60602

16IWCC0647

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)

Maricruz Lopez
Employee/Petitioner

v.

Debbies Customized Staffing et al
Employer/Respondent

Case # **12** WC **11027**

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 **Bocanegra**, Arbitrator of the Commission, in the city of **Chicago**, on **August 11, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☐ What were Petitioner's earnings?

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

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

J. ☐ Were the 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 ______

BACKGROUND

Maricruz Lopez ("Petitioner") and Debbie's Customized Staffing ("Respondent") proceeded to arbitration on 8/11/15 on all disputed issues in case number 12 WC 11027 for which Petitioner alleged a 3/14/12 accident arising out of and in the course of her employment with Respondent. At issue were the following: causal connection, temporary total disability benefits and future medical under Section 8(a). Ax1, Ax2.

FINDINGS OF FACT

On direct examination, Maricruz Lopez ("Petitioner") testified, via Spanish translator/interpreter Paul Krompier, that she sustained an undisputed work accident to her right hand on 3/14/12 during the course of her employment with Debbie's Customized Staffing ("Respondent"), a temporary work office that loaned her to Gold Eagle Company ("Borrowing Employer"). Ax1. On said date of accident, Petitioner was a 34 year-old machine operator for the Borrowing Employer.

According to Petitioner's testimony, a plastic molding machine caught her right wrist and then pressed on the radial portion of her wrist, just below the thumb. The machine also applied pressure to the ulnar side of the wrist. Petitioner said she was stuck like this in the machine for approximately 20 minutes. A co-worker released her from the machine and Petitioner reported the accident to Martha Hinojosa.

On the same date of the accident, She then sought medical attention at Clearing Clinic on the date of accident. Clearing Clinic documented a crushing type injury to both the right hand and wrist after a machine caught her hand. Physical exam showed gross effusion of the right second digit, contusion over the second MCP joint, deformity and effusion of the distal radius, bony tenderness over distal radius and overlying deformity over the second metacarpal and phalanges. There was no snuff box tenderness. She was diagnosed with right hand and wrist contusion. Petitioner was given restrictions of no use of the right hand. Respondent was unable to accommodate this restriction. Clearing Clinic continued these restrictions thru March. On 3/23/12, Petitioner followed up with Clearing Clinic who noted that Petitioner continued to complain of pain and tingling in the right hand made worse with movement. She also noted tingling in the fingers and the palm. Exam noted pain on the right dorsolateral wrist and throughout the second finger
Petitioner's unrebutted testimony was that at some point in the weeks following the accident, Petitioner had a conversation with the Borrowing Employer and Respondent where Petitioner came away with the impression she was no longer employed.

On 6/5/12, Petitioner sought medical treatment with Dr. John Fernandez, a hand specialist at Midwest Orthopedics at Rush. Px2a. the doctor noted Petitioner's work accident and treatment history. He noted pain along the dorsoradial wrist, numbness and tingling in the index and middle fingers, worse at night, and some dorsal greater than volar wrist complaints. Neurologic testing showed irritability of the median nerve with positive Tinel's, positive Phalen's and positive median nerve compression. Dr. Fernandez diagnosed right wrist dorsoradial sensory neuritis, carpal tunnel syndrome and forearm intersection syndrome. He ordered an EMG, MRI and issued medications and light duty work restrictions. On 7/13/12, MRI of the right wrist was unremarkable. Px2a:65. EMG of the right arm confirmed the diagnosis of right carpel tunnel and also diagnosed right cubital tunnel. Id. at 63.

On 8/16/12, Dr. Fernandez administered a right wrist carpal tunnel injection. Id. at 19. Petitioner's follow up form noted symptoms in the first three digits and along both sides of the wrist. Id. at 21. The doctor

Dr. Vender subsequently testified via evidence deposition on 11/7/14. Rx1. Dr. Vender testified to diagnosing Petitioner with post carpel tunnel release, extensor carpi ulnaris tendonitis and flexor stenosing tenosynovitis of the right middle and ring fingers. He was not certain of the latter two diagnoses, stating: "The less certain diagnoses related to flexor stenosing tenosynovitis of the right ring and middle finger and also the possibility of extensor carpi ulnaris tendonitis." He opined that these were not diagnosed at anytime prior and appeared to have developed separate and after Petitioner's initial injury. He did not find causal connection between the two new possible diagnoses and the original work accident. Dr. Vender believed Petitioner was at maximum medical improvement and that further treatment was both unnecessary and unrelated.

On 3/20/15, Dr. Fernandez testified regarding his medical opinions and conclusions related to Petitioner's injuries via evidence deposition. Px3. He noted that at her initial visit with him there was pain to palpation along the inner section of the forearm. He noted that in August 2012 she continued to have pains along the wrist dorsally and ulnarly without instability. He testified that her pain diagram was consistent with his clinical findings. When Petitioner followed up with the doctor in June 2013, he noted she was having loss of motion and pain along the ulnar aspect of the wrist with rotation, pronation and supination. The doctor opined that a causal relationship existed between the work accident and the ulnar-sided wrist complaints. He explained that if there appeared to be a delay in symptom reporting, although he stated she immediately complained of wrist pain consistent with her current diagnosis, then it may be from splinting and restrictions. On cross, he acknowledged he had not seen Petitioner for some time. He did not believe she exhibited pain behaviors but rather myofascial pain. He also testified that without the MRI arthrogram he previously recommended, Dr. Fernandez was unable to articulate a working diagnosis.

CONCLUSIONS OF LAW

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

The Arbitrator adopts and incorporates the findings of fact as though fully set forth herein. After careful review of the available medical evidence as well as Petitioner's credible and unrebutted testimony, the Arbitrator concludes that Petitioner's current condition of ill-being is casually related to her undisputed work accident, including her conditions of right wrist carpal tunnel syndrome, right ulnar wrist pain and her asymptomatic right cubital tunnel syndrome. In so finding, the Arbitrator relies on the testimony of Petitioner and on the treating records and opinions of Dr. Fernandez over those of Dr. Vender for the reasons that follow.

As an initial matter, the Arbitrator notes that it does not appear from the record there is any genuine dispute that Petitioner's right carpal tunnel syndrome and related care is causally related based upon the opinions of both Drs. Fernandez and Vender stating as much. Ax1. Nevertheless, the Arbitrator formally concludes the carpal tunnel syndrome to be causally related based on those opinions. The primary dispute on this issue centers on Petitioner's right ulnar-sided wrist complaints.

In reviewing the medical record, the Arbitrator finds that Petitioner's mechanism of injury is consistent with Dr. Fernandez's diagnosis of right ulnar-sided wrist complaints. Initial treatment records document that Petitioner's right hand and wrist became stuck in a machine after the machine pulled her arm into it. Px1. Clearing Clinic did not differentiate between the ulnar or radial side of the wrist in terms of what was caught or crushed in the machine. The Clinic did not do so either with the hand. Dr. Fernandez found this mechanism of injury the type of which could cause damage to structures in and around the wrist and hand. Petitioner's trial testimony was also consistent in stating that both the ulnar and radial sides of her wrist became trapped or

ISSUE (L) What temporary benefits are in dispute?

The Arbitrator adopts the findings of fact and conclusions of law as though fully set forth herein. Having found in favor of Petitioner on the issues of causation and prospective medical, the Arbitrator finds and concludes that Petitioner's current condition of ill-being has not yet stabilized or otherwise reached a state of permanency and that remains temporarily and totally disabled per the medical opinions of Dr. Fernandez. *Freeman United Coal Mining Co. v. Indus. Comm'n*, 318 Ill.App.3d 170, 175-176, 741 N.E.2d 1144, 1148-1149 (5th Dist. 2000).

The medical evidence at hearing established that Petitioner was on light duty from the date of the accident until her final visit with Dr. Fernandez on 6/25/13. At her last visit, she remained on light duty of a 5-10 pound lifting restriction pending additional treatment and evaluation. Dr. Fernandez has not placed Petitioner at maximum medical improvement or otherwise opined that her condition has stabilized. At Dr. Fernandez's evidence deposition in March 2015, he did not indicate any change from his last work restriction that last time he saw Petitioner. At hearing, Respondent did not present evidence that it offered light duty to Petitioner and Petitioner's unrebutted testimony at trial was that she was not offered light duty or an opportunity to return to work.

Therefore, Respondent shall pay Petitioner temporary total disability benefits of **$220**/week for **177-6/7th** weeks, commencing **March 12, 2012** through **August 11, 2015**, as provided in Section 8(b) of the Act. Respondent is entitled to a credit in the amount of **$15,840.00** for any and all TTD benefits paid to date. Ax1.

ARBITRATOR SIGNATURE

10/19/15
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 MCLEAN	)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
			☐ PTD/Fatal denied
		☒ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Contrina Williams,
Petitioner,

vs. NO: 15 WC 2558

16IWCC0648

PHD Services,
Respondent.

DECISION AND OPINION ON REVIEW

Petitioner and Respondent appeal the decision of Arbitrator McCarthy finding Petitioner sustained an accidental injury arising out of and in the course of her employment on August 22, 2014. As a result Respondent is ordered to pay for all reasonable and necessary medical expenses related to the right carpal tunnel syndrome and diagnostic investigation of the right ganglion cyst problem. The Arbitrator further found Petitioner only temporarily aggravated her right shoulder and cervical and her right shoulder and cervical conditions are not causally related to the August 22, 2014 work accident. Lastly, the Arbitrator found Petitioner is not entitled to any temporary total disability benefits since the time Petitioner was taken off of work was due to the cervical and right shoulder areas.

The issues on Review are whether Petitioner sustained an accidental injury arising out of and in the course of her employment on August 22, 2014, whether a causal relationship exists between the alleged August 22, 2014 work accident and Petitioner's present condition of ill-being and/or need for current and prospective medical services, and if so, the extent of Petitioner's temporary total disability benefits.

The Commission, after reviewing the entire record, affirms the Arbitrator's finding that Petitioner sustained an accidental injury arising out of and in the course of her employment on August 22, 2014. It further affirms the Arbitrator's finding that Petitioner's right carpal tunnel

condition is causally related to the August 22, 2014 work accident but it finds the cervical, right shoulder and ganglion cyst conditions are not causally related to the August 22, 2014 work accident. The Commission awards all current medical bills related to Petitioner's carpal tunnel condition and orders Respondent to pay for all reasonable and necessary medical expenses related to Petitioner's prescribed carpal tunnel release surgery. The Commission further awards the OSF St. Francis Medical Center bill for the diagnostic cervical MRI ordered by Dr. Cohen, the independent medical evaluator. With the exception of the cervical MRI bill, the Commission denies any current and prospective medical bills related to Petitioner's cervical, shoulder and ganglion cyst conditions. Furthermore, the Commission finds Petitioner was temporarily totally disabled from July 2, 2015 through August 31, 2015 for Petitioner's right carpal tunnel condition. Lastly, the Commission remand the case to the Arbitrator pursuant to Thomas v. Industrial Commission, 78 Ill. 2d 327, 399 N.E.2d 1322 (1980), for the reasons set forth below.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

1. Petitioner, a 41 year old housekeeper, testified her duties consist of dusting, vacuuming and emptying the trash in a commercial building. On August 22, 2014, Petitioner testified that she was pulling a trash bag weighing 40-45 pounds out of a garbage can when she experienced a sharp pain which went up her right hand to her wrist. The pain caused her thumb and all her fingers, except for her pinky finger, to go numb.

2. On September 4, 2014, Petitioner was seen at Illinois Work Injury Resource Center for an evaluation of her right hand. Petitioner reported that on August 22, 2014 she was taking the trash out of a trash can. Upon lifting the trash can to dump it into a larger trash can she felt a sharp pain in her palm which she rated as being 10 out of 10 on the pain scale. Petitioner said she kept on working over the next two weeks and her pain increased during this time. Currently, she was reporting that her pain rating was a 9 out of a 10. She initially felt a sharp pain and she is now experiencing tingling in the first through fourth digits of her right hand. The pain also radiates up into her forearm. Petitioner was diagnosed with right epicondylitis and a right wrist strain. She was instructed to take over-the-counter Naproxen and Aleve, use hot and cold packs, wear wrist and elbow braces, return to work without any restrictions and to recheck her condition in 5-7 days with Dr. Hauter.

3. On September 9, 2014, Petitioner followed up at the Illinois Work Injury Resource Center. At that time, she reported her symptoms had gotten worse since her last visit. She was diagnosed with a resolved right epicondylitis and a right wrist strain. She was treated with a Medrol Dose Pack, was told to stop using Naprosyn and the wrist and elbow braces. She was instructed to see Physical Therapist Wyckoff, to recheck in 7-10 days and was told to return to work without restrictions.

4. On September 23, 2014, Petitioner was seen at the PRP Emergency Department. The nurse noted Petitioner presents with a wrist injury as a result of an incident that occurred more than a week ago. She reports that the incident occurred at work approximately on August 24, 2014 while she was twisting and lifting. Petitioner was diagnosed with carpal tunnel syndrome and she was advised to follow up with an orthopedic surgeon.

5. On September 29, 2014, Petitioner began treating with Dr. Garst at Great Plains Orthopedic. He noted Petitioner works as a housekeeper. She injured her right arm approximately five weeks ago. She was apparently lifting a trash bag when she felt a sharp pain in her hand and forearm that radiated up to the shoulder. Dr. Garst diagnosed her with probable acute right carpal tunnel syndrome and possible right shoulder rotator cuff tendinitis. He prescribed an EMG/NCV test for the right wrist. He specifically noted that in regard to the shoulder he believes she has some referred symptoms from her hand but she possibly has some rotator cuff tendinitis. He noted that Petitioner asked to go back to work with a restriction of no lifting of trash bags. He said he thought that was reasonable given the fact that that was the activity that set this condition off in the first place.

6. On October 16, 2014, Petitioner had an EMG/NCV test. The doctor noted that Petitioner relayed a history of approximately 6-8 weeks duration of sudden onset of pain and paresthesias involving her right hand. She reported her pain originated in the palm and thenar area of her hand and was accompanied by some paresthesias of the thumb, index and middle finger. She also stated that the pain extends upward into her forearm to the level of the elbow and it occasionally reaches her shoulder. She also has some complaints of a chronic cervical spine syndrome but he opined that there does not seem to be a correlation between the worsening of her neck symptoms and the symptoms in her right upper extremity. Lastly, he noted that the EMG findings are compatible with moderate right median neuropathy at the wrist; the studies are otherwise normal.

7. On November 10, 2014, Petitioner followed up with Dr. Garst. He noted that Petitioner's diagnosis is still the same. He further noted that Petitioner reported her pain is inhibiting her work and the splints have not been helping. She also reported that she is having difficulty at work. Specifically, she is having trouble vacuuming because of the vibration from the vacuum cleaner. Dr. Garst prescribed carpal tunnel surgery. He noted that she can still keep working until the surgery. He modified her restrictions to include no picking up trash bags and no vacuuming. He said he was working with the theory that her shoulder pain is related to her hand and wrist problems, but it is possibly a separate problem such as rotator cuff tendinitis. He noted that if her condition does not improved after the carpal tunnel surgery then they would further work up her shoulder condition.

8. On November 19, 2014, Petitioner left Dr. Garst a telephone message in which she stated that she is now experiencing a sharp pain radiating up to her neck and it is a pain she

never had before. She wanted to know what it was. Dr. Garst indicated that he could not diagnose the cause of the pain for her if the pain was not constant and intolerable.

9. On the December 8, 2014 follow up visit with Dr. Garst, he indicated that not much has changed. Petitioner is quite sore at the shoulder. On examination she has a + Phalen and a – Tinel. She experiences numbness in a median nerve distribution but sometimes it goes into the whole hand. He indicated that her diagnosis is status quo and he is still re-commending right carpal tunnel surgery. He noted that the shoulder seems to be little bit worse. He instructed Petitioner to start physical therapy for the shoulder and to recheck with him in one month. If she is worse at that time, we will need to get x-rays and maybe a MRI.

10. On December 29, 2014, a cervical MRI was ordered by Dr. Cohen. It showed shallow central to rightward C5-6 disc material which merges with right uncovertebral spurring, resulting in effacement of the right anterolateral subarchnoid space and indicates at least a minimum/mild right foraminal encroachment.

11. On January 5, 2015, Petitioner followed up with Dr. Garst who indicated Dr. Cohen, an evaluator, ordered a cervical MRI that shows a bulging disc at C5-C6 mainly on the right side. Dr. Garst noted that it is possible that the cervical spine could be giving her some pain at the right arm and giving her trouble with her shoulder and hand. He opined that Petitioner needs to be looked at further and he is sending her to a neurosurgeon for an evaluation.

12. Petitioner's January 15, 2015 Application for Adjustment of Claim lists a date of accident of August 22, 2014 and lists the body parts which were affected as right wrist and arm.

13. On January 20, 2015, Petitioner followed up with Dr. Garst who indicated that Petitioner's condition has not changed much. The evaluating doctor suggested a carpal tunnel injection. Dr. Garst noted that it is an accepted form of treatment for carpal tunnel syndrome but it tends to provide only temporary relief. The injection can be used for diagnostic purposes. However, we already know her EMG/NCV testing was + for carpal tunnel syndrome. He indicated he was going to hold off doing anything at the carpal tunnel in lieu of something being done at her cervical spine. He told her to continue to work with her restrictions and recheck with him in five weeks.

14. On January 2, 2015 Petitioner saw Dr. Tsung, a neurosurgeon, and she reported she most recently she has had intermittent pain in her neck when she performs overhead work. Dr. Tsung diagnosed her with a cervical disc bulging and symptoms consistent with carpal tunnel syndrome. He opined that at this point the disc bulging is not contributing to her current symptoms. He instructed her to continue to treat with Dr. Garst. He opined that Petitioner may have a cervical strain which may need physical therapy. The cervical

condition appears to be minor and it is not contributing to her current symptoms within her distal forearm and hand.

15. On February 24, 2015, Petitioner followed up with Dr. Garst. He noted that although Petitioner had an October 2014 EMG/NCV that was negative he still thought she had right carpal tunnel syndrome on a clinical basis[i]. She has continued on restrictions but there is some question as to whether they have been followed. Apparently, the evaluating doctor thought she could do full duty work. She saw a neurosurgeon who told her the neck was not the source of her hand pain. She has been having other troubles since she has been working regular duty. She previously had trouble at the right shoulder and she is now having some trouble at the left shoulder along with a little soreness in the left elbow. He gave her a right carpal tunnel injection for both diagnostic and therapeutic purposes, told her to recheck in five weeks and to continue with her work restrictions.

16. On March 31, 2015, Petitioner again saw Dr. Garst. At that time she reported she had significant improvement in her carpal tunnel after the injection, but it only provided temporary relief and she is now starting to get the numbness again. On the basis of her symptoms, clinical findings and response to the injection, he said he was still making a diagnosis of carpal tunnel syndrome and he was still recommending carpal tunnel release surgery.

17. Petitioner testified that when the bills were not paid to Dr. Garst she had to find another doctor and she chose Dr. Rhode.

18. On April 30, 2015, Petitioner was seen at Orland Park Orthopedic by Physician Assistant Welke who works for Dr. Rhode. She noted that Petitioner is here for an evaluation of her right shoulder and carpal tunnel syndrome. She noted Petitioner's EMG/NCV shows right carpal tunnel syndrome. Petitioner had an improved with a cortisone injection but her symptoms have since returned. She noted that Petitioner has clinical findings consistent with a rotator cuff tear or tendonitis. She prescribed a right shoulder MRI, medication and sedentary work of no above the shoulder work, no pushing or pulling and no use of repetitive grasp, vibratory tools.

19. Petitioner testified she could not vacuum in April of 2015, but she still was able to pull the trash and dust. She agreed that she is right-handed and she always used her right hand to perform her job. She agreed that she could do the job with her left hand. She said she was suspended on May 1, 2015 and she has not worked from May 1, 2015 to the present. She denied that she did not sign the return to work slip. Rather, she did not sign the therapy slip.

20. Kevin Murray testified he is Petitioner's supervisor. He testified that Petitioner stopped working on May 1, 2015. He further testified that Petitioner seemed to be struggling with her restrictions. She complained that her left hand was being aggravated from overuse.

He agreed that someone would be able to do most of the job one-handed. The person might need help lifting up a large bag. Petitioner was given help when she worked there. She left work at the end of April because she complained she could not do most of her job duties. He believed Petitioner could do her job within her restrictions and with the exception of lifting a 40 pound trash bag. Petitioner could do all of her job duties with her left hand. She was advised to place lighter loads in the larger garbage can and to make more frequent trips.

21. Petitioner said that in a conversation with Kevin prior to the August 22, 2014 accident Kevin told them they were cutting back costs and they had to use their bags wisely and to not be dumping the trash frequently like they used to do.

22. Petitioner May 14, 2015 Right shoulder MRI showed mild AC joint arthritis.

23. On May 18, 2015, Petitioner followed up with Physician Assistant (PA) Welke. At that time Petitioner indicated she had noticed increasing neck pain over last few weeks, especially while doing low impact exercises at the gym. Ms. Welke noted that the MRI showed Petitioner does not have any significant tendonitis or a tear of her right shoulder but she does have mild AC joint arthritis. She also has findings consistent with acromio-clavicular degenerative joint disease. She treated Petitioner with an AC joint injection and referred her to Dr. Kube, a spine specialist, for a neck s/p AC injection.

24. Petitioner was taken off of work by PA Welke from May 18, 2015 through August 31, 2012.

25. On May 28, 2015, Petitioner was seen at Prairie Spine & Pain Institute by Dr. Morrow. Petitioner reported she had not had problems with her neck prior to the August 22, 2014 injury. Over the next couple of weeks after August 22, 2014 Petitioner reported she noticed the pain starting to go into her shoulder and also across the right periscapular distribution. Petitioner reported that it has progressively gotten worse over the past three weeks. On exam, Dr. Morrow noted that Petitioner seemed to have sensory deficits that may be consistent with potentially a C6 nerve irritation in that it goes into the thumb, 2nd and 3rd digits. She has motor weakness on the right upper extremity with wrist flexion and extension. He opined that Petitioner's cervical MRI shows a very mild disc protrusion that looks to be located at the right paracentral at C5-6. Other than that he did not see much going on in the nerve. He recommended physical therapy, medication, and instructed her to recheck in four weeks. Petitioner may be able to work light duty.

26. On June 10, 2015, Petitioner followed up with PA Welke who noted that Dr. Kube diagnosed cervical radiculopathy and double crush syndrome. Petitioner had a subacromial steroid injection which gave her relief.

27. On June 22, 2015, Petitioner began physical therapy for her neck.

28. On June 30, 2015, Petitioner presented with a shoulder problem. The physical therapist opined that he did not believe the problem is related to her neck.

29. On July 2, 2015, Petitioner again saw PA Welke who noted that Petitioner tried physical therapy last month but it worsened her shoulder symptoms. She reported the injection only helped for a day or so. An AC injection was prescribed and it was noted that they were awaiting surgical authorization.

30. On August 3, 2015, Petitioner followed up with PA Welke who indicated that Petitioner continues to experience symptomatology consistent with a double crush syndrome with right sided carpal tunnel. She is currently awaiting authorization for right carpal tunnel release surgery. She reported that her shoulder improved with the injection but it is painful again. PA Welke opined that Petitioner may need distal clavicle resection surgery.

31. On August 31, 2015, Petitioner again saw PA Welke. At that time Petitioner complains of bump on her wrist that has progressively gotten larger over the past month. PA Welke opined that Petitioner has developed what appears to be a ganglion cyst in her right wrist. She further opined that this cyst could have been present prior but became enlarged due to lack of use and immobilization. Her fifth finger also has a more mobile mass, which is possibly a lipoma or ganglion. She ordered an MRI for further evaluation.

32. The October 9, 2015 right wrist MRI showed a 1.4 cm ganglion cyst within the lateral palmar soft tissue of the wrist.

33. On October 15, 2015, Petitioner followed up with PA Welke who noted that Petitioner continues to experience symptomatology consistent with a double crush syndrome with right-sided carpal tunnel syndrome. Her wrist ganglion does not appear to be originating from any joint but could additionally have been causing compression on her median nerve. PA Welk noted that the volar ganglion will be able to be resected at the time of her carpal tunnel release surgery. Currently, they are still awaiting surgical authorization. Petitioner was given a modified/sedentary work slip from PA Welke.

34. On October 21, 2015, Dr. Rhode, a board certified orthopedic surgeon/sports medicine and evaluating doctor, was deposed. He testified that Petitioner was primarily seen by PA Lori Welke, but he saw her as well. He does not know how Petitioner came to be seen by them. She had been working for Respondent for approximately 2-1/2 years. Her job required her to perform cleaning activities with a lot of repetitive movements including taking out the trash.

    In addition to the carpal tunnel syndrome diagnosed by Dr. Garst she was having problems with her right shoulder. The shoulder became symptomatology in February of 2015. She said she had a history of a C5-6 disc bulge that had been evaluated by a

neurosurgeon. We left the care of her neck to Dr. Kube. We were treating her for carpal tunnel syndrome and her right shoulder. Dr. Rhode was asked what was the significance, if any, of Petitioner stated that she was picking up a 40 pound garbage bag and she felt a sudden onset of palmer wrist pain with numbness and tingling of the thumb, index and long finger and he said that he does not think this is overly significant. Rather, it just suggests that she had an acute exacerbation of her symptoms on that date. He noted that the relief Petitioner obtained from her shoulder injection indicated that at least that component of her shoulder pain was coming from her acromioclavicular degenerative change.

At the August 31, 2015 visit, it was noted that Petitioner had developed a wrist ganglion and a ganglion over the right fifth finger. Dr. Rhodes opined that Petitioner's right wrist carpal tunnel syndrome was secondary to the repetitive nature of Petitioner's work. Dr. Rhodes opined that Petitioner could have a temporary aggravation of her AC arthritis as a result of her work activities. Dr. Rhodes said he had no opinion regarding Petitioner's neck condition or ganglion cyst and its relationship to her work. Dr. Rhodes opined that at this time it would be appropriate to proceed with the right carpal tunnel release surgery. He was again asked whether he attributed the carpal tunnel syndrome to her repetitive work as opposed to the August event that the patient described and he said this was correct. He further testified that considering the fact that her shoulder symptoms reportedly started in February of 2015 he would not relate her shoulder aggravation to the August 22, 2014 work event. My June 10, 2015 note states Petitioner underwent the evaluation in June with Dr. Cohen and she was returned to full-duty work. She then developed her right shoulder pain upon returning to work. On cross-examination, Dr. Rhodes agreed that his PA saw Petitioner six times and he only saw her once in June of 2015. He agreed that it was fair to say he is relying on the contents of the medical records and the documents created by his PA in rendering his causation opinion.

35. Dr. Cohen, an orthopedic surgeon with a specialty in hand and upper extremity, was deposed on July 15, 2015. He evaluated Petitioner on December 3, 2014. He opined that the mechanism of lifting a 30 to 40 pound bag of materials did not cause acute carpal tunnel syndrome.

    The level of the cervical MRI that showed the most significant amount of nerve impingement did not correlate with the root that would be affected based on her physical examination and her symptomatology. Petitioner did not have an acute cervical disc herniation. Rather, the arthritic cervical changes had been going on for some time. As such, he did not relate her cervical condition to the August 2014 event. When he saw the Petitioner, he believed she was not a surgical candidate for a carpal tunnel release surgery because she had not had any injection for the condition and she did not have the classic exam findings for carpal tunnel syndrome. He does not believe the potential carpal tunnel syndrome is related to August incident because there is no mechanism of injury to support that idea. He believes she is capable of performing her normal job activities. He

testified that Petitioner may have carpal tunnel syndrome and may have a double crush but it has not been completely worked up yet. He recommended she undergo a further evaluation to rule out cervical herniated disc as well as carpal tunnel syndrome.

The Commission finds that the Arbitrator held Petitioner sustained an accident arising out of and in the course of her employment on August 22, 2014. Furthermore, the Arbitrator based his findings on the medical records of Illinois Work Injury Resource Center, the PRP Emergency Department and Dr. Garst.

Upon reviewing the record, the Commission finds that the Arbitrator held that Petitioner's carpal tunnel syndrome condition was either caused or aggravated by the lifting incident on August 22, 2014. In support of this position, the Commission finds that the Arbitrator only addressed specifically an "acute" theory of the claim and did not address a "repetitive trauma" theory of the claim. In identifying the basis for an acute theory, the Arbitrator specifically pointed out that on September 29, 2014 Dr. Garst stated that the lifting of trash bags set this (the carpal tunnel syndrome) off in the first place. In terms of the "repetitive trauma" theory of the claim, the Arbitrator did not address Dr. Rhodes' causation opinion and the basis for the same at all. Nor did the Arbitrator address the inconsistency between the "acute" and "repetitive trauma" theories posed by Drs. Garst and Rhodes and the weight to be assigned to both opinions. In short, the Commission finds that the Arbitrator's analysis is incomplete.

The Commission notes that the evidence supports the fact that Dr. Rhode's PA primarily treated Petitioner and Dr. Rhode's acknowledges he only saw Petitioner one time. As such, the Commission views Dr. Rhode's role as more of an evaluating doctor rather than a treating doctor. Furthermore, the Commission finds that Dr. Rhode's "repetitive trauma" theory has no basis in fact to support the same. The Commission finds that evidence describes an "acute" trauma that took place on August 22, 2014. Petitioner testified to a specific incident of transporting a smaller bag of trash into a larger trash can at the onset of her pain complaints. She did not attribute repetitive tasks to her carpal tunnel condition. The Commission finds that Dr. Garst's opinion provide sufficient support to find that Petitioner sustained an acute trauma on August 22, 2014 and Petitioner's carpal tunnel condition is due to the acute trauma of August 22, 2014.

In terms of the right shoulder and cervical conditions, the Commission finds that the Arbitrator's decision contains an internal inconsistency. Specifically, in the causation portion of the decision the Arbitrator found that Petitioner's shoulder and cervical conditions were temporarily aggravated by the August 22, 2014 work accident, which presupposes a finding of causation. However, in the medical portion of the decision the Arbitrator found no medical treatment was necessary in that there is no causation between Petitioner's cervical and shoulder conditions and the August 22, 2014 accident. As such, the Commission finds that the Arbitrator's decision is internally inconsistent

In terms of the right shoulder, the Commission notes that Petitioner was treated on three occasions before she complains about her right shoulder and she does not mention any right shoulder problems until September 29, 2014, which was over a month after the August 22, 2014 accident. On this date, Dr. Garst only comments that Petitioner "possibly" has some rotator cuff tendinitis as his working diagnosis. It is not until November 10, 2014 that Dr. Garst states that he was working with a theory that her shoulder pain is referable from the hand and wrist problem. This is followed by his statement that her right shoulder condition is "possibly a separate problem such as rotator cuff tendinitis". In short, the Commission finds that these statements by Dr. Garst do not rise to the level of medical certainty that the shoulder condition is causally related to the August 22, 2014 work accident. When Petitioner files her Application for Adjustment of Claim on January 15, 2012 she only lists her right wrist and arm as part of the problem. She does not specify that she has a shoulder condition resulted from the August 22, 2014 work accident. Petitioner's shoulder is mention once again on December 8, 2014.The evidence shows that the shoulder is not mention again until Petitioner sees PA Welke on April 30, 2015. At that time a right shoulder MRI is ordered and it shows mild AC joint arthritis. Petitioner again mentions the shoulder on May 28, 2015 when she is seen by Dr. Morrow. Specifically, she states that the shoulder pain started a couple of weeks after the accident. She mentions the same during her June 30, 2015 physical therapy appointment and the physical therapist indicates that he does not believe that her shoulder condition is related to her neck for which he is providing physical therapy. During his deposition, Dr. Rhodes notes that Petitioner's shoulder became symptomatic in February of 2015, which would be approximately six months after the August 22, 2014 work accident. When Dr. Rhodes is asked to express a causation opinion in terms of the right shoulder he states that Petitioner could have had a temporary aggravation of her AC arthritis as a result of her work activities. In short, the Commission finds that his opinion does not rise to a level of reasonable and necessary medical certainty needed to substantiate a claim nor is it attributed specifically to the August 22, 2014 date of accident. Based on all of the evidence, the Commission finds that it does not appear that any of Petitioner's treaters registered an opinion that Petitioner's right shoulder is causally related to the August 22, 2014 accident. As such, the Commission finds that there was no causation between Petitioner's right shoulder condition and the August 22, 2014 work accident.

In terms of the cervical condition, the first mention which is found regarding Petitioner's neck condition is in the October 16, 29014 EMG/NCV report where the doctor notes that Petitioner has some complaints of "chronic" cervical spine syndrome and he further notes that there does not seem to be a correlation between her neck symptoms and the right upper extremity symptoms. Next, on November 19, 2014 Petitioner telephones Dr. Garst's office and reports she is "having (a) sharp pain radiating up to her neck and it was a pain she never had before". Approximately a month later, she see Dr. Cohen, the evaluating doctor, and complains of cervical pain. As part of her workup, the doctor recommends she undergo a cervical MRI. The December 29, 2014 cervical MRI shows a C5-6 disc bulge. On January 5, 2015, Dr. Garst set forth a working

theory that the cervical disc bulge may possibly be giving Petitioner some pain in her right arm as well as her shoulder and hand. Again, Petitioner does not include the cervical condition in her January 15, 2015 Application for Adjustment of Claim. On January 27, 2015, Petitioner reports an intermittent neck pain upon performing overhead work. Petitioner is seen by Neurologist Tsung and he opines that the disc bulge is not contributing to Petitioner's current symptoms within her forearm and hand and her cervical strain is a "separate problem". Petitioner returns to Dr. Garst on February 24, 2015 and the doctor notes that Petitioner's neurosurgeon said her neck was not the source of her hand pain. Three more months elapse before Petitioner reports increased neck pain over the last few weeks especially while doing low impact exercises at the gym. When Petitioner sees Dr. Morrow ten days later she provides a history that her neck pain began after the August 22, 2014 accident. When Dr. Rhode is asked to express a causation opinion in regard to the neck he states in his deposition that he has no causation opinion. Given all of the above, the Commission finds that Petitioner failed to prove her neck condition is causally related to the August 22, 2014 work accident.

Again, the Commission finds that there is an internal inconsistency in the arbitrator's decision. Specifically, the Arbitrator notes in the causation section of his decision that there is no opinion indicating the ganglion cyst is related to the August 22, 2014 accident. Yet, the Arbitrator in the medical portion of the decision allows for prospective medical care for the cyst.

In regard to evidence pertaining to the cyst, the Commission finds that the diagnosis of a ganglion cyst is not made until August 31, 2015, which is almost a year after the August 22, 2014 work accident. PA Welke at most says that the cyst could have been present prior. The Commission finds that this comment does not rise to a level of medical certainty. Nor does it connect the cyst to the August 22, 2014 work accident, which occurred approximately one year earlier. When Dr. Rhode is asked to express a causation opinion regarding the relationship of the cyst to the work accident he declines to do so. Thus, again there is no evidence to support a finding that Petitioner's cyst is causally related to the August 22, 2014 the work accident. As such the Commission vacates the Arbitrator's award of prospective medical in regard to the cyst.

To summarize all of the above, The Commission finds that Petitioner proved her right carpal tunnel syndrome resulted from an "acute" work injury on August 22, 2014. The Commission finds that the cyst is not causally related to the August 22, 2014 work accident and as such Petitioner is not entitled to any prospective medical treatment regarding the same. Lastly, the Commission finds that the cervical and shoulder conditions are not causally related to the August 22, 2014 work accident and the Commission vacating the reference to a "temporary aggravation" caused by the August 22, 2014 work accident.

The evaluating doctor. With this one exception, the Commission affirms the Arbitrator's finding that any medical bills related to Petitioner's right shoulder or cervical condition not be awarded based on the threshold finding of no causation.

In terms of the prospective medical issue, the Commission finds that there is yet another potential inconsistency. In the analysis portion of the decision the Arbitrator allows for prospective medical in the form of a carpal tunnel release surgery recommended by Dr. Rhodes. In the Order section of the decision the Arbitrator allows for both the treatment for the carpal tunnel and for all treatment and diagnostic testing involving the right ganglion cyst. Since the ganglion cyst has been found not to be causally related to the August 22, 2014 accident, the Commission finds that the prospective medical award should be strictly for the carpal tunnel release surgery and not for the ganglion cyst.

The Commission finds that Petitioner's transition from working light duty to being off work all together occurred with her change in doctors from Dr. Garst to PA Welke. Petitioner was first taken off of work on May 18, 2015 for what appears to be primarily her cervical care. On May 28, 2015, Dr. Morrow indicates she can work light duty. She is given an off duty slip for June 3, 2015 for her right shoulder, wrist and neck. It appears that she is off of work again on June 10, 2015 for her neck condition. From July 2, 2015 through August 31, 2015 it appears she is off for her carpal tunnel and shoulder conditions. She is told she can work modified work again on October 15, 2015. The Commission was not provided any medical records after October 15, 2015. Given all of the above, it appears that the only period that can be truly isolated to Petitioner being off work for her carpal tunnel alone is from July 2, 2015 through August 31, 2015. As the Commission finds that Petitioner's carpal tunnel condition had not yet stabilized the Commission finds Petitioner was temporarily totally disabled from July 2, 2015 through August 31, 2015.

Lastly, the Commission finds that this case should be remanded to the Arbitrator for further proceedings pursuant to Thomas v. Industrial Commission, 78 Ill. 2d 327, 399 N.E.2d 1322 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $253.00 per week for a period of 8-5/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act, and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or compensation for permanency, if any.

IT IS FUTHER ORDERED BY THE COMMISSION that Respondent shall pay reasonable and necessary medical services for all treatment involving the right carpal

tunnel syndrome and for the diagnostic cervical MRI conducted at OSF St. Francis Medical Center on December 29, 2014 as provided in Section 8(a) and 8.2 of the Act.

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

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $4,500.00. The party commending the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: OCT 6 - 2016

MB/jm

O: 9/8/16

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Mario Basurto

David L. Gore

Stephen Mathis

[i] The Commission notes an internal inconsistency present in Dr. Garst's medical records. In the majority of the records Dr. Garst finds that Petitioner's EMG/NCV was + for CTS. However, on February 24, 2015, Dr. Garst indicates EMG/NCV was – for CTS but he still finds on a clinical basis that she has right carpal tunnel syndrome. It appears from the finding of moderate right medial neuropathy at the wrist in the October 16, 2014 EMG/NCV that the doctor found Petitioner has + EMG/NCV and the comments in the February 24, 2016 entry are an anomaly.

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

Rhodora Gatdula,
Petitioner,

vs.
University of Illinois Medical Center
At Chicago,
Respondent,

NO: 09 WC 21179

16IWCC0649

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 11, 2015 is hereby affirmed and adopted.

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

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

No bond or summons for State of Illinois cases.

DATED: OCT 6 - 2016

MB/mam
o:9/29/16
43

Mario Basurto

David L. Gore

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GATDULA, RHODORA
Employee/Petitioner

Case# **09WC021179**

16IWCC0649

UNIVERSITY OF ILLINOIS MEDICAL CENTER AT CHICAGO
Employer/Respondent

On 12/11/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.53% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5446 WOLF & TENNANT
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CERTIFIED as a true and correct copy pursuant to 820 ILCS 305 / 14

DEC 11 2015

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

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

RHODORA GATDULA,
Employee/Petitioner

16IWCC0649

Case # **09 WC 21179**

v.

Consolidated cases:

UNIVERSITY OF ILLINOIS MEDICAL CENTER OF CHICAGO HOSPITAL.
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 **MARIA S. BOCANEGRA**, Arbitrator of the Commission, in the city of **CHICAGO**, on **August 12, 2015 and October 1, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS **16IWCC0649**

On **1/8/2008**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$90,952.68**; the average weekly wage was **$1,749.09**.

On the date of accident, Petitioner was **53** years of age, ***single*** with **0** dependent children.

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

Respondent ***has*** 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 **$297,914.24** for other (SURS) benefits, for a total credit of **$297,914.24**. Respondent is entitled to a credit of all amounts paid by CIGNA and other qualified benefits paid under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of **$1,164.37**/week for **8-4/7th** weeks, commencing **1/25/08** through **3/24/08**, as provided in Section 8(b) of the Act. Respondent shall be given a credit for benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act. Respondent shall pay Petitioner the temporary total disability benefits that have accrued from **1/25/08** through **3/24/08** and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall pay reasonable and necessary medical services from **1/24/08** through **3/24/08** for the cervical sprain/strain, as provided in Section 8(a) of the Act. Respondent shall be given a credit for benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act. Medical bills/benefits after 3/24/08 are denied.

Respondent shall pay Petitioner permanent partial disability benefits of **$636.15/week** for **17.5 weeks**, because the injuries sustained caused the **3.5%** loss of the person as a whole, as provided in Section 8(d)2 of the Act.

Respondent shall pay to Petitioner penalties of **$0.00**, as provided in Section 16 of the Act; **$0.00**, as provided in Section 19(k) of the Act; and **$0.00**, as provided in Section 19(l) of the Act.

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

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

Signature of Arbitrator

12-11-15
Date

DEC 1 1 2015

BACKGROUND

Rhodora Calderon Gatdula ("Petitioner") and University of Illinois Medical Center at Chicago Hospital ("Respondent") proceeded to arbitration on 8/12/15 and 10/1/15 on all disputed issues concerning Petitioner's injuries, which she alleged to have arisen out of and in the course of her employment with Respondent on 1/8/08. At trial the following issues were in dispute: accident, causation, liability for unpaid medical bills, temporary total disability, maintenance benefits, nature and extent of the injury.

FINDINGS OF FACT

Rhodora Calderon Gatdula ("Petitioner") testified she was a registered nurse working in the intensive care unit at the University of Illinois Medical Center at Chicago Hospital ("Respondent"). Petitioner testified that she had been a nurse since 2001. Her resume was admitted to evidence, showing her experience as a nurse and some her duties working with Respondent. Px1.

Petitioner testified that on 1/8/08 she worked for Respondent and assisted in transferring a 300-pound transplant patient with the assistance of 6 other nurses. Petitioner pulled the bed sheet to transfer the 300-pound patient. Petitioner reported that she didn't notice anything immediately. Petitioner finished the rest of her shift. Petitioner worked the following day, 1/9/08.

On 1/9/08, Petitioner again had to transfer the same patient to a different bed. Petitioner testified that her neck began to hurt more. Petitioner placed an ice pack on her neck. Petitioner began a previously scheduled vacation to Las Vegas starting 1/10/08. At trial, Petitioner testified that she did not take her son back to college. She did not receive any medical treatment during her vacation. Petitioner took pain medication, Advil, to alleviate her symptoms. On 1/24/08, Petitioner returned to work.

On 1/25/08, Petitioner presented to Dr. Marder at UIC for treatment. The morning note indicated that she presented for follow up of left upper extremity pain, persistent pain, inability to sleep, and worsening pain with left head and tingling sensation to the medial four fingers was noted. The doctor noted she had been seen by her primary care and a neurologist.

The afternoon note indicated that chief complaint was left back chest pain and left upper extremity pain for 2 weeks. She related part of her job duties was to transfer intubated patient to bed. Petitioner reported that she suffered an injury on 1/8/08 while lifting a heavy male patient weighing 90 KG. The next morning, she noticed left neck stiffness. The next day she had to lift the same patient to another bed because he was put in the wrong bed. She complained of chest pain at the back of her chest radiating to the left upper extremity to the left 4th and 5th fingers, shooting pain, 6-8/10 pains, and worse with lifting the left upper extremity. She related she had been taking Advil for the last 2 weeks and the pain was worsening. She related she had been on vacation and could not perform work upon her return. She stated she could not lift, push, pull, shampoo hair or scratch her back. She was barely able to lift a cup of coffee. There was no prior history of similar issues. Exam showed decreased range of motion in the left shoulder, decreased left hand grip strength more prominent at the 4th and 5th digits. Petitioner was diagnosed with an injury to her left upper extremity and possible radicular pain from C6-7, which the doctor attributed to a pinched nerve. The doctor recommended continuing Celebrex and was advised to call her primary care physician for an appointment within 24 hours.

On 1/25/08, the same date in which Petitioner saw Dr. Marder, she also saw her primary doctor, Dr. Remegio Vilbar. Px3. She complained of pain in the neck and arm. Dr. Vilbar noted that there was no history of trauma. He surmised she was probably lifting and pulling a patient. Neck rotation was limited and hand grip

over the left arm was decreased. Impression was cervical disc disease with radiculopathy. An MRI of the thoracic and cervical spines was ordered and Petitioner was prescribed Fiorcet and Celebrex. Petitioner was then referred to Dr. Matz.

Petitioner testified that on 1/27/08, she completed an application for disability. In it, she wrote that she woke up with a stiff neck on 1/9/08 and that she was disabled during a recent vacation. Petitioner reported that the first date of disability was 1/25/08. Petitioner was paid her salary through 3/2/08.

On 1/28/08, Petitioner presented for evaluation with Dr. Maria Hofmaier, DC. Px4. Petitioner complained of severe left neck and upper back pain, paresthesias and pain in the left arm. No prior problems in that area were noted. She complained of 7-9 out of 10 pain in the left upper back, intermittent left arm shooting pain and numbness into the left 2nd through 4th digits. Pain diagram noted pain in the neck, left shoulder, left arm and left hand. Aggravating factor was getting up in the morning on 1/9/08. Cervical range of motion was decreased. Palpation showed severe myofacitis, left greater than right in cervical paraspinals, upper and midtrap. Cervical compression was positive for left arm pain, cervical distraction was positive for relief of left upper extremity discomfort. Dr. Hofmaier reviewed a cervical MRI as showing protrusion at C3-4 distorting the visualized epidural space and spondylosis at C5-6 without disc disease. Diagnosis was cervical disc, cervical radiculitis and myositis. Therapy was recommended.

On 1/29/08, Petitioner presented to Dr. Marshall Matz. Petitioner reported to Dr. Matz that she woke up with stiffness in her neck followed by numbness in the left 4th and 5th digits. On 1/29/08, MRI of the cervical spine revealed a C3-C4 central protrusion and C5-C6 minimal disc bulging. Px3.

On 2/4/08, Petitioner began following up with an advanced practice nurse at UIC. Px2. Severe pain in the left arm was noted, along with mild neck and trapezius pain. numbness of the 2nd digit was noted. Assessment was cervical pain with radiculopathy. She was ordered off work.

On 2/4/08, in a letter to Dr. Vilbar, Dr. Matz wrote that Petitioner gave a history of waking on 1/9/08 with a stiff neck followed by numbness in the left 4th and 5th digits. Rx3. She had experienced severe left arm pain but the right arm and both legs were normal. The doctor concluded that although signs were consistent with a C7 radiculopathy, nothing on MRI accounted for Petitioner's self-reported neck and left upper extremity problems.

On 2/11/08, Petitioner completed Respondent's Report of Injury. Rx1. It was marked as a claim for workers' compensation and then scratched out. Petitioner wrote that on 1/8/08, she lifted a heavy patient weighing approximately 300 pounds with other staff members and that the next morning she experienced stiffness and pain in the neck, progressively worsening. Symptoms included numbness, spasms and tingling on the left upper extremity. Body parts injured were listed as cervical spine, right rotator cuff and lumbar spine. *Id.*

On 2/11/08, NCV/EMG of the left side only completed by Dr. Shenker at the referral of Dr. Vilbar showed mild left carpal tunnel syndrome, left ulnar sensory neuropathy without evidence of left cervical radiculopathy. Px3. On 2/13/08, Dr. Vilbar referred Petitioner to Dr. Frank of Hinsdale Hospital to evaluate the neck and shoulder/arm pain. On 2/20/08, Petitioner was found to be unable to return to work. Px2. She continued to report neck and left shoulder/arm pain along with numb 2nd and 3rd digits.

On 2/25/08, Petitioner was evaluated by Dr. Frank at the referral of Dr. Vilbar. Px3, Rx4. Dr. Frank noted that on 1/9/08, Petitioner woke up with a stiff neck left greater than right with some radiation down into the arms but mostly into the shoulder. Petitioner recalled moving a heavy patient with several of the nurses the day before. Dr. Frank diagnosed the Petitioner with a cervical strain without any objective evidence of radiculopathy or myelopathy. He also diagnosed bilateral carpal tunnel syndrome. He recommended therapy for the neck and hands. Px8. Petitioner was splinted.

On 2/27/08, UIC assessed cervical strain and bilateral carpal tunnel syndrome. Petitioner remained off of work. On 2/29/08, Petitioner underwent initial cervical evaluation at ATI Physical Therapy at the referral of Dr. Frank. Px3. Therapists noted Petitioner woke up with stiffness in the left side of the neck after lifting 300-pound patient the previous day and that complaints were present since 1/9/08. Px8. Petitioner demonstrated muscle spasm, decreased range of motion, decreased upper extremity strength and pain in all activities "secondary to trauma suffered on 1/9/08." Impression was cervical strain.

On 3/12/08, Petitioner followed up with UIC. She reported 75% improvement. Px2. She now had right arm pain she believed was from carrying groceries on 2/23/08. The left arm/shoulder and neck were reported pain free. Then records note she continued to have neck tenderness and pain across the middle of her back, along with bilateral wrist pain, left greater than right, improved with splinting. Objectively the nurse practitioner found hand grasp was 5/5 bilaterally, full range of bilateral shoulders was noted, strength was 5/5, and tenderness to palpation over the cervical and thoracic spine areas, left and right sided scapular pain, tenderness to palpation over the right AC joints and no tenderness to palpation over the left shoulder. Thoracic/cervical strain, right shoulder pain and bilateral CTS were assessed. Petitioner was released to sedentary duty, unable to be accommodated. Petitioner related she felt as though she could not return to work because she felt she could not lift.

On 3/13/08, Dr. Vilbar noted complaints over the right shoulder and arm. Px3. Neck rotation produced mild pain on the right side and in the shoulder. Impression was cervical strain and bilateral carpal tunnel syndrome. On 3/24/08, Petitioner returned to Dr. Frank. Rx4. Dr. Frank could not find evidence of radiculopathy. He suggested that *if* Petitioner did have bilateral carpal tunnel syndrome, a referral to a hand specialist would be appropriate. He declined to keep her off of work and noted she did not want to go back to work. Neurologically, there was nothing else to do for her. He noted that much of her symptoms might be functional. On 3/26/08, Dr. Vilbar noted that although Petitioner had been released by Dr. Frank to return to work and that although she was eager to work, she was still symptomatic. Px3. He referred her to a second opinion with Dr. Calimag. *Id.* In March, Petitioner also followed up with Dr. Hofmaier, who noted an onset of right should arm pain. Petitioner related she had recently lifted a frozen chicken.

On 3/29/08, Petitioner presented to Dr. David P. Calimag for a second opinion at the referral of Dr. Vilbar. Px5. Petitioner related that she had neck pain radiating to the left arm since 1/8/08 after lifting a patient at work. She went on vacation, returned to work on 1/28 but the pain got worse and she had not returned to work since. The doctor summarized Petitioner's medical treatment, including medication, chiropractic care and EMG study. Dr. Calimag ordered repeat EMG of both upper extremities to rule out bilateral carpal tunnel and cervical radiculopathy. He referred her to ATI for cervical radiculopathy.

On 3/31/08, Petitioner returned to Dr. Calimag for follow up of neck and arm pain. Px5. Right arm pain was now greater than left. Exam showed negative Tinel's bilaterally, no motor or sensory deficits and deep tendon reflexes were normal. Impression remained to rule out carpal tunnel and cervical radiculopathy. On

3/31/08, Dr. Calimag performed EMG/NCV testing on Petitioner, which he interpreted as showing early carpal tunnel on the right and suspicious C5-6 radiculopathy. Px3, 5.

On 4/3/08, Petitioner followed up at UIC with complaints of pain to the right arm and shoulder from carrying groceries. Px2. The left arm/shoulder was improved. Petitioner was assessed with right shoulder/arm pain, bilateral CTS and left shoulder/arm pain. She remained off work. On 5/8/08, Petitioner returned to UIC reporting no relief following cervical injection. Px2. MRI of the right shoulder revealed tendonitis of the right supraspinatus tendon with partial tear.

On 4/25/08, Petitioner began treating with Dr. Bong Phetchamphone. Px6. Petitioner presented with complaints of neck, mid-back and low back pain. Petitioner complained of increased neck pain for the past three months. Petitioner also complained of left arm tenderness and numbness in the left hand and fingers. Petitioner also reported right arm tenderness for two months. Dr. Phetchamphone noted that Petitioner has hip pain. Petitioner reported that she was injured on 1/9/08 transferring a patient to a special bed. She continued to receive acupuncture with Dr. Phetchamphone until July 2008.

On 5/2/08, MRI of the right shoulder revealed partial tear and/or tendinosis. On 5/3/08, Dr. Vilbar noted continued pain of the right shoulder and neck pains radiating to the left shoulder. Px3. Impression was fibromyalgia. On 5/3/08, Petitioner returned to Dr. Calimag for follow up of cervical radiculopathy and carpal tunnel. Px5. She reported 50% improvement but difficulty with raising the arms overhead. The doctor suspected fibromyalgia and that Petitioner "had all the features necessary for the diagnosis." On 5/13/08, Dr. Vekkos and/or Dr. Frankel issued a prescription for physical therapy for chronic plantar fasciitis to ATI. Px8. On 5/22/08, Dr. Vilbar again noted neck pain and bilateral shoulder pain, worse on the right. Px3. Impression was tendinosis of the right shoulder. On 5/23/08, Dr. Calimag's impression was cervical radiculopathy, improving and evidence of tendon tear in the right shoulder. Px5. Petitioner remained off work. On 5/23/08, Petitioner presented for reevaluation with Dr. Hofmaier, who noted Petitioner rated her pain in the left upper back 1 out of 10 and right neck pain 0 out of 10. Petitioner stopped seeing Dr. Hofmaier in May 2008. On 5/27/08, Dr. Pahwa issued a prescription for therapy to ATI for the right shoulder for a diagnosis of right supraspinatus tendinitis. On 5/28/08, ATI completed a shoulder evaluation at the referral of Dr. Pahwa. Px8. Petitioner identified the mechanism of injury as lifting a patient.

On 6/9/08, Petitioner saw Dr. Benjamin Goldberg. Px7. He documented that she thought she hurt her shoulder at work on 1/8/08 working with a patient. He noted that a neurologist had recently informed her that her symptoms may be referred from the shoulder. MRI of the right shoulder showed partial thickness tear. The doctor's impression was posterior capsular tightness, possible partial thickness rotator cuff tear and reported herniated nucleus pulpous of the neck. He recommended posterior capsular stretching of the shoulder, physical therapy and follow up. light duty for the right shoulder was ordered.

On 6/10/08, ATI issued a progress report for cervical therapy as prescribed by Dr. Calimag. Therapists noted 80% improvement following completion of 2 cervical injections but ongoing stiffness. Petitioner was also concurrently treating for right shoulder rotator cuff syndrome and bilateral plantar fasciitis. On 6/21/08, Dr. Calimag saw Petitioner for carpal tunnel, cervical radiculopathy and left shoulder rotator cuff tear. Px5. He noted left sided cervical epidural steroid injections with no improvement. On 6/25/08, ATI issued a separate progress report for right shoulder therapy as prescribed by Dr. Pahwa. Petitioner reported improvement and therapists recommended discharge to home exercise. On 6/29/08, correspondence regarding vocational

counseling services associated with long term disability and possible available positions were documented. Px2. Petitioner continued to update Respondent on her work status for SURS purposes. Px2, Ax1.

On 7/18/08, Petitioner followed up with Dr. Calimag for cervical radiculopathy and right shoulder pain secondary to rotator cuff pain. Px5. She remained off of work through 10/18/08. On 7/31/08, Dr. Vilbar referred Petitioner to Dr. Iamarttno to rule out fibromyalgia of the neck or tendinosis of the right shoulder.

On 9/11/08, ATI issued a third progress report for cervical therapy as recommended by Dr. Calimag. Therapists noted that Petitioner had not attended therapy for 4 weeks and that increase in cervical pain was due to recent vacation. On 9/23/08, Petitioner was evaluated by Dr. Brinda Joshi, DO in rheumatology at the referral of Dr. Vilbar. Px3. The doctor noted Petitioner's report of onset of neck pain after lifting a heavy patient at work. Pain was initially localized to the neck and later began radiating to both fingers with spasms into the left upper extremity. The doctor noted that prior work-up revealed a C7 radiculopathy. The doctor noted recent nodule formation over the right 4th PIP and enlargement of the PIP joints of both hands. Petitioner was taking Advil daily for hand pain. A history of degenerative joint disease of the lumbar spine was noted, along with a history of lower and upper back pain. Dr. Joshi's impression was cervical radiculopathy since January 2008 after lifting heavy at work. The doctor noted that work up was consistent with EMG and MRI of the cervical spine. The doctor also noted diffuse pain in the hands and through the joints and muscles with evidence of osteoarthritis in the hands. The doctor noted extra-articular tender points and poor restorative sleep consistent with a component of fibromyalgia. On 9/26/08, Petitioner returned to Dr. Vilbar who noted a new complaint of low back pain at times radiating to the legs. Px3. MRI of the lumbar spine was ordered.

On 10/18/08, Dr. Calimag noted weakness of the left leg and that Petitioner had problems with lumbar radiculopathy at some point prior. Px5. The doctor took Petitioner off of work with no end date. Dr. Calimag referred Petitioner to ATI for physical therapy and evaluation for the low back. ATI completed a lumbar evaluation and noted the mechanism of injury as "insidious onset" and not work related.

On 11/22/08, 12/21/08, 1/24/09 and 2/26/09, Dr. Calimag summarized Petitioner's treatment and continued Petitioner off of work and also issued light duty type work restrictions.

On 4/1/09, Petitioner returned to UIC for return to work documentation completion related to her SURS paperwork. It was noted she had been off work due to several comorbidities which Petitioner stated prevented her from returning to work since 5/2008. Px2.

On 5/21/09, Petitioner returned to Dr. Vilbar complaining of neck, shoulders, arms and back. Px3. She was noted to be seeing a physical therapist and doing home exercise. Exam showed limited rotation of the neck, tender back and spine and limited rotation of the extremities in both shoulder joints, worse on the right. Impression was cervical disc disease with radiculopathy, lumbar disc disease and carpal tunnel syndrome. Flexiril, Lyrica and Celebrex were continued. Id. Petitioner also saw Dr. Calimag, who completed a report for UIC Health Services. Px5.

On 6/18/09, Petitioner complained of left shoulder pain and Dr. Calimag ordered an MRI of the left shoulder. On 6/29/09, Petitioner returned to Dr. Vilbar for her back problem. Px3. On 7/6/09, ATI completed a referral intake form from Dr. Benjamin Domb for physical therapy to the bilateral shoulders. It was indicated that treatment was *not work related.*

On 7/30/09, Dr. Calimag noted Petitioner was being followed for bilateral shoulder tears. Px5. On 8/24/09, ATI issued its discharge summary with respect to bilateral shoulder therapy as recommended by Dr. Domb. She displayed full range of motion, functional strength and less pain compared to initial evaluation. Discharge to home exercise was recommended. On 10/29/09, 12/3/09, 1/9/10 Dr. Calimag's opinions were unchanged in follow up regarding her ability to work except that Petitioner could do seated work. On 11/19/09, Petitioner returned to Dr. Vilbar for follow up, still complaining of neck and low back pain, bilateral shoulder pain. Impression was cervical and lumbar disc disease with radiculopathy, fibromyalgia and carpal tunnel syndrome.

In January 2010, Dr. Calimag noted that Petitioner now complained of numbness in the dorsum of the left foot. Throughout the remainder of 2010, Petitioner continued to follow up with Drs. Calimag and Vilbar, whose impressions were largely unchanged. Disability forms were completed. Petitioner also continued acupuncture.

On 4/23/11, Dr. Calimag noted Petitioner had returned from the Philippines and now had restless leg syndrome. Petitioner was started on Mirapex. Restricted duty was continued. On 5/28/11, Petitioner complained of pain in the temporomandibular joint and increasing neck pain. Dr. Calimag's impression was temporomandibular joint pain, cervical radiculopathy and fibromyalgia. Another MRI of the cervical spine was ordered. On 6/24/11, MRI of the right shoulder was again completed. Petitioner continued to see Dr. Calimag for summary follow up and completion of disability paperwork.

In February 2012, Petitioner saw Dr. Calimag for left shoulder pain and he ordered another MRI. In March 2012, Petitioner followed up with Dr. Vilbar, who noted ongoing pain in the back and neck. Px3. He noted she was in therapy and was taking Lyrica and Flexiril. On 10/11/12, Petitioner followed up with Dr. Vilbar. Px5. Petitioner rated her pain 4-6 out of 10 and noted numbness of the left small and ring fingers at this time. A regimen of Lyrica, Flexeril, B12 shots, vitamin D and multi-vitamin continued. On 12/13/12, Petitioner followed up with Dr. Vilbar for chronic pain from fibromyalgia, chronic cervical and lumbar radiculopathy and carpal tunnel, 5 years post injury. Exam showed Heberden nodes in the right ring finger, slight right quad weakness, knee jerk 2+ on the right and 3+ on the left and ankle jerk 2+ bilaterally. The doctor noted Petitioner was the same but stable. He placed her at maximum medical improvement. Petitioner was released to return to work with restriction.

In 2013, Petitioner was working with Respondent to coordinate a possible return to work in an accommodated position. Petitioner again followed up with Dr. Vilbar on 3/21/13, 6/20/13, 8/27/14 and 8/28/14. Most recent exam showed full range of motion in the neck, no tenderness and no muscle spasm. Neurologic exam was normal. Petitioner complained of chronic pain from fibromyalgia. Assessment was chronic pain due to neck, back, shoulder injuries from work resulting in chronic pain and fibromyalgia.

The parties to the evidence deposition of Dr. Calimag. The doctor testified he specialized in both neurology and pain management and was board certified in pain management. He testified that Petitioner's initial visit was fairly normal and there was questionable positive Tinel's sign in both wrists. The doctor testified that the nerve conduction results found the only abnormality of delayed onset latency of the right median nerve but not by very much. The needle exam or the EMG portion of the testing however found abnormalities in the right deltoid and right bicep area which was indicative of radiculopathy at right C5 and C6. When asked whether those conditions are conditions that could be caused by someone engaging in the lifting a

heavy heavy patient the doctor answered that he did not know if the trauma was event that brought her to the doctor in the first place. The Arbitrator sustains Respondent's objection to Dr. Calimag's testimony on Dr. Joshi's medical record as speculative as to the reasons why the doctor whose records whenever admitted into evidence may or may not have ordered x-rays of the bilateral hands.

Dr. Calimag further testified that the MRI of the cervical spine in June 2011 was essentially the same as the original one completed in January 2008. He believed both MRIs contribute to the diagnosis that he suspected all along. The doctor opined that in his opinion Petitioner sustained injury at work on 1/8/09 to the neck and shoulder which continued to the point of giving her a lot of pain. He opined that the cervical radiculopathy, right-sided carpal tunnel and right rotator cuff tear with tendinosis were causally related to the work injury.

When asked whether he believed Petitioner's condition to be permanent the doctor replied the following "I would hate to speculate permanency of her condition. All I know is that her condition has evolved into a chronic pain syndrome. And chronic pain syndrome to us deals with pain on a regular or daily basis and we've seen these in our practice almost daily, the pain would last for a long time and its individuals as you know their own time frame when they will improve to the extent that they are able to perform like they were previously minus the pain."

On cross the doctor admitted that it was not his opinion that the left shoulder conditions were related. He testified that he believed Petitioner was at MMI as of December 2012. He testified that when he first saw petitioner in March 2008 she began complaining of right shoulder pain and that that is why he ordered a repeat EMG/NCV study for the right side. On cross the doctor admitted that he did not review the medical records of Dr. Hofmaier, Dr. Matz or Dr. Hegel. On cross exam the doctor also acknowledged that although his second EMG/NCV of the right *suggested* a C5-6 radiculopathy, a later cervical MRI completed in April 2009 was negative for spinal cord compression, herniation or compromise at that very same level. On cross the doctor also testified that although he was aware of prior treatment before his initial evaluation he did not review those records. He testified he did not order an FCE and was not entirely clear on what they were.

The parties took the evidence deposition of Dr. Alexander J. Ghanayem. Rx5. The doctor testified he practices medicine specializing in spine surgery and that in October 2012, he performed a records review of Petitioner's medical record on behalf of Respondent. his report was admitted into evidence.[1] Records reviewed included chiropractic records that pre-dated the injury in question[2], MRIs, neurology records, an EMG, correspondence and records from Dr. Hofmaier. Dr. Ghanayem noted that Petitioner was treated pre-injury for back problems between the shoulder blades around the T3 area and continued to be so treated after the injury in question. He testified that Petitioner's reported history of the injury was not consistent and to the extent that it was, at most she suffered a cervical strain. Dr. Ghanayem stated that given the Petitioner's negative cervical MRI findings he did believe that the Petitioner could return to work regular duty.

He explained that he noted no initial mention of a work injury in the chiropractic records but that there was documentation of caring frozen food in March of that year causing symptoms. The doctor testified he reviewed the cervical MRI from January 2008 it did not find any evidence of structural injury and that later cervical MRIs were also consistent with the initial MRI. The doctor also pointed out the lack of definitiveness in radiculopathy on EMG/NCV. On cross exam, the doctor stated that the mechanism of injury of lifting and

[1] The Arbitrator overrules Petitioners' hearsay objection to Dr. Ghanaian's report as the declarant, in this case Dr. Ghanayem, made himself available and subject to cross-examination. Ill.R. Evid 803.

[2] Those records were not submitted into evidence.

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moving the patient would not be consistent for herniation but would be consistent with upper back sort of cervical strain. Regarding the arm pain, the doctor clarified not causally related to this problem because there's no compression cervical spine based on his review the MRI scans as well as EMG which only suspicion retina clear-cut cervical radiculopathy.

The Petitioner's husband testified at trial. He testified that the Petitioner and he went on vacation days after the alleged accident at work. He testified during that time Petitioner did not leave the hotel room. He also stated that Petitioner did not seek any medical care, emergency or otherwise.

CONCLUSIONS OF LAW

ISSUE (C) Did An Accident Occur That Arose Out Of And In The Course Of Petitioner's Employment By Respondent?
ISSUE (F) Is Petitioner's Current Condition Of Ill-Being Causally Related To The Injury?

The Arbitrator has considered all testimonial evidence as well as available medical evidence and a concludes that Petitioner has proven by a preponderance of the evidence that she sustained an accident on 1/8/08 arising out of and in the course of her employment with Respondent. Petitioner credibly explained her work duties as a nurse and that on 1/8/08 she and other co-workers were assigned to the transfer of a 300-pound patient. She stated that she lifted and moved the patient and did not feel pain initially. She finished her shift and the next morning, noticed neck pain, which worsened after having to move the same patient again. She stated she applied ice. Petitioner candidly disclosed that she went on a vacation, during which time she testified she noticed worsening neck pain. Her husband credibly testified that he noticed Petitioner unable to do much on vacation. During this time, Petitioner stated she took over the counter medications to help with pain that is corroborated by contemporaneous medical records.

Petitioner's testimony regarding the details of the injury was corroborated by the initial treatment records of Dr. Marder later that month. The Arbitrator does not find Petitioner's initial treatment with Dr. Marder as any significant delay so as to foreclose further analysis of whether an accident occurred. Dr. Marder noted that there was no prior similar history regarding Petitioner's then current complaints of left arm and neck pain. Dr. Marder's record did note that Petitioner presented for "follow up of left upper extremity pain," and that she had recently seen her primary. There is no indication in Dr. Marder's record when and where any prior left upper extremity treatment took place. Dr. Marder also recommended "continuing" Celebrex, which may indicate a prior prescription for same but there was insufficient information in the record to determine as much. The record does show that on the same day as Petitioner first saw Dr. Marder, she did also see Dr. Vilbar, whom prescribed Celebrex and who was described at trial as her primary doctor. The Arbitrator finds that it is most likely that Petitioner saw Dr. Vilbar first, hence Dr. Marder's reference to Petitioner having seen her primary doctor, presenting for follow up and Dr. Marder's recommendation that Dr. Vilbar's prescription for Celebrex continue. Dr. Vilbar's 1/25/08 medical note indicated that Petitioner probably injured herself lifting a patient but also noted no history of trauma. The doctor diagnosed cervical radiculopathy.

Dr. Ghanayem testified that there was a history of pre-injury treatment to the back but those medical records do not appear anywhere in the trial record and therefore the Arbitrator is unable to conclude that Petitioner's onset of symptoms pre-date the injury described.

Medical records also show that Petitioner presented to Dr. Hofmaier. Px4. Those records did not specify any injury or accident. Aggravating factor noted was getting up on the morning of 1/9/08. The doctor diagnosed cervical radiculitis and myositis. The Arbitrator can reasonably infer that the use of the phrase "aggravating factor" by Dr. Hofmaier was intended to indicate the prior problem, namely the work injury. In this case, Petitioner credibly testified she told Dr. Hofmaier about lifting a patient and waking the next day with cervical/neck pain.

Petitioner also presented to Dr. Matz on 1/29/08, who documented Petitioner woke up with stiffness in the neck. The doctor found her complaints and exam to be consistent with a C7 radiculopathy and diagnosed an acute "spontaneous" cervical herniation. The doctor also noted that Petitioner's MRI could not account for any

abnormalities. Medical records continued to document cervical and left arm radiating pain. However, initial EMG/NCV of the left side by Dr. Shenker showed no evidence of radiculopathy and instead showed possible early carpal tunnel syndrome.

Petitioner's report of injury form is also consistent with her testimony and treatment records that same month. The mechanism given was lifting a heavy patient. Petitioner credibly testified that she marked the form as work related and that she had not scratched anything out.

Further records with Dr. Frank noted that Petitioner woke up with neck pain but recalled having lifted a heavy patient the day before. He diagnosed cervical strain without radiculopathy and carpal tunnel syndrome. Similarly, in February 2008, medical staff at UIC also diagnosed cervical strain.

In March 2008, Petitioner reported for the first time to UIC and to Dr. Hofmaier right arm pain following an episode of carrying groceries and/or a frozen chicken. That same month, Dr. Frank released Petitioner to return to work and noted he could not find evidence of radiculopathy and that he believed her symptoms to be functional in nature. Petitioner requested a second opinion and Dr. Vilbar referred her to Dr. Calimag. Records of Drs. Joshi, Phetchamphone, Goldberg and Calimag document lifting a patient at work.

Having carefully reviewed and considered Petitioner's testimony as well as all available medical evidence, the Arbitrator concludes that Petitioner has proven by a preponderance of the evidence that she sustained an accident arising out of and in the course of her employment on 1/8/08 with Respondent. In so finding, the Arbitrator relies on various contemporaneous medical records noting a consistent history of lifting a heavy patient at work then waking with worsening neck pain. The Arbitrator is aware that Dr. Matz's record is the only record noting Petitioner woke up with stiffness one morning without any mention of a work incident. The Petitioner, the in Arbitrator's view, credibly testified she indicated to her treating doctors the incident that had occurred at work. The Arbitrator resolves this one record in favor of Petitioner in light of a preponderance of the other evidence.

Turning to the issue of causation, the Arbitrator finds that Petitioner's cervical sprain/strain is causally related to her work accident and which reached maximum medical improvement as of 3/24/08. In so finding, the Arbitrator notes the extensive and various medical treatment records and incorporates the findings of fact regarding same as though fully set forth herein.

The medical record documents that Petitioner only complained of cervical/neck and left arm pain with some radiating pains following the lifting accident. Initial treatment with Dr. Marder noted that he suspected C6-7 involvement but this impression was made without the benefit of having any diagnostic performed. Dr. Hofmaier's initial record on 1/28/08 suggested she read the cervical MRI as possibly showing radiculitis. However, the first cervical MRI does not appear until 1/29/08, one day before Dr. Hofmaier's initial evaluation. The Arbitrator is unclear how Dr. Hofmaier could have reached such a conclusion a day before the test was done. Subsequent treatment records were unable to find evidence of true radiculopathy. For example, the first EMG/NCV only suggested the possibility of cervical radiculopathy but was definitive of early stage carpal tunnel. The Arbitrator's interpretation of this record is supported by Dr. Calimag's decision to order another EMG/NCV to rule out radiculopathy, which, in the Arbitrator's view, confirms that the first test was not definitive. In another example, Dr. Frank's initial note found some radicular type pain extending only to the left shoulder. Accordingly, the doctor diagnosed her with cervical strain without any objective evidence of radiculopathy or myelopathy. Various readings of multiple cervical MRIs were unable to confirm any

compression or pathology that would account for Petitioner's complaints as noted by Drs. Matz, Frank and Ghanayem. The preponderance of the evidence points to a correct diagnosis of cervical sprain/strain without evidence of radiculopathy as outlined by the aforementioned records. Further, as late as March 2008, Dr. Vilbar's impression remained cervical strain. On 3/24/08, Dr. Frank released Petitioner to return to work again stating he could not find evidence of radiculopathy. The Arbitrator finds that Petitioner reached maximum medical improvement for her cervical strain on 3/24/08.

However, despite being informed there was no evidence of radiculopathy and that she could return to work, Petitioner sought out another opinion. Dr. Vilbar referred Petitioner to Dr. Calimag. Despite diagnosing cervical radiculopathy, Dr. Calimag ordered another EMG/NCV to rule out radiculopathy. Those results again only showed suspicion rather than confirmation of radiculopathy. The Arbitrator's conclusions are also supported by subsequent medical records documenting a lack of radicular findings on new MRIs of the cervical spine. Dr. Ghanayem credibly testified that all of the cervical MRIs were the same and without evidence of structural damage, herniation or radiculopathy. In addition, Petitioner reported no relief following cervical epidural steroid injections, which indicates to the Arbitrator that the non-finding of cervical radiculopathy to be accurate. Given that Dr. Calimag's findings and opinions stand largely in contrast to much of the other conclusions regarding Petitioner's cervical condition, the Arbitrator does not adopt Dr. Calimag's opinion and instead relies on the treatment records of Drs. Vilbar, Matz and Frank and on the opinion of Dr. Ghanayem in concluding Petitioner's cervical sprain/strain is causally related.

Dr. Calimag's conclusion that Petitioner suffers from chronic pain syndrome is also not related to the work injury. Petitioner's plethora of complaints as documented extensively in the record were not explained to be causally related.

Regarding the left arm, records show the initial diagnosis was simply left arm pain. On 6/21/08, Dr. Calimag diagnosed left shoulder tear but there were no diagnostic studies prior to that date confirming same. It was not until one year later that MRI of the left shoulder showed partial tearing. There is nothing in the record to support a conclusion that the left shoulder tear, found more than one year after the date of injury, is causally related. In addition, the Arbitrator notes that ATI and Dr. Domb thought the shoulder was unrelated to work.

In so finding Petitioner's cervical sprain/strain causally related, the Arbitrator specifically concludes that the following conditions are not casually related as they are not supported by Petitioner's testimony, the mechanism of injury, the onset of symptoms and complaints, the history in the medical record nor any credible medical opinion: mid-back/thoracic pain, right arm and shoulder pain and cuff tear, low back pain, lower extremity radiculopathy, chronic plantar fasciitis, bilateral carpal tunnel syndrome, left ulnar sensory neuropathy, fibromyalgia, pain in the hips and knees, osteoarthritis of the hands, restless leg syndrome, jaw pain and Heberden nodes.

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?

Having found Petitioner's cervical sprain/strain pain causally related, the Arbitrator finds that certain treatment for this injury was reasonable and necessary.

According to the medical record, Petitioner initially treated with Dr. Marder at Respondent's clinic at UIC. Respondent shall pay for all casually related treatment rendered by UIC for the cervical spine and left arm up to the date of MMI or 3/24/08. Respondent shall be given a credit for medical benefits that have been paid for UIC, 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.

Petitioner then sought her own treatment within her first chain of physician choice with her primary care doctor, Dr. Vilbar, who in turn referred her to Dr. Matz for an opinion, to an EMG with Dr. Shenker, to Dr. Frank for another opinion, to Dr. Joshi for evaluation and to Dr. Calimag for an additional consultation. Dr. Frank additionally referred Petitioner to ATI for therapy to the cervical spine. Dr. Calimag referred Petitioner to a second EMG/NCV, which he himself performed, to ATI for therapy and to various clinics for MRIs. The Arbitrator finds that the treatment with Dr. Vilbar, Dr. Matz, the EMG/NCV with Dr. Shenker, the consultations with Dr. Frank to be reasonable and necessary in determining the cause of Petitioner's pain and awards those bills. Respondent shall pay for all casually related treatment rendered by Drs. Vilbar, Shenker, Matz and Frank through the date of MMI or 3/24/08, as well as all treatment from ATI for therapy, MRIs and EMG/NCV studies for the cervical spine and left arm through the date of MMI or 3/24/08. Treatment with Dr. Joshi is not awarded as it was for fibromyalgia consultation, which is not causally related. Respondent shall be given a credit for medical benefits that have been paid and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

In reviewing the treatment rendered by Dr. Calimag, the Arbitrator finds that treatment with Dr. Calimag, although within the allowed chain of referrals, is not reasonable or necessary. The evidence shows that Petitioner, dissatisfied with Dr. Frank's opinion that no radiculopathy, that he could find nothing objectively wrong with her and that she could return to work, again sought out another opinion. Given that the Arbitrator has concluded that petitioner suffer nothing more than a cervical strain, any and all treatment with Dr. Calimag, including any referrals for treatment he made thereto, is not causally related, reasonable or necessary. In so concluding, the Arbitrator finds that Dr. Calimag's treatment, recommendations and follow up, in relevant part, were based upon a faulty diagnosis of cervical radiculopathy. The Arbitrator further finds that Petitioner reached maximum medical improvement on 3/24/08, the date in which Dr. Frank opined he could find no objective evidence of radiculopathy and released her to work.

Petitioner also treated with Dr. Hofmaier, which would constitute her second choice of physician. There, she received chiropractic treatment from 1/28/08-5/23/08 for various areas, including the cervical spine, upper left arm and right arm. Respondent shall pay for all casually related treatment rendered by Hofmaier to the cervical and left arm/shoulder/upper arm only through the date of MMI or 3/24/08. 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.

Petitioner also treated with Dr. Phetchamphone, for which no referral exists and therefore outside the allowed chain of referrals under the Act. Similarly, no referral is found for treatment with Drs. Domb, Vakeel, Frankel, Goldberg and Pahwa. The record indicates some of these doctors referred Petitioner back to ATI for therapy treatment, which is also outside the chain of referrals. Respondent is not liable for any outstanding balances associated with treatment beyond the chain allowed.

ISSUE (K) What Temporary Benefits Are In Dispute?

The Arbitrator finds that Petitioner suffered strain to her cervical spine and left arm pain following the accident. The Arbitrator finds the opinions of Dr. Frank and Dr. Ghanayem to be consistent with the medical evidence. Here, Petitioner reached maximum medical improvement on 3/24/08, the date in which Dr. Frank opined he could find no objective evidence of radiculopathy and released Petitioner to work. Both Dr. Ghanayem and Dr. Frank found no structural damage to the Petitioner's cervical spine. Dr. Frank found the Petitioner could return to work full duty as of 3/24/08.

Therefore, Respondent shall pay Petitioner temporary total disability benefits of **$1,164.37**/week for **8-4/7th** weeks, commencing **1/25/08** through **3/24/08**, as provided in Section 8(b) of the Act. Respondent shall be given a credit for benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Regarding maintenance benefits, the Arbitrator denies same, having found Petitioner reached maximum medical improvement as of 3/24/08 and was able to return to work without restriction for the cervical sprain/strain as of that date.

ISSUE (L) What Is The Nature And Extent Of The Injury?

Having found that Petitioner reached maximum medical improvement for her cervical sprain/strain on 3/24/08, the date in which she was released by Dr. Frank, Petitioner's claims are ripe for adjudication of permanency if any. The Arbitrator incorporates the medical records and relies on same in finding that Petitioner's cervical strain had improved substantially by the time of her release with Dr. Frank. Specifically, records from UIC showed Petitioner reported 75% improvement and the left arm/shoulder and neck were reported pain free. Objectively, the nurse practitioner found hand grasp was 5/5 bilaterally, full range of bilateral shoulders was noted, strength was 5/5, and tenderness to palpation over the cervical and thoracic spine areas, left and right sided scapular pain, tenderness to palpation over the right AC joints and no tenderness to palpation over the left shoulder.

Petitioner testified that she has been unable to return to work. However, Dr. Frank released her to full duty work as early as 3/24/08. The Petitioner failed to prove that she was entitled to a wage differential award. The Petitioner failed to prove that she was entitled to maintenance benefits. Petitioner also failed to prove that she suffered a loss of occupation as it relates to her cervical sprain/strain. The Petitioner did testify that she voluntarily retired upon speaking to someone at SURS. Petitioner also stated that she receives retirement benefits from SURS. Therefore, Respondent shall pay Petitioner permanent partial disability benefits of **$636.15/week** for **17.5 weeks**, because the injuries sustained caused the **3.5%** loss of the person as a whole, as provided in Section 8(d)2 of the Act.

ISSUE (M) Should Penalties Or Fees Be Imposed Upon Respondent?

The Respondent was not unreasonable or vexatious in denying the claim. Petitioner's medical histories, somewhat incomplete at first glance, provide a sufficient basis for Respondent to deny the claim based on accident. Further, Petitioner's medical record was extensive and unable to conclude anything beyond a cervical sprain/strain and left arm pain following her accident. Respondent had a reasonable basis to dispute the claim based on causal connection.

Furthermore, the Petitioner received SURS benefits, on which the Arbitrator relies on in finding that Respondent's conduct was not unreasonable or vexatious. Ax1. *Hull v. Illinois*, 2008 Ill. Wrk. Comp. LEXIS 388 (March 26, 2008). Therefore, Petitioner's petition for penalties and attorneys fees is ***denied***.

Signature of Arbitrator

12-11-15
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

Patricia Johnson,

Petitioner,

vs. NO: 06 WC 31245

16IWCC0650

City of Chicago,

Respondent,

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 8, 2015 is hereby affirmed and adopted.

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

DATED: OCT 6 - 2016

MB/mam
o:9/29/16
43

Mario Basurto

David L. Gore

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
SECOND CORRECTED

JOHNSON, PATRICIA
Employee/Petitioner

Case# **06WC031245**

16IWCC0650

CITY OF CHICAGO
Employer/Respondent

On 10/8/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.53% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5614 LAW OFFICE OF CAMERON B CLARK
203 N LASALLE ST
SUITE 2100
CHICAGO, IL 60601

0113 CITY OF CHICAGO-LAW DEPT
ELIZABETH MANNION
30 N LASALLE ST SUITE 800
CHICAGO, IL 60602

e

FSSTATE 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
SECOND CORRECTED

Patricia Johnson
Employee/Petitioner

v.

Case # 06 WC 31245

16IWCC0650

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 **David Kane**, Arbitrator of the Commission, in the city of **Chicago, Illinois**, on **July 20, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **4/5/2006**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the 4/5/2006 injury, Petitioner earned **$39,402.89**; the average weekly wage was **$757.75.**

On the date of 4/5/2006 accident, Petitioner was **49** 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 **$219.72** for TTD, **$00.00** for TPD, **$00.00** for maintenance,

and **$00.00** for other benefits, for a total credit of **$00.00.**

Respondent is entitled to a credit of **$292.50** under Section 8(j) of the Act.

With respect to petitioner's claims of injuries to her right ankle, the Petitioner is entitled to have and receive from Respondent $454.65/week for 8.35 weeks, representing 5% loss of use of the right foot, as provided in Section 8(e) of the Act.

With respect to petitioner's claims of injuries to her left wrist, the Petitioner is entitled to have and receive from Respondent $454.65/week for 30.75 weeks, representing 15% loss of use of the left hand, as provided in Section 8(e) of the Act.

Respondent shall receive the stipulated credit of $219.72 for TTD overpayment.

Respondent shall resolve medical bills to Illinois Bone and Joint related to the left wrist only up to date of service September 17, 2009, pursuant to Section 8.2 of the Act, and shall receive a credit for payments made including those under group health insurance 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.

David A. Kane
Signature of Arbitrator

December 8, 2015
Date

DEC 8 - 2015

FINDINGS OF FACT: 16IWCC0650

The parties stipulate that the City of Chicago (hereinafter referred to as the "Respondent") was operating under the Illinois Workers' Compensation Act on April 5, 2006. On said date, Patricia Johnson (hereinafter referred to as the "Petitioner") sustained accidental injuries that arose out of and in the course of her employment with the Respondent. On this date she was a water quality engineer for the City of Chicago's Department of Water Management, when she injured her left wrist and right ankle.

Parties proceeded to hearing on July 20, 2015, with disputed issues as to causation and nature and extent of Petitioner's injuries, and medical bills.

Petitioner testified that on the date of incident, Petitioner was carrying equipment while walking down uneven concrete stairs when she fell, injuring her right ankle and left wrist. Petitioner reported to Mercy Works that day, where she was diagnosed with "contusion and strain, left wrist and right ankle." (Px 1, p. 2-3). On April 12, 2006, Petitioner was released full duty by Dr. Arnold at Mercy Works and advised to return as needed. (Px 1, p. 3).

Petitioner worked for the following two months and returned to Mercy Works on June 6, 2012. At this time, the medical records reflect Petitioner's right ankle had "normal active range of motion" with "no pain on palpation." (Px 1, p. 4). At this time, Petitioner also reported no pain on palpation and active range of motion in her left wrist. (Id.). Petitioner participated in occupation therapy for her hand, and was kept at full duty. (Px 1, p. 5-6).

Petitioner continued to work full time throughout her treatment. By July 2006, Petitioner reported an improvement in her left wrist. (Px 1, p. 5).

16IWCC0650

Petitioner had two MRIs done on her left wrist, the first on June 30, 2006 and the second on September 15, 2006. (Px 2, Px 4). Petitioner also sought treatment with Dr. Heller, and followed up with a second opinion with Dr. Baxamusa at Illinois Bone & Joint for possible surgical intervention for her left wrist. On July 27, 2006, Dr. Baxamusa reviewed the diagnostics and opined that although Petitioner's MRI "does show some irregularity in the lunate, it is not clearly indicative of Kienbock disease." His impression was left wrist injury with possible ulnar impaction. (Px 3). She continued to treat with Dr. Baxamusa, who gave her a corticosteroid injection to her left wrist on August 10, 2006. (Px 3). On September 21, 2006, Dr. Baxamusa changed his impression of the injury to "left wrist Keinbock disease." (Px 3). Petitioner's medical records reflect she was in a "fender bender" motor vehicle accident around June 2007, but did not report any pain or injuries the following month. (Px 3). Petitioner continued with follow visits and working full time for the Respondent.

Dr. Baxamusa noted on September 17, 2009, that "the Patient stated that she is essentially doing well with her symptoms well controlled and her range of motion well maintained with the restrictions in place." Dr. Baxamusa kept Petitioner at a medium-duty work restriction, and Petitioner reported that her symptoms "are actually well controlled and that she is not interested in any surgical intervention at this time." (Px 3). On this date, Petitioner also advised Dr. Baxamusa that she occasionally notices some waxing and waning of her symptoms, but "she is really essentially pain free" with the restrictions. (Id.)

Petitioner saw Dr. Jay Levin on April 24, 2013 for an independent medical examination at the Respondent's request. (Rx 1). Dr. Levin examined Petitioner and reviewed the medical records, and found Petitioner had Kienbock changes in her right wrist, which was not injured at all in the work incident, and opined "Since it is bilateral and the contralateral right wrist was not injured at all in the April 5, 2006 occurrence, this Kienbock disease may be unrelated to any trauma." (Rx 1). Dr. Levin continued that it was his opinion that the left wrist disease until proven otherwise with serious x-ray review is related by aggravation or causation to the April 5, 2006 incident. He further continued that there is a possibility "that her Kienbock disease may very well have come on absent any trauma, which occurs with this diagnosis." (Rx 1). Dr. Levin found Petitioner was at MMI and based on her job duties, she could perform her job in a full duty capacity. (Id.).

Petitioner also went to an independent medical examination with Dr. Jeffrey Coe at the request of Petitioner's counsel on May 31, 2011. (Px 5). Dr. Coe opined that there was a causal relationship between the injuries suffered by Petitioner and her current symptoms to her left wrist and right ankle. Dr. Coe also commented on causation with regard to Petitioner's knees, which Petitioner did not testify to permanency to and is not claiming as related. Almost 6 months following her last visit regarding her right ankle, on September 25, 2006, Petitioner began treating for bilateral ankle pain, unrelated to the underlying work incident, as medical records reflect that pain began the prior month, when a shopping cart ran over her left foot. (Px 3).

Petitioner testified on the date of trial that she did not have any outstanding surgical recommendation for her left wrist. Petitioner has not had any treatment for her claimed injuries since 2009. She is working full duty within

her job description full time. She has no treatment scheduled for the claimed injuries as of the date of trial. She testified she is not on any prescription pain medication, and takes herbal store bought remedies for the wrist inflammation. Petitioner testified to ongoing issues in her left wrist and right ankle only. She testified to swelling in her right ankle which she ices. She also testified that she notices she cannot consistently driving with her left hand, although she admits she is right-handed and has no restrictions on her driver's license.

Petitioner did not miss time from work and is not claiming TTD as a result of this incident. Parties stipulated that Respondent is entitled to an overpayment of TTD for three days in the amount of $219.72.

CONCLUSIONS OF LAW:

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

Based on the testimony and medical records admitted into evidence, it appears Petitioner's current condition of ill-being to her left wrist and right ankle are causally related to the work incident of 4/5/06. Petitioner complained of pain to these body parts immediately following the incident and sought treatment at Mercy Works as a result.

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

Based on the evidence, medical records, and Petitioner's testimony, Petitioner's injury to her right ankle as a result of the April 5, 2006 incident was that of a resolved contusion/ankle strain. Petitioner reported an improvement in symptoms to her left ankle the following week on April 12,

2006, where she had "right ankle normal active range of motion no pain on palpation." When she returned to Mercy Works two months later, she had no complaints to her ankle, only her left wrist. The only additional ankle complaints in the records came several months later, which involved bilateral ankle complaints (primarily to the unrelated left ankle), which Petitioner related to a shopping cart incident in the records on September 25, 2006. Petitioner sustained a resolved right ankle strain as a result of the work incident.

16IWCC0650

With regard to Petitioner's left wrist, this arbitrator finds that Petitioner's left wrist condition was aggravated by the work incident of April 5, 2006. The medical records and IME report of Dr. Levin note that the condition of Kienbock Disease exists in both the injured left wrist and the unrelated, uninjured right wrist, but Petitioner exhibited complaints in her left wrist following the incident as a result. Petitioner treated with one injection and through occupational therapy. She does not have a current surgical request outstanding for her wrist. Petitioner has not had a doctor's appointment or treated for her left wrist since July 2009. Petitioner testified to some difficulty using her left wrist for certain tasks. Petitioner continues to work full duty within her job description at the same position with the Respondent. Petitioner did not sustain any loss of earning capacity as a result of the injury. Petitioner is right-handed.

With respect to petitioner's claims of injuries to her right foot, the Petitioner is entitled to have and receive from Respondent $454.65/week for 8.35 weeks, representing 5% loss of use of the right foot, as provided in Section 8(e) of the Act.

With respect to petitioner's claims of injuries to her non-dominant left wrist, the Petitioner is entitled to have and receive from Respondent $454.65/week for 30.75 weeks, representing 15f% loss of use of the left hand, as provided in Section 8(e) of the Act.

16IWCC0650

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

Petitioner seeks payment of medical bills to Illinois Bone and Joint related to the left wrist up to the amount of $2,952.00. Respondent submitted proof of payments made through Workers' Compensation and group insurance. Petitioner's medical records and testimony reflect she last treated with Illinois Bone and Joint for her left wrist on September 17, 2009. This Arbitrator finds that treatment up to September 17, 2009 for the left wrist is reasonable and related. Respondent shall receive a credit for all payments, including those under Worker's Compensation and group insurance, and shall resolve the remaining balances up to DOS September 17, 2009 for the left wrist directly to the provider per the Fee Schedule.

Regarding (N) Is Respondent due any credit?

Respondent shall receive a stipulated credit of $219.72 for a TTD overpayment.

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STATE OF ILLINOIS)
) SS.
COUNTY OF DUPAGE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

John Patralski,
Petitioner,
vs.
NO: 15 WC 13359

YRC Worldwide,
Respondent,

16IWCC0651

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 18, 2016, 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: OCT 6 - 2016
o092916
DLG/mw
045

David L. Gore

Mario Basurto

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

PATRALSKI, JOHN
Employee/Petitioner

Case# **15WC013359**

16IWCC0651

YRC WORLDWIDE
Employer/Respondent

On 2/18/2016, 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 0.41% 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:

2333 WOODRUFF JOHNSON &PALERMO
RUSSELL HAUGEN
4234 MERIDIAN PKWY SUITE 134
AURORA, IL 60504

0766 HENNESSY & ROACH PC
ERIN FIORE
140 S DEARBORN ST 7TH FL
CHICAGO, IL 60603

STATE OF ILLINOIS)
)SS.
COUNTY OF DuPage)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

John Patralski
Employee/Petitioner

v.

YRC Worldwide
Employer/Respondent

Case # **15** WC **13359**

Consolidated cases: ____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Jessica A. Hegarty**, Arbitrator of the Commission, in the city of **Elgin**, on **October 6, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

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

Timely notice of this accident *was not* given to Respondent.

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

In the year preceding the injury, Petitioner earned $**70,266.19**; the average weekly wage was $**1,351.27**.

On the date of accident, Petitioner was **62** 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 $**0** for other benefits, for a total credit of $**0**.

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

ORDER

- Petitioner failed to prove by a preponderance of the evidence that his accident arose out of and in the course of his employment with Respondent. Accordingly, no benefits are awarded.

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

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

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

Signature of Arbitrator

2/16/16
Date

FEB 1 8 2016

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

STATE OF ILLINOIS)
) SS
COUNTY OF DUPAGE)

JOHN PATRALSKI, Petitioner,

v.

YRC WORLDWIDE, Respondent.

No. 15 WC 13359 ELGIN

ADDENDUM TO THE DECISION OF THE ARBITRATOR

This matter was presented for hearing before Arbitrator Jessica A. Hegarty on October 6, 2015 in Elgin, Illinois pursuant to sections 19(b) and 8(a) the Illinois Workers' Compensation Act. (Arb. Ex. 1)

The issues in dispute are:

- Accident
- Causal connection
- Notice
- Medical bills
- TTD
- Prospective medical treatment

FINDINGS OF FACT

Petitioner testified that on April 1, 2015, he was employed by Respondent as an overnight truck driver, and had been so employed for 10 years. At that time, he was 5'7" or 5'8" and weighed approximately 162 pounds. He testified that his typical route was dispatched from his home base terminal in Montgomery, Illinois, he would then drive freight to Akron, Ohio, stay over in Akron for rest and then return to Montgomery, Illinois. He had some other routes previously but that he had been doing

the Montgomery to Akron, return to Montgomery, route exclusively for the last three years.

YRC employees who stay over in Akron on rest are housed at a Clarion Hotel. It is undisputed that the Clarion Hotel sleeping arrangements are organized by YRC and paid for by YRC. The Clarion provides a shuttle that picks the employees up at the Akron terminal and it drives them to the hotel.

Petitioner testified he first met Mr. Paul Howe (hereinafter "Howe") approximately four months prior to the April 1, 2015, altercation. He testified that he had been telling a story to other YRC employees about a time he went to Sturgis, where he had so much fun with his lady, and Howe made fun of the way he said the name "Sturgis," like he said it "stooges."

Petitioner testified that on April 1, 2015, he was in Akron, had completed his trip and was checking into the Clarion Hotel for rest. He saw a couple other YRC employees in the lobby, said "hello" and noted that Howe was situated by the pool table area drinking a beer. On cross examination, Petitioner testified he does not socialize with other co-workers, but does get along with everyone but Howe. He checked into his room, unpacked his things, and settled in for approximately 45 minutes. He then went to the ice machine to get ice to keep his water and food cold. He testified that he does not eat out while he is on the road because he previous had food poisoning.

Petitioner testified that he stepped out of his room to get ice and he saw Howe coming from the ice machine. Howe bumped into him with his elbow, Petitioner tried to go around him, and he could not because Petitioner was too big. On cross examination, Petitioner testified that the hallway is four to five feet wide and that Howe extended his elbow so that he could not get around him, although there is room for two people in the hallway. Petitioner then said, "That's it, I'm going to report you to the supervisor". Howe replied, "Let's get it over with," pushed him into his room and hit him in the face. Petitioner did not know how many times he was hit because he was dizzy and Howe was trying to kill him. His glasses then fell off, and as he was bending over to get them, Howe put him in a choke hold. Petitioner began losing air and as he was trying to pull Howe's forearm away from his neck, Howe pulled his little finger and it popped. He said, "You broke my finger." Petitioner then noticed a gap in the door because the door stop was still on and he yelled for help. He stated he heard voices and could tell that a hotel employee had come because of his shoes. Eventually, the police arrived while he was still on the ground in a choke hold.

Petitioner testified that he gave a statement to the police that was exactly what he testified to in court. He testified that he never said he shouldered by Howe. He further testified he could not talk well at the time the police were there because his tongue was swollen.

Respondent called Howe as its witness. Howe testified that he is 6'3" and weighs 265 pounds. Howe testified that he met Petitioner for the first time about one month prior to the April 1, 2015, altercation. At that time, they were waiting for the shuttle bus to the Clarion in a room with about 12 other employees. Petitioner was talking to some of the other employees about motorcycles and Harley Davidsons, of which Howe has interest because he owns motorcycles as well. He heard Petitioner bragging about picking up chicks with his motorcycle. Howe then joined the conversation and inquired if Petitioner had any pictures of the chicks that he picks up. Petitioner then began scrolling through his phone, abruptly stopped and said "F you," and "I'll kick your ass." At some point during that conversation, there was also mention of Petitioner going to Sturgis. Howe admitted he had made fun of how Petitioner said Sturgis because he cannot pronounce it. That conversation at some point ended. The parties went their separate ways and they both checked into the Clarion Hotel later that day.

Howe testified that while at the Clarion, he ran into Petitioner while getting ice. He testified that he attempted to apologize, and told Petitioner I apologize, let's start over. Howe then extended his hand to Petitioner as part of the apology and Petitioner refused to accept his handshake. Howe did not take Petitioner's previous threat "to kick his ass" seriously because kicking someone's ass over pictures of chicks was silly. Howe felt it was necessary to apologize because he knew Petitioner was upset about what he had said before.

On rebuttal, Petitioner testified that the first incident Howe described above never happened. He also testified that Howe never apologized to him. Petitioner later admitted that the first incident had in fact occurred, but nothing was said about chicks, and that he did not think that it was nice that Howe had picked on him for how he says Sturgis.

Howe testified as to the altercation in the hallway. According to him, he had checked into the Clarion on the day of Petitioner's alleged accident. He testified that he was never playing pool that day or in the area by the pool table. He checked into his room and went to get ice like he usually does for his fruit and water. As he was walking back, Petitioner popped out of a room. Howe clarified that "popped out" meant that Petitioner quickly entered the hallway while his hands were full, carrying the bag of ice like a baby. When Petitioner popped out, he immediately cracked Howe. Howe then said, "What the F was that?", and Petitioner replied, "Come on M-F'er, let's go." They got into a wrestling match in the hallway and then somehow ended up in the hallway of Petitioner's room. Howe was trying to restrain Petitioner when he noticed Petitioner's head was bleeding. On cross-examination, Paul testified that they were facing each other and he believes Petitioner's head hit the ground which caused Petitioner's head to bleed. At that point, Howe asked Petitioner if he had enough, that he would let him go, and Petitioner replied "Yes." As Howe released Petitioner, he

cracked him again in the face. Howe had to continue to restrain Petitioner, which he described as having his arms around Petitioner's neck, but not in a traditional choke. He continued to restrain Petitioner until the police came, which was approximately five to ten minutes. Howe also sustained injuries, which he documented in photos he took on April 1, 2015. RX3. The pictures show a swollen top lip and scratches to the back of the head and forearm. Id.

Upon the police's arrival, the two were split up. Howe testified that the police threatened to taser Petitioner if he did not calm down and actually had a Taser touching Petitioner's body. Both Petitioner and Howe denied any previous contact with the responding officers. Howe testified that he was asked if he had been drinking and he answered "no". He also testified that he heard the police officer ask Petitioner if he had been drinking and Petitioner answered "yes". On cross examination, Petitioner testified he could not recall if he was asked about drinking, but that he never drinks. This Arbitrator notes that Ms. Aleta Butler (herein Butler), his girlfriend of 21 years, testified that Petitioner drinks beer approximately twice a month.

Boston Heights police officer John Stirm, Chief Heatwell and officer Chad McArdle arrived on the scene responding to a fight involving two subjects. Officer Stirm noted he met with "one of the combatants, a white male with a cut over his left eye" who was subsequently identified as John Z. Patralski. Id. Officer Stirm interviewed Petitioner noting the following:

> Patralski stated that he went to the ice machine in the hall outside his room. As he was walking back to his room he encountered Paul W. Howe, who began teasing him about his accent. Patralski further stated that Howe was standing in front of him, and therefore he 'shouldered' him to get by. As he did so, Howe punched him. During the scuffle, the two fell into Room No. 268. As Patralski fell, he struck his head on the door frame just inside the room. As a result, Patralski suffered a cut over his left eye. Valley Fire responded to the scene and transported Patralski to Sagamore Hills Medical Center for treatment. Id.

Officer Stirm further noted that, "Throughout the interview, Patralski was vague and very brief with his answers. He also moved from topic to topic making it difficult to obtain his version of events." Id.

The report further documented Officer McArdle's investigative note in which he recorded the following:

> I was dispatched to respond to room #268 at the Clarion Inn in regards to an active fight between two males entangled with each other on the floor. The suspects were separated. Id. The officer documented the following noted with respect to his interview with Howe:

> Mr. Howe advised that he left his room (No. 279) to get ice for his room. When walking back to his room, he encountered Mr. Patralski in the hallway. Mr. Howe advised that he went to step around Mr. Patralski when Mr. Patralski "shouldered" him, at which time they fell into Mr. Patralski's room (No. 268). Mr. Howe advised that punches were exchanged inside the room, at which time Mr. Howe advised that he then restrained Mr. Patralski. Mr. Howe advised that he restrained Mr. Patralski until Officers ordered him to let go. Mr. Howe advised that he didn't want to press charges against Mr. Patralski. Id.

On cross examination, Howe stated he did not remember saying he stepped around Petitioner. Regardless, he testified that Petitioner was the one who made the first physical contact with him.

There is no evidence in the record that either Petitioner or Howe pressed charges against each other.

Howe was questioned as to how and why he appeared at trial. He testified that although there is a general comradery between union brothers, and that he has never testified against another union brother previously, that this instance is different due to Petitioner's vicious attack. On cross-examination, Howe was asked whether he was subpoenaed to testify. He answer that he was not, and that he paid for his own travel to Chicago, from his home of New York, to testify, but hopes that he will be reimbursed by Respondent for the travel.

UH Valley Fire District records note that an ambulance arrived on the scene at 10:55:00 hours on April 1, 2015 where Petitioner, noted to be 62 years of age and 170 pounds, was transported to South Point Emergency Room. The ambulance records indicate:

> A+OX3 denies LOC, neck or back pain or dizziness. Pt. has a 1" laceration over his lt. eye, bleeding controlled. Pt. also sts. his lt. pinky finger is sore. Pt. stated he was assaulted with fists and was not struck by any other objects. Pt. denies alcohol or drugs. Pt. stated that he was attached because of his nationality. (PX1).

Medical records from South Point Hospital indicate that Petitioner was treated and diagnosed for a left pinky finger dislocation and eyebrow laceration. (PX2). The laceration was noted to be 1 cm in length over the left eyebrow and was given three sutures. Id. The dislocation was reduced and splinted. Id.

Petitioner initially treated at Fox Valley Orthopaedic Institute. (PX5). He was evaluated on April 9, 2015 by Dr. Max Berdichevsky. Id. He complained of left neck and shoulder pain. Id. He was given a buddy strap, a cervical collar, and an MRI of the cervical spine

was ordered. Id. The doctor advised against driving as Petitioner could not make his shoulder check with the neck collar. Id. The work status slip indicates no driving and C-collar. Id. On April 10, 2015, Petitioner followed up for his finger. Id. The buddy straps had caused maceration to the ring and little fingers. Id. The doctor recommended a dorsal blocking splint, therapy and Petitioner was to follow up in two weeks. Id. A letter was sent to Petitioner on May 20, 2015, saying he had not followed up and is non-compliant with his finger care. Id.

On May 22, 2015, Petitioner returned to Dr. Berdichevsky with complaints of headaches, dizziness and a popping in his neck. Id. The doctor noted the lights were dimmed and Petitioner appeared to be having a severe headache. Id. The doctor recommended ambulance transport to the emergency room, which Petitioner refused and indicated he would drive on his own. Id. The doctor documented that he called Petitioner later to check, and Petitioner advised he went home to rest. Id. Petitioner then went to Delnor Community Hospital on May 23, 2015 where he reported migraines and blurred vision since an assault in April. (PX4) He underwent a CT of neck which revealed cervical spondylosis with no fractures or mal-alignment. Id. He also underwent a CT if the head which revealed no acute intracranial hemorrhage but underlying sinus disease. Id. The diagnosis was cervical sprain and post-concussive syndrome. Id.

Petitioner testified he was referred to a Dr. Ronald Bukowy from the emergency room. He was evaluated on June 1, 2015, and complained of headaches, dizziness, issues with word pronunciation, difficulty focusing attention and neck pain. (PX8). He reported the injuries came from an altercation on April 1, 2015, where the other person hit his head against the floor multiple times. Id. He did not like the medication from the emergency room because it was sedating. Id. The doctor diagnosed post-concussive syndrome and post-traumatic migraine headaches, recommended a VNG, EEG and MRI of the brain and prescribed Depakote for migraines. Id. The MRI was administered on June 12, 2015, and showed no acute findings, but chronic white matter and mircroangiopathic changes. (PX4). The EEG of June 9, 2014, was normal and the VNG of June 24, 2015, showed central vestibular dysfunction. (PX8). Petitioner followed up with Dr. Bukowy on June 26, 2015, and advised he had not taken the full dose of Depakote for fear of side effects. Id. The doctor reviewed the diagnostic tests and said Petitioner did not need medications. Petitioner requested medications and was switched to Topamax. Id. Petitioner continued to complain of headaches at the July and August visits and the doctor reviewed medication management. Id. Petitioner reported he did not feel safe to drive. Id. Petitioner testified that he attended an appointment on September 23, 2015, and was recommended to undergo vestibular therapy, of which he attended one session. (PX11).

On June 12, 2015, Dr. Berdichevsky noted that he believed Petitioner had more of a head issue and deferred treatment to Dr. Bukowy. (PX7). Petitioner continued to complain of neck pain and an MRI of the cervical spine was re-ordered. Id. That MRI revealed (1)

multilevel mild facet arthrosis and mild to moderate spondylotic change with several broad-based disc osteophyte complexes; (2) multifactorial mild to moderate spinal stenosis, most notably at C4-5; (3) multilevel foraminal stenosis, most advanced at C4-5 on the right. Id. Dr. Berdichevsky reviewed the results on July 7, 2015, recommended against surgery and encouraged Petitioner to follow up with Dr. Bukowy. Id.

Petitioner participated in physical therapy at ATI, ending on August 6, 2015, for his neck. (PX9).

Petitioner testified as to his current condition. He is taking medicine but it makes him forgetful. He takes Topamax for his migraines, muscle relaxers and Norco for pain. He states that he still has headaches but that they are controlled with medications. His neck is stiff. His pinky finger has returned to normal and he has no pain. He states he never had any prior migraines or neck pain. He has also suffered no subsequent injury. Butler testified that she has noticed Petitioner is more scatterbrained now and likes to spend more time outside.

Petitioner testified that he has never returned back to work for YRC and that he was never offered light duty work. He testified that his claim was denied by Sedgwick , Respondent offered the notice of denial, dated April 17, 2015, as its Exhibit 1.

None of Petitioner's medical bills have been paid. Petitioner submitted a medical bill summary which indicates there are $27,405.09 in outstanding charges. (RX12).

Petitioner testified that he attended a meeting on April 6, 2015, in which he gave a statement that was recorded by someone else as he could not write due to his hand injury. (RX4). Petitioner confirmed Respondent's Exhibit 4 accurately described what transpired in the meeting. This written statement conforms substantially to what Petitioner testified to at trial. However, the statement states, in part:

> Ran into other employee. John was elbowed in the hall while passing. John stated this is the last time, I will report you to the company. Then the other employee stated let's get it over with once and for all. Then John was pushed into room 268 and the other employee tried to close the room door. Then John was punched in the face.

Per the statement, Petitioner had left shoulder pain, stiff neck, four stitches above the left eye and a possible dislocation of his left pinky finger at the time of the recording.

Petitioner was subject to disciplinary action by his union. Bob Hesse (hereinafter "Hesse"), called as Respondent's witness, testified that the above meeting was part of the investigation done by Respondent. The written statement from April 6, 2015, indicates that Petitioner had been taken out of service pending investigation at that

time. Hesse testified that Petitioner was not eligible to return to work until certain requirements were met pursuant to his union settlement. Mr. Mike Albiniak (hereinafter "Albiniak"), Labor Relations Manager for YRC, testified that as part of his job he investigated the altercation and alleged work accident. He testified that he did not recommend moving to a full discharge hearing but instead agreed to settle outside of the hearing. Albiniak's recommendation was that Petitioner participate in anger management. This recommendation was based on the history of Petitioner known to him, which involved two prior discharges, in part for reckless driving, (RX6), and an allegation of reckless driving from April 1, 2015, immediately prior to the altercation. Those prior incidents, in conjunction with the altercation, led Albiniak to believe that Petitioner had anger issues and could benefit from an anger management program.

Hesse testified that there is sedentary and light duty work available at the Montgomery terminal for employees out on workers' compensation claims. He also testified that he could not offer light duty work to Petitioner as his claim was denied.

Petitioner testified as to no disciplinary action during his direct examination and was evasive as to whether he even recalled a meeting with the union or receiving any disciplinary actions. When Petitioner eventually admitted to the settlement terms from his disciplinary action, he was asked whether he had attended anger management. Petitioner responded that he is not angry. When asked repeatedly whether he had taken an anger management course, he admitted he had not.

CONCLUSIONS OF LAW

Accident

The burden is on the Petitioner seeking an award to prove by a preponderance of credible evidence all the elements of his claim, including the requirement that the injury complained of arose out of and in the course of his employment. Martin v. Indus. Comm'n, 91 Ill.2d 288, 437 N.E.2d 650 (1982). Petitioner has not met his burden and this Arbitrator finds that the injuries of April 1, 2015, did not arise out of and in the course of his employment with Respondent.

In altercation cases the "arising out of" analysis turns to, first, whether the fight was in some way connected to the injured worker's employment. Thurber v Indus. Comm'n, 49 Ill.2d 561, 276 N.E.2d 316 (1971). Petitioner must prove by a preponderance of evidence that his work injury arose out of and in the course of his employment rather than a purely personal dispute. To establish that his injuries "arose out of" his employment, Petitioner must prove that there was some connection between the injury and conditions under which work was to be performed. Board of Trustees of the University of Illinois v. Indus. Comm'n, 44 Ill.2d 207, 214, 254 N.E.2d 522 (1969); see

also Hansel & Gretel Day Care Center v. Indus. Comm'n, 215 Ill.App.3d 284, 574 N.E.2d 1244 (1991).

Petitioner did not prove any connection between the altercation and his work duties. The police report, initial medical records, interviews with his union and Petitioner's own trial testimony established that Petitioner was teased about his accent. Petitioner's accent is personal to him and in no way related to his job or the performance of his job duties.

Illinois courts have long held that fights arising out of a personal nature are not compensable. See e.g. Chicago Hardware Foundry Co. v. Indus. Comm'n, 393 Ill. 294, 65 N.E.2d 779 (1946) (accident did not arise out of his employment when a suspected co-worker's alleged motive for assault was due to divorce of a family member from the Petitioner); Thurber v. Indus. Comm'n, 49 Ill.2d 561, 276 N.E.2d 316 (1971) (truck driver assaulted by a co-worker with a metal bar for unknown reasons did not suffer an accident which arose out of his employment); Pazara v. Indus. Comm'n, 81 Ill.2d. 76, 405 N.E.2d 767, (1980) (Petitioner who was attacked by a co-worker with a history of anger issues did not suffer an accident which arose out of his employment); Huddleston v. Indus. Comm'n, 27 Ill.2d. 446, 189 N.E.2d 353 (Petitioner who was assaulted by a co-worker regarding a parking space did not prove his accident arouse out of his employment).

It is undisputed that Petitioner and Howe do not work together and have never worked together. Their only interaction is at the Akron terminal when they have completed their routes and were waiting for their rest period, or at the hotel during their rest period. None of the testimony or evidence produced at trial indicates that there were any issues between Howe and Petitioner regarding routes, completion of work or any other work related matter.

This Arbitrator notes that Petitioner referenced being made fun of for his nationality multiple times. Nothing in the record supports a finding that Petitioner was teased for his nationality, ethnicity or race, and the accident, therefore, is not compensable. See Rodriguez v. Indus. Comm'n, 95 Ill.2d 166, 447 N.E.2d 186 (1982). In Rodriguez, the court held that the Petitioner's injuries arose out of his employment because the assault by a co-worker was predicated solely on the claimant's Mexican heritage – the two parties had not even met each other until the day of the assault. Id. at 171-172. The court reasoned that an assault based on racial or ethnic prejudice is akin to an assault from an insane or drunken co-employee. Id. at 172. The facts of the instant case are distinguishable. There is no evidence of anger, discrimination or animus based on nationality or ethnicity other than Petitioner's testimony. Petitioner did not testify what his nationality was, nor how Howe had allegedly assaulted him based on his nationality. Instead, the evidence shows that Howe had teased Petitioner regarding

some personal incidents. Additionally, Howe's actions, even taken in the light most favorable to Petitioner, cannot be analogized to those of a drunken or insane co-worker.

Even if Petitioner could establish that the altercation was in some way connected to his employment, the evidence establishes that Petitioner was the initial aggressor.

Injuries caused by fighting may be compensable where the altercation is work-related, provided that the injured party was not the initial aggressor. Ford Motor Co. v. Indus. Comm'n, 78 Ill.2d 260 (1980). On the other hand, injuries will not be treated as compensable where the injured worker was the initial aggressor. Graphic Group & KLW, Inc. v. Indus. Comm'n, 167 Ill.App.3d 1041, 522, N.E.2d 128 (1st Dist. 1988). The courts have held that there can only be one initial aggressor in an altercation. Franklin v. Indus. Comm'n, 341 Ill.App.3d 128 (1st Dist. 2003). Finally, the question of who is the first aggressor does not turn on who initiates the first physical contact because the first aggressor can be the person whose antagonistic words caused the altercation. Ford Motor Co., 78 Ill. 2d 260.

In the instant case, the initial aggressor analysis boils down to credibility. The Illinois Supreme Court has held that a claimant's testimony standing alone may be accepted for the purposes of determining whether an accident occurred. However, that testimony must prove credible. Caterpillar Tractor v. Indus. Comm'n, 83 Ill.2d 213, 413 N.E.2d 740 (1980). In addition, a claimant's testimony must be considered with all the facts and circumstances that might not justify an award. Neal v. Indus. Comm'n, 141 Ill.App.3d 289, 490 N.E.2d 124 (1986). Uncorroborated testimony will support an award for benefits only if consideration of all facts and circumstances support the decision. See generally, Gallentine v. Indus. Comm'n, 147 Ill.Dec 353, 559 N.E.2d 526, 201 Ill.App.3d 880 (2nd Dist. 1990), see also Seiber v. Indus. Comm'n, 82 Ill.2d 87, 411 N.E.2d 249 (1980); Caterpillar v. Indus. Comm'n, 73 Ill.2d 311, 383 N.E.2d 220 (1978).).

Considering all facts and circumstances, the Arbitrator finds Petitioner did not provide credible testimony regarding who initiated the altercation and further finds that Petitioner was the initial aggressor by shouldering by Howe in the hallway. As part of this analysis, the Arbitrator finds Howe's testimony regarding interactions with Petitioner leading up to the incident, and the incident itself, to be more credible than that of Petitioner. Howe admitted that he had teased Petitioner for bragging about chicks and for saying the name Sturgis funny. It was undisputed that Howe teased Petitioner regarding how he pronounced the word Sturgis, although Petitioner was contradictory in rebuttal. This Arbitrator also finds credible the testimony that Howe tried to apologize and Petitioner refused to accept. Based on this prior history, attempted apology and refusal to accept the apology, this Arbitrator finds that Petitioner initiated the altercation on April 1, 2015, and that he was the initial aggressor.

The Arbitrator also notes the difference in size between Petitioner and Howe as part of the initial aggressor analysis. The record reflects that Howe is taller and weighs more than Petitioner. Howe testified that he only was restraining Petitioner during the altercation and was not trying to engage in any fighting. The records created immediately after the accident document that Petitioner suffered no dizziness, no loss of consciousness and only a laceration and a pinky finger dislocation. Had Howe been actually fighting with Petitioner, this Arbitrator notes that Petitioner's injuries immediately after the accident would have been much more severe.

Second, the Arbitrator also relies on the contemporaneous statements made by Petitioner and Howe to the Boston Heights police department. Petitioner reported to Officer Sturgis that Howe "was standing in front of him, and therefore he 'shouldered' him to get by". Howe's statement to police was that he "went to step around Mr. Patralski when Mr. Patralski "shouldered" him, at which time they fell into Mr. Patralski's room". The Arbitrator places more weight on these statements (as they were made at or near the time of the event) and they should be considered more reliable than statements made later in time. Additionally, this Arbitrator assumes the police report is accurate as there was no motivation for the police officers to falsify the report. Both Petitioner and Howe testified they had never had any contact with the officers previously and there was nothing for the police officers to gain by falsifying their report.

As no work accident occurred, the remaining issues are irrelevant and will not be considered by the 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 MADISON	)	☐ 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

John Gavin,
Petitioner,

vs. NO: 14 WC 38376

Cerro Flow,
Respondent.

16IWCC0652

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 11, 2015, 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.

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 $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: OCT 1 1 2016

Joshua D. Luskin

Charles J. DeVriendt

o-10/04/16
jdl/wj
68

Ruth W. White

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

GAVIN, JOHN
Employee/Petitioner

Case# **14WC038376**

CERRO FLOW PRODUCTS
Employer/Respondent

16IWCC0652

On 8/11/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.24% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in 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
MATTHEW R CHAPMAN
PO BOX 488
GRANITE CITY, IL 62040

0507 RUSIN & MACIOROWSKI LTD
THEODORE J POWERS
10 S RIVERSIDE PLZ SUITE 1530
CHICAGO, IL 60606

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
19(b) ARBITRATION DECISION

JOHN GAVIN
Employee/Petitioner

Case # **14** WC **038376**

v.

Collinsville

CERRO FLOW PRODUCTS
Employer/Respondent

16IWCC0652

An *Application for Adjustment 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 **June 25, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of 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. [ ] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [x] Other **Prospective Medical Treatment**

FINDINGS

On **6-2-14**, 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 $**39,813.80**; the average weekly wage was $**765.65**.

On the date of accident, Petitioner was **51** years of age, ***single*** with **0** children under 18.

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 $ for TTD, $ for TPD, $ for maintenance, and $ for other benefits, for a total credit of $.

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

ORDER

Respondent shall pay reasonable and necessary medical services pursuant to the medical fee schedule (Section 8(a) and 8.2 of the Act) as follows: Signature Medical Group (Dr. Dennis Dusek)............$534.00.

Respondent shall approve and pay for the surgery recommended by Dr. Dennis Dusek and Dr. Richard Lehman.

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

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the 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] 7/31/15

Signature of Arbitrator Date

AUG 1 1 2015

FINDINGS OF FACT

On June 2, 2014, Petitioner was employed as a relief pointer with Respondent. On that date, Petitioner was hitting a pipe with a knocker rod when he missed and struck his left index finger, causing a laceration to that finger. After striking his finger, Petitioner recoiled from the pain, jerking his left arm back and striking his elbow on a structure. After this incident, Petitioner felt pain in his left shoulder and pain and numbness in his finger, hand, and arm. The laceration bled heavily. Prior to this accident, Petitioner was working full duty with no pain complaints and no physical restrictions related to his left shoulder.

Petitioner immediately reported the incident and was sent to Midwest Occupational Medicine (PX1), where he was evaluated by Andy Colon, a physician's assistant. Mr. Colon noted that Petitioner's chief complaint was a finger laceration and shoulder pain. Mr. Colon took a history of the workplace accident. Mr. Colon noted a laceration to the index finger and pain to the anterior shoulder. Mr. Colon noted that there was a less than 2.5 inch laceration to the medial aspect of the left index finger in the area of the middle phalanx. The index finger was repaired with three 5-0 nylon stitches after administration of Lidocaine. With regard to the left shoulder, Mr. Colon performed a physical examination and diagnosed Petitioner with a strain to the left shoulder. Mr. Colon advised Petitioner to apply cool compresses for 20 minutes every 2 to 3 hours and take over-the counter Ibuprofen for pain relief. Mr. Colon then requested that Petitioner follow up in 36 hours for wound check and to reevaluate the shoulder. (PX1, 1).

On the day of the accident, Petitioner was provided an Employee Statement of Incident & Injury With Corrective Action form. (RX1) Petitioner testified that he was asked to fill out the report with respect to his finger injury. A supervisor's report (RX2) and a Report of Incident Investigation (RX3) also focused on the finger injury, not the shoulder injury.

On June 4, 2014, Petitioner presented to Midwest Occupational Medicine and was seen by Dr. Keith Byler. (PX1, 3) During this visit, Petitioner reported no significant complaints relating to the finger laceration. Petitioner did report that his shoulder was still sore and seemed to pop at times. Dr. Byler noted decreased range of motion. Dr. Byler noted that Petitioner was tender with elevation against resistance. Dr. Byler continued restrictions of no lifting, grasping greater than five pounds with left hand and no use of the left arm above shoulder level. (PX1, 3)

On June 9, 2014, Petitioner again reported to Mr. Colon with a chief complaint of laceration to the left index finger and left shoulder pain. Mr. Colon recalled that, on the date of the accident, Petitioner had "complained of shoulder pain." (PX1, 5) Mr. Colon noted that Petitioner was experiencing no problems with the finger laceration. With regard to the shoulder, Mr. Colon noted that Petitioner is still reporting pain, trouble with overhead work, and nocturnal symptoms since the injury. (PX1, 5) On physical examination, Petitioner reported pain with forward flexion and restricted range of motion. When Mr. Colon externally rotated Petitioner's arm, the maneuver produced significant pain over the interior right shoulder. Mr. Colon's assessment with respect to the shoulder was "persistent shoulder pain, left shoulder, rule out rotator cuff tear." (PX1, 5) Mr. Colon ordered a MRI to further diagnose the rotator cuff injury. (PX1, 5) Mr. Colon continued the modified work duty restrictions.

Respondent did not approve an MRI at that time. Instead, Respondent scheduled a Section 12 examination with Dr. Richard Lehman, which took place on August 14, 2014. (RX7) On that date, Petitioner gave a consistent history of the workplace injury. Petitioner also reported that he had not had shoulder pain

before but had "stingers" while playing college football. At trial, Petitioner explained that, over 25 years ago, he had a few stingers, but only after contact, and the stingers were related to the neck, not the shoulder. Dr. Lehman diagnosed Petitioner with dead arm syndrome and wanted to rule out a labral tear vs. a rotator cuff tear. Dr. Lehman opined that it would be plausible for Petitioner to have dead arm syndrome due to the mechanism of injury. Dr. Lehman further opined that "I believe that the mechanism is reasonable in terms of possible labral incident or abduction moment as relates to abducting his shoulder against stress from his greater tuberosity." (RX4, 3) Dr. Lehman also recommended an MRI of Petitioner's shoulder. Finally, Dr. Lehman opined that Petitioner could continue working with the same restrictions. In his discussion, Dr. Lehman noted that, "[i]f the MRI shows long term chronic changes, I believe that this is non-compensable and not due to this injury. If the MRI shows an acute process, I do believe that it would be compensable based on the MRI and acute findings of MRI." (RX4, 3)

On September 19, 2014, Petitioner underwent an MRI of the left shoulder. (PX2). The MRI revealed a moderate size full thickness rotator cuff tear; infraspinatus tendinosis; and moderate acromioclavicular joint degenerative changes; mild subacromial bursal effusion communicating with the glenohumeral joint; and inhomogeneity of the superior labrum and biceps anchor, which may represent tears. The MRI also showed mild periarticular bone marrow edema suggestive of "active" inflammatory process. (PX2)

On October 6, 2014, Dr. Lehman authored a supplemental report. (RX6) Dr. Lehman agreed with the findings on the MRI. Dr. Lehman further noted that it appears that the labrum may be torn. However, there was no atrophy or edema of the rotator cuff musculature. Dr. Lehman also noted there appeared to be mild bone marrow edema suggestive of an inflammatory process – omitting the word "active" in his report. Dr. Lehman believed that the MRI findings were chronic as opposed to an acute process.

On December 17, 2014, Petitioner saw Dr. Dennis Dusek for help with his injury. (PX3) Petitioner gave Dr. Dusek a consistent history of the work injury and lack of prior problems with his left shoulder. Dr. Dusek noted that the history of football stingers is associated with a cervical spine strain, which would be completely unrelated to the left shoulder. (PX3, 1) Dr. Dusek noted that, despite ongoing pain, Petitioner has been working with light duty restrictions, but is, essentially, performing his full duty job anyway. Petitioner's pain is waking him up from sleep each night and it is difficult for Petitioner to raise his arm more than horizontally. On physical examination, Dr. Dusek noted a lack of range of motion in the shoulder. Dr. Dusek noted that the MRI clearly shows a full thickness tear of the supraspinatus tendon involving almost 2 cm, which would be about two-thirds of the supraspinatus in a man of Petitioner's size from front to back with slight retraction of less than 1 cm. (PX 3, 3)

Dr. Dusek also noted that there was no significant atrophy or edema of the rotator cuff musculature. "The most important fact is there is no atrophy, which is what would be expected if this were a chronic condition. The fact that there is no edema is simply consistent with the fact that the MRI was done 3 ½ months after the injury date." (PX3, 3) Dr. Dusek noted that Petitioner's injury occurred when Petitioner had his workplace accident. Dr. Dusek noted that Petitioner had no pain at all before this event and has had pain ever since. The patient's pain complaints are consistent with the MRI findings. Dr. Dusek recommended arthroscopic rotator cuff repair. Since Petitioner was working his full duty job anyway, Dr. Dusek released him to regular duty work until surgery could be approved.

Dr. Dusek testified on behalf of Petitioner via evidence deposition. (PX4) Dr. Dusek testified that he had reviewed the Midwest Occupational Medicine chart, as well as Dr. Lehman's IME reports. Dr. Dusek testified that he diagnosed Petitioner with a rotator cuff tear of his left shoulder. Dr. Dusek testified that Petitioner's condition is causally related to the workplace injury. (PX4, 10) Dr. Dusek explained his opinion as follows:

"The fact that he had no pain in his history to me nor apparently in any reports to any physicians or his work prior to June 2 of last summer; the fact that he had this pain since the injury; that we have an MRI with all the hallmarks of a study that is consistent with an injury that would have occurred on June 2; the fact that he has findings in his physical exam that are consistent with a rotator cuff tear, it all fits to me." (PX4, 11) Dr. Dusek testified that Petitioner's mechanism of injury is consistent with his diagnosis. (PX4, 11)

Dr. Dusek further explained that the lack of significant atrophy in the rotator cuff musculature supports his causation opinion. (PX4, 11) Dr. Dusek explained as follows: "With a chronic tear, a tear that is going on for a long time, the muscle isn't attached, so since the muscle isn't attached, it's not being used, so the muscle atrophies. When I say atrophy, that's the first hallmark of something that's chronic, and yet they say right here on the MRI there's no atrophy of the muscle. That's consistent with a fresh tear, and the MRI was done three and a half months after the injury." (PX4, 11-12) Dr. Dusek also noted that the lack of edema in the rotator cuff musculature is an irrelevant finding since the musculature is well distant from where the rotator cuff tear occurs. (PX4, 12) When the rotator cuff tears, the edema occurs in the rotator cuff or in the adjacent bone, not the muscle. (PX4, 12) Dr. Dusek further noted that the MRI did find an active inflammatory process in the para-articular bone marrow edema, right where the tendon pulled loose. (PX4, 12-13). In short, the MRI did find edema and it is present where the rotator cuff tear occurred. (PX4, 13) Dr. Dusek noted that in Dr. Lehman's report, Dr. Lehman quoted from the MRI but "conveniently" left out the word "active," when discussing the finding with respect to the inflammatory response. (PX4, 13)

Dr. Lehman testified on behalf of Respondent via evidence deposition. (RX7) Dr. Lehman testified that dead arm syndrome is functionally known as a stinger, which usually comes from your neck. (RX7, 13) Dr. Lehman testified that, after his first visit with Petitioner, he was not sure whether Petitioner's condition was related to the work injury, since there had not been an MRI or CT performed. (RX7, 15) Dr. Lehman also discussed the lack of atrophy and significant edema in the rotator cuff musculature. Dr. Lehman explained, that with an acute process, things swell, and effusion occurs within the tendon. Over a period of time, that edema resolves itself. (RX7, 18-19) Dr. Lehman testified that there didn't appear to be any rotator cuff edema or secondary changes as related to swelling. (RX7, 19) Dr. Lehman explained that Petitioner had a big rotator cuff tear that is retracted that has a big spur, and this has been going on for a period of time creating a degenerative process in the rotator cuff. (RX7, 20-21) In other words, Dr. Lehman believed that the spur was rubbing the rotator cuff every time Petitioner moved his arm in a position that was going to stress his shoulder, slowly causing the large rotator cuff tear. (RX7, 21)

Dr. Lehman was questioned as to why there was no atrophy if Petitioner had a long-standing or chronic condition. (RX7, 22) Dr. Lehman's answer was: "[i]t happens sometimes and doesn't happen sometimes." (RX7, 23) Dr. Lehman opined that Petitioner's rotator cuff tear was chronic, mainly because there were no acute changes on the MRI, which was taken over three months after the accident. Dr. Lehman also testified that Petitioner's mechanism of injury was not consistent with a rotator cuff injury. (RX7, 23-24)

On cross-examination, Dr. Lehman testified that he was hired by Travelers Insurance to perform the IME in this case, and he performs several independent medical examinations per week. (RX7, 26) Dr. Lehman acknowledged that, by history, Petitioner had worked for Cerro Flow for 26 years after playing football in college. (RX7, 29) Dr. Lehman acknowledged that Respondent did not provide him any reports documenting pain or complaints related to Petitioner's left shoulder that were dated before the June, 2014 accident in this case. (RX7, 29) Accordingly, Dr. Lehman testified as follows:

> Q: Can we agree then, Doctor, that by history, Mr. Gavin's left shoulder complaints that he reported to you started with this June 2nd, 2014 workplace injury?

A: Yes, sir. (RX7, 29)

Dr. Lehman acknowledged that, in his physical examination and review of the MRI, he was able to rule out that the Petitioner's symptoms were coming from his neck. (RX7, 30) Dr. Lehman admitted that, by history, Petitioner had acute symptoms on the date of his accident. (RX7, 37) Dr. Lehman further testified: "I believe that the symptoms that he manifested were subsequent to this hammering the plugs and catching his finger." (RX7, 37) In other words, Petitioner's mechanism of injury was a factor in causing the symptoms that he described:

> Q: My question was, the mechanism of injury that he described based on history was a factor in, in causing the symptoms that he described that day, true?
> A: Yes. I think that's, that's where his – that's when he had his symptoms. Yes, sir. (RX7, 37)

Dr. Lehman acknowledged that the mechanism of injury was reasonable based on abduction and extension. (RX7, 37) Dr. Lehman acknowledged that the MRI was reasonable and necessary to further diagnose Petitioner's condition. Dr. Lehman acknowledged that he would find the injury compensable if there were any alterations in the pathology that is attributable to the injury, even an exacerbation. (RX7, 41) In this case, Dr. Lehman believed that Petitioner suffered a stinger, not a rotator cuff tear. (RX7, 42) When questioned regarding Petitioner's lack of symptoms before the injury, Dr. Lehman testified that, he believed, that if a doctor saw Petitioner a month before the incident, he would have had a similar physical examination, the same weakness and discomfort, "his brain is going to try to compensate for that and say, "John don't do that." (RX7, 43) In other words, Dr. Lehman believes that Petitioner has subconsciously compensated for the chronic injury for years before this accident. (RX7, 43) When asked why Petitioner would not have exhibited any atrophy if he had been compensating for this large rotator cuff tear, Dr. Lehman answered, "The real answer is, this is not a well understood phenomenon." (RX7, 46)

Dr. Lehman agreed that Petitioner should have his rotator cuff repaired. (RX1, 47)

Finally, Dr. Lehman was questioned regarding an agreement between Dr. Lehman and the Missouri State of Registration for the Healing Arts designed to resolve the question of whether Dr. Lehman's license as a physician and surgeon would be subject to discipline. (RX1, 54) Dr. Lehman acknowledged that he agreed as a joint stipulation of fact that, during an IME in a workers' compensation case, he documented "a physical examination without performing such physical exam, and then basing said documentation on information that is over two and a half years old, constitutes unprofessional conduct in the performance of the functions and/or duties of licensee's profession." (RX1, 58-59) Dr. Lehman acknowledged that he received a public reprimand for improperly documenting a physical examination within an IME report. (RX1. 59)

Wherefore, based on the foregoing, the Arbitrator finds that:

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

Respondent is disputing only the shoulder injury, not the left index finger injury. The Arbitrator finds that Petitioner's current condition of ill-being in his left shoulder is causally related to the June 2, 2014 work accident based on Petitioner's testimony, the medical evidence, the chain of events, and the more persuasive opinion of Dr. Dusek over that of Dr. Lehman. More specifically, there is no evidence that Petitioner ever experienced shoulder pain before the incident. While there was some discussion of neck stingers that occurred over 25 years ago, Petitioner's mechanism of injury is not consistent with a football injury. Also, it is likely Petitioner would know a stinger if he had one. It is likely that Petitioner's report of numbness is an incidental

finding that came from striking his elbow. As noted by both Dr. Dusek and Dr. Lehman, the mechanism of injury is consistent with a rotator cuff tear and/or labral tear. In fact, Dr. Lehman was suspicious of either a labral tear or a rotator cuff tear from the beginning, which is why he ordered an MRI. If the MRI found evidence of an acute injury, Dr. Lehman was willing to find medical causation.

The MRI was consistent with an acute injury. The MRI revealed a substantial rotator cuff tear that explained Petitioner's pain complaints, which started with the workplace injury and never subsided. Dr. Dusek credibly explained that the lack of atrophy at the rotator cuff musculature is consistent with a recent, acute injury. If Petitioner's substantial shoulder pathology was chronic and Petitioner had been subconsciously compensating for on-going pain and dysfunction, it seems reasonable that muscle atrophy would be present. Finally, the MRI found an "active" inflammatory process where Petitioner's tendon pulled loose.

Dr. Lehman agreed with Dr. Dusek's interpretation of Petitioner's pathology, but opined that Petitioner's pathology was chronic. Yet, when asked how a chronic condition would not result in atrophy, Dr. Lehman had no explanation. Dr. Dusek is more credible on this point. Further, since there was no evidence of prior symptoms, Dr. Lehman agreed that the workplace accident was a factor in causing Petitioner's symptoms.

Respondent submitted Petitioner's incident report as RX1 and a supervisor's report as RX2. Both reports reference Petitioner's finger injury, but not his shoulder injury. Petitioner testified that the finger laceration bled heavily. Petitioner further explained that his supervisor wanted to know how he had injured his finger, so he filled out his report on the finger injury. In any event, when seeking treatment for his injuries, Petitioner reported shoulder pain to Midwest Occupational Medicine on the day of the accident and was placed on work restrictions for that injury. As noted above, Dr. Lehman admits that Petitioner reported shoulder pain on the day of the accident, which has not abated. Respondent could have deposed Mr. Colon or Dr. Byler on this issue, but did not. Accordingly, Petitioner's testimony that he reported left shoulder pain after the accident is not only unrebutted, but also supported in the medical chart. As such, the incident reports do not subtract from the medical evidence in this case.

<u>Issue (J):</u> **Were 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 only disputed medical service is Dr. Dusek's office visit. Respondent argues that Dr. Dusek performed a Section 12 independent medical examination and was not acting as a treating physician. This position lacks merit. The office note reads like a treating physician office note and not an IME. There is no disclaimer of a physician/patient relationship. Dr. Dusek discussed the recommended surgery and recovery with Petitioner during the visit and issued a work note, stating: "[t]his is to certify that John Gavin has been under my care for an orthopaedic condition." (PX3, 4) Dr. Dusek also returned Petitioner to work full duty. Petitioner testified that he went to Dr. Dusek for help with his shoulder injury. Accordingly, the office visit was reasonable and necessary and Respondent shall pay the $534.00 bill for that service, per the medical bill fee schedule.

<u>Issue (O):</u> **Is Petitioner entitled to prospective medical treatment?**

Both Dr. Lehman and Dr. Dusek agree that the recommended surgery is reasonable and necessary to treat Petitioner's condition. In light of the finding of medical causation under Issue (F), Respondent shall approve and pay for the recommended surgery and any reasonable post-surgical 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 ADAMS	)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
			☐ PTD/Fatal denied
		☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Chauncey Redding,
Petitioner,

vs. NO: 14 WC 31817

Illinois Department of Corrections,
Respondent,

16IWCC0653

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 March 28, 2016, is hereby affirmed and adopted.

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

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

No bond or summon required for State of Illinois Cases.

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

DATED: OCT 12 2016
O100616
DLG/mw
045

David L. Gore

Mario Basurto

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

REDDING, CHAUNCEY
Employee/Petitioner

Case# **14WC031817**

ILLINOIS DEPT OF CORRECTIONS
Employer/Respondent

16IWCC0653

On 3/28/2016, 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 0.44% 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:

4707 LAW OFFICE OF CHRIS DOSCOTCH
DAMON YOUNG
2708 N KNOXVILLE AVE
PEORIA, IL 61604

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

5300 ASSISTANT ATTORNEY GENERAL
CODY KAY
500 S SECOND ST
SPRINGFIELD, IL 62706

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

1350 CMS BUREAU OD RISK MANAGEMENT
WORKERS' COMPENSATION MANGER
PO BOX 19208
SPRINGFIELD, IL 62794-9208

... true and correct copy
...

MAR 28 2016

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

STATE OF ILLINOIS)
)SS.
COUNTY OF Adams)

- [ ] 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

CHAUNCEY REDDING
Employee/Petitioner

v.

ILLINOIS DEPARTMENT OF CORRECTIONS
Employer/Respondent

Case # 14 WC 31817

Consolidated cases: _____

16IWCC0653

An *Application for Adjustment 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 **Quincy**, on **March 2, 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. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [ ] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [ ] TTD
L. [x] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [x] Other **IME Credit**

FINDINGS

On **08/30/14**, 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 week preceding the injury, Petitioner earned $39,373.88; the average weekly wage was $**757.19**.

On the date of accident, Petitioner was **29** 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 $**3,179.49** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**0**.

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $492.84/week for 25 weeks, because the injuries sustained caused the 5% loss of the person as a whole, as provided in Section 8(d)(2) of the Act.

Respondent shall pay reasonable and necessary medical services of $ 7319.55 as provided in Section 8(a) and 8.2 of the Act.

Respondent is not allow credit for the charges incurred as a result of the Petitioner's inability to attend a Section 12 examination on September 22, 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.

D. Dylan McCarthy

Signature of Arbitrator

3/23/2016

Date

MAR 2 8 2016

Chauncey Redding v. Illinois Department of Corrections
14 WC 31817

PROPOSED DEICISION

FACTS:

Petitioner testified he was employed at Western Illinois Correctional Center. He stated his job duties consisted of being a Correctional Officer, and he worked in Housing Unit 4. Petitioner testified on August 30, 2014, there was a fight in Cell House 2. Petitioner stated he was in Cell House 4 and began to run to respond to the fight. About half way to Cell House 2, he had severe low back pain. Petitioner testified he notified the shift commander and went to the emergency room at Sarah D. Culbertson Memorial in Rushville, Illinois. (Px 2).

Petitioner reported to the emergency room with back and/or flank pain. Petitioner gave a history of running to a cell block with a sudden onset of right low back pain. (Px 2). X-rays were taken of the lumbar spine. There was a finding of mild narrowing of the L4-5 and S1 disk space. The impression was low back pain. (Px 2).

Petitioner followed up with HSHS Medical Group on September 2, 2014, complaining of a low back injury that occurred at work. (Px 3). Petitioner gave a history of working as a correctional officer responding to a fight and he had an immediate pain in his low back. Petitioner was having trouble sleeping at night and walking due to pain. The assessment was lumbar pain and lumbar radiculopathy. The recommendation was a CT of the lumbar spine. (Px 3).

A CT scan of the low back was taken on September 5, 2014 at Graham Hospital. (Px 4). The CT scan illustrated L5-S1, right sided nerve root impingement. Based on the findings on the CT scan, a lumbar MRI was recommended. A lumbar MRI was completed at Graham Hospital on September 16, 2014. (Px 4). The lumbar MRI illustrated spondylosis and degenerative disk disease, the findings were more pronounced at the L5-S1 level where there was a large posterior disk bulge/disk protrusion causing encroachment on the lateral recesses. Based on these findings, PAC-Fawcett referred Petitioner to an orthopedic surgeon at Springfield Clinic in Springfield, Illinois. (Px 3).

Also, at PAC-Fawcett's recommendation, Petitioner performed physical therapy at HSHS Medical Group. (Px 3).

Petitioner followed up with Springfield Clinic and was seen by Dr. MacGregor on November 3, 2014. (Px 5). Petitioner gave a history of running to a call at work where there was an altercation between inmates on August 30, 2014. Petitioner stated he felt extreme pain in his low back and right leg. Petitioner stated he was better and was given a full duty release by his primary care physician about 2 to 3 weeks prior. Petitioner did report he was continuing to have pain, which he rated at "1" on a 10 point scale.. After an examination and review of the MRI, Dr. MacGregor diagnosed Petitioner with an annular tear of the lumbar disk, herniation of the lumbar intervertebral disk, lumbar canal stenosis and lumbar spondylosis. Dr. MacGregor felt Petitioner's symptoms had settled down but prescribed Toradol. She also ordered him to continue physical therapy and later home exercise. (Px 5). Petitioner's final visit with Dr. MacGregor was on February 23, 2015. (Px 5). Petitioner stated he had to work a double shift the weekend prior, and had so much pain he had to go to the emergency room after work. Petitioner also stated about 2 to 3 weeks prior he had a coughing fit and he felt something tighten in his back. Dr. MacGregor's assessment was the same. Dr. MacGregor's plan was to release Petitioner without restrictions. (Px 5).

Respondent scheduled an Independent Medical Exam on September 22, 2014 with Dr. Li. Petitioner missed this appointment. Petitioner testified at trial that his truck broke down and he had to have it towed and did not make the appointment. He also told his treating medical provider at HSHS on September 25, 2014 that he had not seen the doctor for his examination on September 22 because his truck had broken down in Pekin. (PX 3) Petitioner presented at trial a bill for the tow. The tow bill was not paid on the date of the missed appointment, but Petitioner explained that he did not have any money and had to borrow the money from his father-in-law. Thus, he paid for the tow after the IME. (Px 7).

Respondent rescheduled the IME with Dr. Li and Petitioner presented on December 1, 2014. Dr. Li took a history of Petitioner working for Department of Corrections. Dr. Li noted Petitioner stated he went to the Department of Corrections Academy in June, 2014 and suffered a muscle pull in his low back while in training. Petitioner also stated on August 30, 2014, while responding to a fight and running down a walk to get there, he felt pain in his lumbar spine which went down into his right buttocks. After reviewing the medical records, which included the CT and MRI scans, Dr. Li diagnosed Petitioner with pre-existing degenerative disk disease that suffered an aggravation due to the August 30, 2014 event. Dr. Li noted Petitioner did have back pain in June, 2014, but it resolved and did not come back until August 30, 2014 when he was running. Petitioner testified consistently with this report. Dr. Li noted Petitioner had a large right paracentral disk protrusion and Dr. Li stated Petitioner should be restricted from any job that required him to bend at the waist and do any kind of lifting. Dr. Li did not feel Petitioner had reached

maximum medical improvement and recommended ongoing physical therapy. If his condition did not improve, Dr. Li recommended epidural steroid injections.

Petitioner testified at trial, while at treatment he had a couple of instances of aggravated symptoms. Specifically, Petitioner stated if he had to wear cowboy boots, it would increase his pain complaints. Petitioner also testified he had a coughing episode that also increased his pain complaints. Petitioner specifically stated his pain complaints never subsided and coughing and wearing cowboy boots only increased his symptoms. Petitioner also explained he had a weight lifting incident in 2011, but it completely resolved. Petitioner testified he still has ongoing back problems. Specifically, he said that his lower back hurts when he is one position for long periods and when he runs. He says he cannot bend fully to get into crawl spaces due to pain. Petitioner uses over the counter pain medications on an occasional basis and avoids lifting heavy objects.

Petitioner also testified he no longer worked at the prison. Due to ongoing back pain he accepted a job working as a cable internet installer. Petitioner stated this is a less physical job which he believed he could physically handle. Petitioner stated he makes less money than he did while working at the prison.

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:

Petitioner stated at time of accident he was not suffering any low back complaints. He did acknowledge that he'd strained his lower back in a training exercise several months prior to this accident, but that his symptoms had resolved. His medical records also show lower back pain with radiation to the right side on July 6, 2011. During that visit at the HSHS facility, he reported that he'd sprained his lower back producing right sided symptoms five times in the preceding seven years. (PX 3) X-Ray's done at the time however were normal, and there are no office notes showing any follow up care. After running to respond to a fight on August 30, 2014, while working for Respondent, he had significant low back pain. Petitioner went to the emergency room and gave a consistent history on the same day as the accident. Petitioner followed up with medical care and had a CT and MRI scan which illustrated disk pathology at L5-S1. He had continuous ongoing treatment for his injuries through his visit with Dr.

MacGregor on November 3, 2014, at which time he reported significant improvement of his symptoms. Petitioner was seen by Dr. Li on December 1, 2014. Dr. Li felt Petitioner's work accident in question aggravated his low back condition. Dr. Li was also aware of the June, 2014 training incident in which Petitioner had prior low back pain. He was seen again by Dr. MacGregor in February 2015, with increased pain in the same areas of his body after working a double shift over the weekend. His symptoms reported at arbitration were consistent with his condition as diagnosed by both Drs. MacGregor and Li.

Based on Petitioner's consistent testimony and Dr. Li's opinions, the Arbitrator finds Petitioner's current condition of ill being is causally related to the August 30, 2014 work accident.

In support of the Arbitrator's Decision relating to (J) Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds and concludes as follows:

The findings and conclusions of the Arbitrator relating to causation are adopted and incorporated herein.

Petitioner introduced into evidence the following medical expenses as a result of Petitioner's August 30, 2014 work accident.

Provider	Charges
Sarah D. Culbertson Memorial Hospital #138018 08/30/14	$ 1,160.80
HSHS Medical Group # 1967660 9/2/14	$ 102.00
Graham Hospital #25299934 9/3-9/25/14	$ 1,507.25
#25326976 9/16/14 MRI	$ 2,904.75
#25341710 9/19/14	$ 795.75
#25637687 1/8/15	$ 2,248.76

Springfield Clinic #1435192 11/3/14-2/23/15	$ 849.00
TOTAL Allowed:	**$ 7319.55**

Based on Arbitrator's findings of causation, the Arbitrator finds the medical treatment rendered to Petitioner in regard to his low back was reasonable and necessary and related to the work accident of August 30, 2014, with the exception of the charges on January 8, 2015. The corresponding medical records show that the treatment was for calf pain and ankle cellulitis, which were not shown by the evidence to be causally related to the Petitioner's accident.

Respondent is order to pay the other bills listed above, pursuant to the fee schedule.

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:

Pursuant to Section 8.1(b) 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's license to practice medicine in it's the branches of preparing permanent partial disability report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but not limited to: loss of range of motion; loss of strength; measured atrophy of tissue, mass consistent with injury; and any other measurements that establish the nature and extent of the impairment.

(b) Also, the Commission shall base its decision on the following factors:

(i) The report 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 collaborated by medical records.

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

No impairment rating was submitted.

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

Petitioner worked for Respondent as a Correctional Officer. At arbitration, Petitioner testified he was unable to continue as a Correctional Officer and took a lessor paying job, due to low back pain, that required less strenuous work. However, he was not given any permanent restrictions by Dr. MacGregor or any other provider. He had reported minimal pain to the doctor in early November 2014 and save for the flare up in February 2015, presented no other evidence consistent with his claim that his symptoms caused him to change jobs. The Arbitrator does not place much weight on this factor.

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

Petitioner was 29 years old at time of accident. The Arbitrator finds Petitioner is a younger individual and will be suffering from the lumbar issues for an extended period of time.

With regard to (iv) of Section 8.1(b) of the Act:

Petitioner testified at trial that he will have a reduction in future earning capacity based on his less strenuous work activities. The Arbitrator does not believe this wage loss, if it in fact has occurred, is due to anything other than the petitioner's choice. It is not indicated by the medical treatment records referenced above.

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

Petitioner was treated conservatively for low back pain. The September 16, 2014 MRI demonstrated spondylosis and degenerative disk disease. It also demonstrated L5-S1, a large disk protrusion causing encroachment on the right side. Dr. Li related said condition to the Petitioner's accident. During his examination, the Petitioner exhibited a positive straight leg raise test on the right at 70 degrees. Dr. MacGregor also noted positive findings when performing the right straight leg raise test on November 3, 2014, and further noted slight discomfort when performing strength testing of the right toe. The arbitrator gives greater weight to these findings on the issue of permanency.

The Arbitrator finds Petitioner sustained temporary partial disability to the extent of 5 % loss person as a whole in accordance with Section 8(d)(2) of the Act.

In support of the Arbitrator's Decision relating to (O) Is Respondent entitled to a credit for the IME bill, the Arbitrator finds and concludes as follows:

Petitioner testified he missed the first IME appointment due to his vehicle breaking down. Petitioner submitted a bill collaborating his story. More importantly, he gave a consistent history to his treating provider three days after the missed appointment. Arbitrator finds Petitioner credible and finds good cause for the missed appointment. Thus, Respondent is not entitled to a credit.

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

Lisa Eller,
Petitioner,

vs. NO: 14 WC 33344

Board of Trustees of Community College Districts No. 505 (Parkland College) ,
Respondent,

16IWCC0654

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident and 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 29, 2016, 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: OCT 12 2016
O100616
DLG/mw
045

David L. Gore

Mario Basurto

Stephen Mathis

A 68000 Primer

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ELLER, LISA
Employee/Petitioner

Case# **14WC033344**

BOARD OF TRUSTEES OF COMMUNITY COLLEGE DISTRICT NO. 505 (PARKLAND COLLEGE)
Employer/Respondent

16IWCC0654

On 3/29/2016, 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 0.47% 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:

2847 TAPELLA & EBERSPACHER LLC
DANIEL C JONES
PO BOX 627
MATTOON, IL 61938

0522 THOMAS MAMER & HAUGHEY LLP
JOHN M SURMANIS
PO BOX 560
CHAMPAIGN, IL 61824-0560

STATE OF ILLINOIS)
)SS.
COUNTY OF CHAMPAIGN)

- [ ] 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

Lisa Eller
Employee/Petitioner

v.

Board of Trustees of Community College District No. 505 (Parkland College)
Employer/Respondent

Case # 14 WC 033344

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 **Urbana**, on **January 28, 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. [ ] Was timely notice of the accident given to Respondent?
F. [ ] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What 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 **January 25, 2013**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$61,754.33**; the average weekly wage was **$1,187.58**.

On the date of accident, Petitioner was **50** years of age, **married** with **0** dependent children.

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

Respondent **has** stipulated it will pay 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 an advancement of PPD, for a total credit of **$0**.

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

FACTS

On January 25, 2013, Petitioner, LISA ELLER, was employed as a Veterinarian at the School of Veterinary Technology of Respondent, BOARD of TRUSTEES OF COMMUNITY COLLEGE DISTRICT NO. 505 (PARKLAND COLLEGE) (Tr. p. 10-11). At that time, she was a classroom instructor, and was also responsible for overseeing the care of animals that were kept at Parkland College, including performing surgery (Tr. p. 12-13). Someone from the Veterinary Technology Program was also required to come to the school on weekends and care for these animals, and Petitioner would perform this duty on weekends when it was her turn (Tr. p. 26). She also owned the Arthur Veterinary Clinic, where she worked as a practicing physician, providing care for dogs, cats, and horses (Tr. pp. 11, 14). Petitioner has been a Veterinarian since 1987, and the work with horses was a special area of passion for Respondent, for which she specialized her practice, especially in the areas of equine reproduction (Tr. pp. 14-15). Such work often required Petitioner to work internally within the mare reproduction system, and required Petitioner to repeatedly keep her arm elevated and reaching (Tr. p. 15).

Petitioner was injured while leaving Parkland College on January 25, 2013 (Tr. p. 16). Respondent provided and maintained parking lots on its property which surrounded the building (Tr. pp. 18-19). There were no special parking lots designated for faculty, and students, staff, and faculty all parked in the same lots on a first come, first served basis (Tr. p. 18). On the day of her injury, Petitioner parked in a lot designated as M6 (Tr. p. 19; Pet. Exh. 3). Petitioner's office is in the "L" wing of Respondent's building, in Room Number L135 (Tr. pp. 19-20; Pet. Exh. 3; Pet. Exh. 4). Petitioner had worked in her office at L135 on the day of her injury, and was leaving that office when she was injured (Tr. p. 19).

Petitioner always parks in Lot M6, as it is the one closest to her office, and is most convenient (Tr. pp. 19-20). In getting to the "L" wing from Lot M6, Petitioner takes the route depicted in Petitioner's Exhibits 5 through 9 (Pet. Exhs. 3-9). At the end of the sidewalk depicted in Petitioner's Exhibit 9 is a service entrance that separates "L" wing from the gymnasium (Tr. p. 22; Pet. Exhs. 9-11). The service entrance leads to a small

parking area which is south and east of the gymnasium: and Petitioner fell in this parking area, which is marked with an "A" on Petitioner's Exhibits 3 and 4 (Tr. pp. 23-24: Pet. Exhs. 3, 4, 11-13).

Petitioner had been told that she was not allowed to park in this parking lot for a lengthy period of time (Tr. p. 24-25). She was to park in one of the outlying parking areas depicted on Petitioner's Exhibit 3 (Tr. p. 25: Pet. Exh. 3). There are 5 parking spaces in this parking lot – three are for public safety or policy cars, and two of them are reserved for short term parking (Tr. p. 25). There are two different kinds of signs in those 5 parking spaces (Tr. pp. 26-27). One type of sign says "No parking, reserved for police vehicles only," and Petitioner knows she is not allowed to park in those spaces, as those are for Parkland security police vehicles (Tr. p. 27). The other two parking spots have a different sign, and say "Two-hour parking limit, official use only" (Tr. p. 27). Petitioner and other faculty members will park in these parking spots when they need to drop something off and run something into the building, and on weekends when the college is closed and they check on the animals (Tr. pp. 25-28). There is also a public safety entrance next to this parking lot (Tr. p. 28: Pet. Exh. 3). She is required to go through the public safety entrance when she is there on weekends, as the other entrances around the parking lot are locked on weekends, and no faculty member she knows of has a key to these doors (Tr. pp. 28-29, 41).

Petitioner exited the "L" wing on January 25, 2013, around 6:00 or 6:15 p.m. from a door marked "D" on Petitioner's Exhibit 4 (Tr. pp. 21, 40: Pet. Exhs. 4, 15, 16). Petitioner's Exhibits 5-16 depict the route Petitioner would take from Lot M6 to her office in the "L" wing, and Petitioners' Exhibit 17-21 depict the rout Petitioner would take from the door she exited that night back toward Lot M6 (Tr. p. 40: Pet. Exhs. 5-21). Petitioners' Exhibit 13 shows the spot where Petitioner fell, and the concrete parking barrier that was in place on the night she fell (Tr. pp. 27-28: Pet. Exh. 13).

Respondent has never restricted Petitioner's use of the doors from which she exited on the night of her fall (Tr. pp. 41-42). No representative of Respondent has ever told her she cannot use these doors, and other faculty members and students use these doors all the time (Tr. p. 42). Respondent's Manager of buildings and grounds testified that he, as well as the 50 employees he oversees, all of whom are Respondent's employees, walk through the parking lot where Petitioner fell to get around Parkland College (Tr. p. 79). He further testified that Respondent maintains this parking lot, and puts salt around the walkways that Plaintiff walked over on her way to this parking lot: and that faculty and students coming from the "L" wing have to walk through this parking lot to get to the public safety office (Tr. pp. 80-82).

On that night, Petitioner exited the door, and went down the stairs depicted in Petitioner's Exhibit 17 (Tr. pp. 43-44; Pet. Exh. 17). She made a right turn, and the view she had is depicted in Petitioner's Exhibit 18, minus the vehicle, as there was no vehicle in the parking space on that night (Tr. pp. 44-45). Petitioner stepped over the concrete barrier and fell on black ice (Tr. p. 47). Petitioner fell on her right side with her arm extended (Tr. p. 48). Petitioner tried to get up, but could not because of the ice, and was forced to scoot over into the rocks in order to be able to stand (Tr. p. 48). Petitioner then walked to her vehicle in Lot M6, opened the car door, and telephoned her husband (Tr. p. 50). It was then she realized she had either dislocated her shoulder or broke her right arm, as she could not move it (Tr. p. 50). As she could not get into the car, she walked back through the parking lot, and entered the school through the public safety entrance so she could call an ambulance (Tr. pp. 51-52).

She was transported by Ambulance to the Carle Clinic Emergency Room, where x-rays revealed that her right shoulder was dislocated (Tr. p. 52: Pet. Exh. 22, pp. 2-3). A closed reduction procedure was performed to put the shoulder back in alignment (Tr. p. 52: Pet. Exh. 22, p. 3). She also had an MRI performed that date, and began seeing Dr. Robert Gurtler the following week (Tr. p. 53: Pet. Exh. 23, p. 1). Dr. Gurtler advised her to keep the arm in a sling, and over the next 3 months, Petitioner did some light physical therapy, but remained in a shoulder immobilizer for those 3 months (Tr. p. 54).

Petitioner did not get any better during those 3 months and this affected her ability to practice veterinary medicine (Tr. pp. 54-55). She could not see clients at her veterinary clinic, and she could not operate on animals at Parkland (Tr. p. 55). She could continue to teach (Tr. p. 55). Three to four weeks after the accident, Petitioner told her medical treaters that she did not feel right and requested another MRI, but she could not have one until April 9, 2013, some 3 months after the injury (Tr. pp. 55-56; Pet. Exh. 23, p. 3). This MRI revealed a severe rotator cuff tear (Tr. pp. 56-57; Pet. Exh. 23, p. 3). Dr. Gurtler performed surgery to repair the rotator cuff tear on April 22, 2013 (Tr. p. 57; Pet. Exh. 22, p.8). Petitioner missed 7 days of work following her surgery (Tr. p. 57).

Following her surgery, Petitioner had a slow recovery (Tr. p. 58). She slept in a recliner for 8 months due to the pain, and she could not raise her arm above shoulder level for at least 8 months (Tr. p. 58). Petitioner was unable to lift her arm that high until November, 2013 (Tr. p. 59; Pet. Exh. 23, pp. 9-10). Petitioner was unable to pour water into a coffee maker with her right arm or lift her right arm high enough to press the button on her car's sunroof until November, 2013 (Tr. p. 59). She was not released by her doctor to perform surgery during the Fall, 2013 semester at Parkland College, and so she was not allowed to teach her surgery class (Tr. p. 72; Pet. Exh. 23, p. 7). In order to maintain her full-time faculty status, she was required to make up those surgical hours in the Spring, 2014 semester, which affected her pay (Tr. p. 72). Although Petitioner last saw Dr. Gurtler on November 5, 2013, Petitioner did not receive a full release from the doctor until May 5, 2014, which was over one year following the surgery (Tr. pp. 60-61, 69; Pet. Exh. 24).

Today, Petitioner's arm still aches at times from the injury (Tr. p. 62). The injured arm restricts her work activities as a practicing veterinarian, as she is totally unable to perform the equine reproductive activities she performed in the past (Tr. p. 62). Dr. Gurtler has informed her that, if she uses her shoulder to perform such activities, she runs the risk of re-tearing the rotator cuff, and that he would not be able to repair it again (Tr. p. 63). Petitioner is also limited in her leisure activities, as she cannot perform activities such as gardening (Tr. pp. 63-64). She also has trouble putting on clothing and performing other daily activities, and she has had to use to learn her left hand more than she had to before the injury (Tr. p. 64). She also suffers from stiffness and decreased range of motion in her shoulder.

DISPUTED ISSUES

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

The facts demonstrate that Petitioner suffered an injury that both "arose out of" and was "in the course of" her employment. Petitioner was injured while she was stepping over a concrete parking barrier onto a parking lot that was under the direct control of Respondent, a risk connected with, or incidental to, the employment. She fell on an accumulation of ice, a hazardous condition which created a risk connected with the employment, and which involved a causal connection between the employment and the injury.

To obtain compensation under the Workers' Compensation Act, a claimant must show, by a preponderance of the evidence, that he or she suffered a disabling injury that arose out of and in the course of the claimant's employment. 820 ILCS 305/2. An injury "arises out of" one's employment if it originates from a risk connected with, or incidental to, the employment and involves a causal connection between the employment and the accidental injury. Mores-Harvey v. Industrial Comm'n, 345 Ill.App.3d 1034, 1037, 804 N.E.2d 1086, 1090 (3d Dist. 2004). "In the course of" refers to the time, place, and circumstances under which the accident occurred. Suter v. Illinois Workers' Compensation Comm'n, 2013 IL App (4th) 130049WC, ¶ 18, 998 N.E.2d 976, 971. 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. Mores-Harvey, 345 Ill.App.3d at 1037, 804 N.E.2d at 1090; Suter, at ¶ 18, 998 N.E.2d at 971.

While the injuries of an employee who slips and falls at a point off the employer's premises while traveling to or from work are generally not found to be compensable, Illinois Courts have found two exceptions to his rule. Mores-Harvey, 345 Ill.App.3d at 1037, 804 N.E.2d at 1090; Suter, at ¶ 19-20, 998 N.E.2d at 976. The first exception is permitted when the employee's presence at the accident site 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. Mores-Harvey, 345 Ill.App.3d at 1037, 804 N.E.2d at 1090; Suter, at ¶ 20, 998 N.E.2d at 976. The second is the "parking lot exception" where an employee is injured in a parking lot provided by and under the control of the employer. Mores-Harvey, 345 Ill.App.3d at 1037, 804 N.E.2d at 1090; Suter, at ¶ 21, 998 N.E.2d at 976. This exception applies in circumstances where the employee's injury is caused by some hazardous condition in the parking lot. Suter, at ¶ 21, 998 N.E.2d at 976.

Illinois Courts have found that slips and falls on an employer-provided lot when hazardous conditions are present are generally compensable. Mores-Harvey, 345 Ill.App.3d at 1037, 804 N.E.2d at 1090; Suter, at ¶ 21, 998 N.E.2d at 976. 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. Mores-Harvey, 345 Ill.App.3d at 1041, 804 N.E.2d at 1092. If this is the case, then the lot constitutes part of the employer's premises. Id. The presence of a hazardous condition on the employer's premises that causes a claimant's injury supports the finding of a compensable claim. Id.

In Mores-Harvey, Petitioner drove to work and parked her car behind the Respondent's restaurant in the parking lot that surrounded the building, as employees were directed to park on either the side or back of the parking lot so that customers could park in front. As she exited her car, claimant put one foot down and slipped and fell on ice, injuring her head and back. In finding the claim compensable, the Appellate Court found that, by restricting where claimant could park her vehicle, the employer exercised control over its employee's actions, and in this way the employee faced risks greater than that of the general public. Id. at 1042, 804 N.E.2d at 1093.

A similar result was reached recently by the Fourth District Appellate Court in Suter v. Illinois Workers' Compensation Comm'n, 2013 IL App (4th) 130049WC, 998 N.E.2d 971. Petitioner was a temporary employee who had been assigned to a State agency, and who fell on ice in a parking lot on her way to work. The parking area was reserved for State workers, but the parking spot had been assigned to Petitioner by a building manager who was not employed by the State or the lending employer, and Petitioner had been directed by a State official to talk to the building manager about a parking space.

In finding the claim compensable, the Court explained that the rationale for the "parking lot exception" is that the conditions of an employer-provided parking lot is that such a lot is considered part of the employer's premises. Id. at ¶ 23, 998 N.E.2d at 976. Once the parking lot is considered part of the employer's premises, any injury on the parking lot is compensable if it would be compensable on the employer's main premises. Id. at ¶ 23, 998 N.E.2d at 977. The Court, in finding the case compensable, noted that the relevant inquiry was whether the employer maintained and provided the lot for its employees' use, and that if this is the case, then the lot constitutes part of the employer's premises, and the presence of a hazardous condition on the employer's premises that causes a claimant's injury supports the finding of a compensable claim. Id. at ¶ 23, 998 N.E.2d at 978.

Illinois has continued to recognize that slips and falls on an employer-provided lot when hazardous conditions are present are generally compensable. *See* Archer Daniels Midland Co. v. Industrial Comm'n, 91 Ill.2d 210, 217, 437 N.E.2d 609, 612 (1982) (injury arose out of and in the course of employment where employee slipped on ice while walking from employer's parking lot through gate to plant grounds as injury

resulted from a risk incident to employment); Hiram Walker & Sons v. Industrial Comm'n, 41 Ill.2d 429, 431, 24 N.E.2d 179, 181 (1968) (injury arose out of and in the course of employment where the claimant injured his hand after he slipped and fell in snowy and icy company parking lot after he had parked his car in the lot because "his presence in the lot was due entirely to his employment"); De Hoyos v. Industrial Comm'n, 26 Ill.2d 110, 114, 185 N.E.2d 885, 887 (1962) (Petitioner's injury after fall on snow and ice was compensable because "an employee who falls on a parking lot provided by his employer while proceeding to work, we believe, is subjected to hazards to which the general public is not exposed"); Litchfield Healthcare Center v. Industrial Comm'n, 349 Ill.App.3d 486, 490-91, 812 N.E.2d 401, 405-06 (5th Dist. 2004) (Petitioner's ankle injury sustained after tripping on an uneven sidewalk connecting parking lot to workplace arose out of her employment where evidence showed that the sidewalk was defective, and the claimant was exposed to the defective sidewalk and the risk of tripping thereon more frequently than members of the general public); Chmelik v. Vana, 31 Ill.2d 272, 278-79, 201 N.E.2d 434, 438-39 (1964) (An injury accidentally received on the premises of the employer by a worker going to or from his actual employment by a customary or a permitted route, within a reasonable time before or after work, is received in the course of and arises out of the employment).

The cases on which Respondent may rely, Caterpillar Tractor Co. v. Industrial Comm'n, 129 Ill.2d 52, 541 N.E.2d 665 (1989) and Wal-Mart Stores, Inc. v. Industrial Comm'n, 326 Ill.App.3d 438, 761 N.E.2d 768 (4th Dist. 2001), are distinguishable from the present case. In Caterpillar Tractor, the claimant was injured on his way to the employee parking lot after his shift. Immediately in front of the employer's building was a sidewalk with a curb running along its edge. A blacktop driveway next to the curb was part of the company premises, and was used by employees and the general public to pick up employees. Claimant stepped off of the curb and onto the driveway, and twisted his ankle. Unlike the case at bar, the Claimant in Caterpillar Tractor, did not trip, skip, or fall, and the Court concluded that Claimant's injury did not result from the condition of the employer's premises because there was no evidence that the curb was either hazardous or defective. Caterpillar Tractor, 129 Ill.2d at 61, 541 N.E.2d at 668. Moreover, that Court found that curbs and the risks that are inherent in traversing them confront all members of the public, which was a different situation than one in which a hazardous condition, such as ice and snow, was present and caused the Claimant's injuries. Mores-Harvey, 345 Ill.App.3d at 1034, 1039-40, 804 N.E.2d at 1091. In Wal-Mart Stores, the Claimant slipped on ice in the parking lot, which was used by both employees and customers. Employees were requested, but not required to park in a certain area of the lot. Claimant testified that, at the time of her fall, she was walking towards her car, which had been parked by a friend waiting to pick her up in the area in which employees were encouraged to park. Unlike the parking lot in question in the present case which was only available to Respondent's employees at certain time, the Wal-Mart Stores case involved a lot that was available to both employees and customers at all times. In addition, no one had asked or instructed Claimant's friend to park where she did, and therefore the Claimant was not under the employer's control when she left the store, and therefore could not have faced any risks to a greater extent than the general public. Mores-Harvey, 345 Ill.App.3d at 1041-42, 804 N.E.2d at 1093. Moreover, Petitioner in this case, who was permitted to park in the lot in question on certain occasions, encountered the risk of slipping on ice more than the general public because of the number of times she used the lot to come in and out of the building. Cassandra Hervey v. Catholic Charities, 10 IL.W.C. 48752, 15 I.W.C.C. 0027, 2015 WL 868845.

In the present case, Petitioner was permitted to park in any of the outlying parking areas surrounding Parkland College, including the M6 parking lot which was closest to her office. One route to and from this parking area used by Respondent's employees went through the parking lot in which she fell. Petitioner was permitted to park in this lot at certain times for short durations and on weekends. Both lots were owned and maintained by Respondent. As noted by the Court in Mores-Harvey, the key question is whether the parking lot is maintained by the Respondent, and provides the lot for its employees' use. In this case, Respondent is responsible for maintaining both parking lots in question for its employees, and Respondent controlled when Petitioner was allowed to park in the lot in which she fell. At that point, the parking lot is treated the same as if

it were in the Respondent's premises, and a hazardous condition, such as the ice encountered by Petitioner, supports the finding of a compensable claim. In addition, Petitioner is required to travel through this lot to get to the door closest to her office, and is required to go through this lot to get to the door leading to the Security Office, the door she was required to go through on weekends when she had to take care of animals that were housed at Parkland College. Petitioner slipped and fell on ice while leaving Parkland College on her way to her car to go home for the evening, and the icy condition of the parking lot further constituted a hazardous condition in the parking lot. Petitioner's injury both arose out of and was in the course of her employment, and her claim is compensable.

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

The parties have stipulated that, should Respondent be found liable, Respondent shall be responsible for payment of all reasonable and related medical bills associated with such medical care, and Respondent shall reimburse Petitioner for any deductible amount Petitioner was required to pay to her private health insurer in order to secure such medical care (Tr. p. 61). Respondent is found to be liable for such medical expenses, and shall be solely responsible for all reasonable and related medical bills associated with Petitioner's medical care, subject to the Illinois fee schedule, and shall reimburse Petitioner for any deductible amounts she has paid her private health insurer in order to secure such medical care.

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

Petitioner has proven that she sustained a permanent partial disability consisting of a dislocation of her right shoulder, and a tear of her right rotator cuff. The rotator cuff required surgery to repair, as wells as a lengthy course of rehabilitation.

The medical evidence reveals that Petitioner did not have a "normal" course of treatment and rehabilitation. Petitioner originally reported to Dr. Bradley Peterson at Carle Clinic Emergency Room, who noted that Petitioner slipped on ice, falling forward onto her chest with her arms sprawled out, with complaints of right shoulder pain which radiated down to her fingertips, with associated numbness and tingling (Pet. Exh. 22, p. 2). There was also radiation of pain into the right side of her upper back, and the pain was made worse with any movement of the arm (Pet. Exh. 22, p. 2). The original diagnosis was of a shoulder dislocation following a fall, and the doctor performed a closed shoulder reduction, and put a shoulder immobilizer in place (Pet. Exh. 22, p. 3).

Petitioner then began treating with Dr. Robert Gurtler on January 31, 2013 (Pet. Exh. 23, p. 1). At that time, Dr. Gurtler noted a lot of edema anteriorly, but did not recommend surgery at that time (Pet. Exh. 23, p. 1). The doctor recommended that Petitioner stay away from treating cows and horses (Pet. Exh. 23, p. 1). She could only raise her shoulder to about 80 degrees, and the doctor recommended wearing her sling in public (Pet. Exh. 23, p. 1).

Petitioner had another MRI exam on April 9, 2013, and saw Dr. Gurtler again on April 11, 2013 (Pet. Exh. 23, p. 3). Dr. Gurtler noted this new MRI showed a supraspinatus tear, large full-thickness tear, and a partial width tear of the supraspinatus tendon at the edges (Pet. Exh. 23, p. 3). Dr. Gurtler noted, "She just has not done well. She has not been able to restore any motion whatsoever. She is extremely weak so the tendency for dislocation is not there but her function because of the rotator cuff tear has never recovered and I think we are in a situation where we have no choice but to go ahead with surgery for her right shoulder. I told her I do

not believe we can make her shoulder normal but conservative care simply has not helped. She has gotten no better. I am going to recommend a right shoulder open rotator cuff repair " (Pet. Exh. 23, p. 3).

Dr. Gurtler performed the right shoulder open rotator cuff repair surgery on April 22, 2013 (Pet. Exh. 22, p. 8). His post-operative diagnosis was "Right large rotator cuff tear" (Pet. Exh. 22, p. 8). The doctor noted that the "Indication for Surgery" was "Severe pain and near complete inability to raise her right shoulder" (Pet. Exh. 22, p. 8).

Petitioner next saw Dr. Gurtler on May 2, 2013, when he noted that her activities, "sticking her arm inside animals is a long reaching, heavy work, hard on rotator cuff type of activity" (Pet. Exh. 23, p. 5). The doctor further noted, "I think we can get her shoulder back to doing many of the things she likes to do, but just try to not do as much" (Pet. Exh. 23, p. 5). She was to begin work on gentle range of motion exercises, and start a home program with a pulley a few weeks after the surgery (Pet. Exh. 23, p. 5). The doctor further stated, "She understands we cannot give her a normal shoulder, but we can certainly give her a shoulder that is better than it has been. She reminds me again how extensively traumatic this fall was, it was black ice, she went down in a microsecond, a very hard fall. I think we are seeing the consequences of that" (Pet. Exh. 23, p. 5).

Dr. Gurtler next saw Petitioner on May 16, 2013, which was almost one month after the surgery (Pet. Exh. 23, p. 6). He noted, "Certainly we do not want her to do any lifting with this right shoulder. She is still getting some muscle spasm, but pain relief is good" (Pet. Exh. 23, p. 6). She was put on a more active therapy program (Pet. Exh. 23, p. 6). On July 23, 2013, Dr. Gurtler saw Petitioner again, and noted she was making progress (Pet. Exh. 23, p. 7). The doctor stated, "We talked about the fact that everything appears that the rotator cuff repair on that right shoulder is intact, although it was a very big tear. She is very concerned because her progress is so slow. I think that the home pulley is her most important exercise and she can get the shoulder overhead. She just cannot lift it on her own "(Pet. Exh. 23, p. 7). Another MRI was ordered (Pet. Exh. 23, p. 7). The doctor further stated, "It is surprising how slow her progress is in some ways, but on the other hand, it is just a very difficult tear. I told her I do not think she be able to do veterinary surgery this fall, but we will shoot for January 2013 (sic)" (Pet. Exh. 23, p. 7). On July 29, 2013, Dr. Gurtler spoke with Petitioner on the telephone to discuss the readings of the most recent MRI, and advised her to keep doing the home pulley exercises (Pet. Exh. 23, p. 8).

Petitioner next saw Dr. Gurtler on September 5, 2013, and he noted that she had "decent passive range of motion helping with her other hand or her home pulley to about 150 degrees, but actively she is still cannot quite get it up, but she is getting close" (Pet. Exh. 23, p. 9). His plan was to continue with the home therapy, work on range of motion, use the shoulder carefully, and anticipate improvement over a 1 year period of time. (Pet. Exh. 23, p. 9).

Dr. Gurtler's final visit with Petitioner was on November 5, 2013, some six months after the rotator cuff surgery (Pet. Exh. 23, p. 10). The doctor noted that Petitioner had "finally gotten the strength to put her arm over her head. I told her that with as big as her tear was, as young as she is, and as much difficulty as she has had, I want to still be awfully cautious.... She just cannot do the physical stuff. Six months from now, we will release her completely" (Pet. Exh. 23, p. 10). Dr. Gurtler then gave Petitioner her final release, without restrictions, on May 5, 2014 (Pet. Exh. 24), over one year after the surgery, and over 15 months after the date of the initial injury.

Petitioner went over two months before Dr. Gurtler even diagnosed her rotator cuff injury. Once it was diagnosed, Dr. Gurtler continuously referred to the injury as a "big, "large," and "difficult" rotator cuff tear. Within 2 weeks of the surgery, Dr. Gurtler noted that Petitioner would "never have a normal shoulder." It was not until November 5, 2013, over 9 months after the injury that Petitioner could put her arm over her head, pour water into a coffee pot, or press the overhead button for her sunroof in her car. Even then, Dr. Gurtler noted she

"just cannot do the physical stuff." She was not cleared to perform surgery again until January, 2014, approximately 1 year after the fall. Petitioner's fall has caused severe, long-term permanent injury to Petitioner's rotator cuff and shoulder.

Based upon the records, exhibits, and testimony, and considering all the factors listed in Section 8.1(b) of the Workers' Compensation Act, Petitioner has suffered permanent partial disability equating to fifteen percent (15%) of the loss of a person as a whole.

CONCLUSION

The Arbitrator has carefully reviewed the medical records, all of the Exhibits submitted by the Petitioner and the Respondent, and has carefully observed the demeanor and credibility of the Petitioner. The Arbitrator finds that the Petitioner has met her burden of proof that a work-related accident occurred on January 25, 2013, causing injury to Petitioner's right shoulder. The Arbitrator finds that Petitioner has proven her surgery and subsequent limitations are all causally related to the January 25, 2013, work-related occurrence.

ORDER

Pursuant to the parties' stipulation, Respondent shall pay all medical services, pursuant to the Illinois medical fee schedule, associated with treatment of Petitioner's right shoulder since January 25, 2013 as provided in Sections 8(a) and 8.2 of the Act, and shall reimburse Petitioner for any deductible amounts she has paid her private health insurer in order to secure such medical care.

As provided in Section 8(d) 2 of the Act, Petitioner is entitled to an award of fifteen percent (15%) Permanent Partial Disability for the loss of a person as a whole, consisting of 75 weeks of compensation at her Permanent Partial Disability rate of $712.55.

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

March 19, 2016
Date

MAR 2 9 2016

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

Anita Chapman,
Petitioner,

16IWCC0655

vs.

NO: 10 WC 38802

SOI/Pickneyville Correctional Center,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 12, 2015, 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: OCT 14 2016
o10/4/16
RWW/rm
046

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

16IWCC0655

CHAPMAN, ANITA
Employee/Petitioner

Case# **10WC038802**

SOI-PICKNEYVILLE CORRECTIONAL CENTER
Employer/Respondent

On 8/12/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.24% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

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

0558 ASSISTANT ATTORNEY GENERAL
KYLEE J JORDAN
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

1350 CENTRAL MANAGEMENT SYSTEMS
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

AUG 12 2015

16IWCC0655

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

Anita Chapman
Employee/Petitioner

Case # **10** WC **38802**

v.

State of Illinois – Pinckneyville Correctional Center
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Herrin**, on **June 9, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **September 27, 2010**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

In the year preceding the injury, Petitioner earned $**56,105.50**; the average weekly wage was $**1,078.95**.

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 for any medical bills paid by its group medical plan for which credit if allowed under Section 8(j) of the Act.

ORDER

Petitioner failed to prove she sustained an accident on September 27, 2010 that arose out of and in the course of her employment with Respondent or that her current condition of ill-being in her hands and arms is causally connected to her accident or her 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.

[signature]
Signature of Arbitrator

August 8, 2015
Date

AUG 12 2015

Anita Chapman v. State of Illinois/Pinckneyville Correctional Center, 10 WC 38802

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Petitioner filed an application for adjustment of claim alleging that she sustained injuries to her bilateral hands and arms as a result of repetitive duties while working for Respondent. Petitioner has alleged an accident date of September 27, 2010. The issues in dispute are accident, notice, causation, medical bills, and nature and extent. Major Jason Thompson was present throughout the hearing as Respondent's representative.

The Arbitrator finds:

Petitioner began working for Respondent in 1998.

Medical records pre-dating Petitioner's accident date were admitted into evidence. Petitioner was involved in a single motor vehicle accident on November 16, 2000 when the vehicle she was driving rolled over several times after "side swiping" a telephone pole. She did not recall how many times the vehicle rolled over. Petitioner was seen at the Pinckneyville Community Hospital emergency room with complaints of right shoulder blade pain, pain to the back of her head, chest pain, and pain when breathing. Right shoulder x-rays were negative. Petitioner hit her right hand in the accident. Petitioner was diagnosed with a fracture of her second right rib and pneumothorax. Petitioner underwent a tube thoracostomy that same day. (RX 15)

On November 21, 2000, Petitioner presented to Dr. C. Reyes at the Family Medical Center. (RX15) Dr. Reyes was seeing Petitioner post-hospitalization for her rib fracture and pneumothorax status post chest tube surgery following her motor vehicle accident. Dr. Reyes noted Petitioner's complaints of neck pain with tingling in her right upper extremity. Petitioner reported numbness and tingling on the index and middle finger, and she was very concerned about it. On physical examination Petitioner showed positive tenderness at the C5-6 area. Dr. Reyes assessed her with a possible cervical neck sprain versus a disc herniation. Dr. Reyes planned to check MRI and refer Petitioner to a neurologist for further management.

On November 23, 2000, Petitioner presented to Dr. A. Sawadisavi for a consultation at the request of Dr. Reyes. (RX15) Dr. Sawadisavi noted Petitioner's only complaint was that she had a tingling sensation over the tip of the right fourth, ring finger. Petitioner also reported she still had pain and tenderness over the right paraspinal area about the T5 level. Dr. Sawadisavi's impression was that of neuralgia over the area supplied by the ulnar nerve or its bundle, probably peripheral not central. Dr. Sawadisavi's recommendation was to refer Petitioner to a neurologist for a neurological evaluation.

On November 28, 2000, Petitioner underwent an MRI of the cervical spine. (RX15) Dr. Robin Biermann noted: 1) straightening of the cervical lordosis; 2) desiccation of essentially all

cervical discs with mild narrowing of the C4-5 and C6-7 disc spaces; 3) anterior extradural defects at C4-5 and C6-7 appearing to represent a combination of posterior vertebral body osteophytes and mild disc bulging; 4) very mild diffuse posterior bulging of the C3-4 disc; 5) no evidence of focal disc herniation; and 6) narrowing of the central spinal canal at C6-7, but "I doubt that this is significant central spinal canal stenosis at this time." There was also mild to moderate bilateral narrowing of the cervical neural foramina at C6-7, more severe on the left.

On July 9, 2003, Petitioner presented to Dr. Reyes with a history of right elbow pain for the previous two weeks. (RX15) Petitioner reported she was engaged in weightlifting, and that she used dumbbells a lot. Petitioner reported that she had stiffness in her right elbow in the mornings, and that she had pain that radiated into the wrist. On physical examination Dr. Reyes noted Petitioner showed positive tenderness on the lateral portion of the right elbow along the lateral epicondyle area and decreased range of motion. Dr. Reyes felt Petitioner's complaints were very consistent with tennis elbow/lateral epicondylitis. Dr. Reyes prescribed Depo Medrol, Bextra, and advised Petitioner to remain off weightlifting for at least 7-10 days.

On November 14, 2008, Petitioner presented to Dr. Reyes with complaints of right wrist and thumb pain for three weeks. (RX15) Petitioner reported that she had popping sensations on the lateral aspect of her right wrist, and that she used her right hand to open a key at the prison a lot. Petitioner denied any numbness of the second and third digits and denied any swelling or recent trauma. Petitioner reported it was worse when she flexed her wrist. On physical examination Dr. Reyes noted Petitioner's pain was reproducible on flexion on the base of the thumb, and that she also had significant tenderness on the base of her thumb. Finkelstein's test was positive. Dr. Reyes assessed Petitioner with tenosynovitis, prescribed voltaren, and advised physical therapy to measure her for a forearm splint. Dr. Reyes also ordered an x-ray of her right wrist. At the bottom of this record it was noted that on November 24, 2008, an appointment was made for Petitioner to see Dr. Young (December 1, 2008)

That same day Petitioner underwent an x-ray of her right wrist due to a history of right thumb and wrist pain. (RX15) Dr. Biermann's impression was of no definite fracture or dislocation identified in the right wrist, and the joint spaces appeared fairly well maintained. On the same date Petitioner also underwent an x-ray of the right thumb. The impression was of: 1) small to moderate sized exostosis projecting from the dorsal aspect of the distal head of the proximal phalanx of the right thumb; 2) minimal osteophyte formation at all joints of the right thumb, but joint spaces remain fairly well maintained;and 3) small separate calcific density seen along the base of the 1st metacarpal between the bases of the 1st and 2nd metacarpals. This appeared fairly well corticated and probably represented either an accessory ossicle or an old fracture fragment, but clinical correlation is advised regarding any acute trauma in the area.

According to Respondent's "Roster Management" log, Petitioner worked as a "Relief Officer" in "B Wing" "Control" and "C Wing" from April 11, 2009 through January 29, 2011. (RX 5)

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On September 15, 2010, Petitioner completed a "New Patient Questionnaire" for Dr. David Brown. (PX3) Petitioner reported that she was being seen for a work-related injury, that she was not/maybe involved in litigation, and that she was represented by an attorney. Petitioner noted she was right hand dominant. Petitioner reported a hobby of gardening/flowers. Petitioner stated her symptoms were located in her right hand and wrist and her left hand-thumb. Petitioner described her symptoms as pain and numbness in right hand, wrist, forearm. Numbness in left thumb. Petitioner denied any prior treatment or tests for her problems. On the questionnaire Petitioner described her job as "[r]epetitive motion performed daily duties of keying tight locks with large keys, open and closing of heavy doors. Operating 4 wing computers, clipping/unclipping keys & radio from my duty belt, cuffing & uncuffing inmates. Carrying mail bag to my assignment and sorting and passing to each cell. Maintain daily log book, counting inmates twice per shift and making a count slip. Report writing as necessary."

Dr. Brown's records also contain a handwritten note by the Petitioner dated September 17, 2010. (PX3) Petitioner titled the note "JOB DUTIES" and described them as "[r]epetitive motion performing regular duties of keying tight locks using large keys, open and closing heavy doors, clipping/unclipping keys and radio from my duty belt, cuffing and uncuffing inmates, maintain daily log books, operation 4 wing computers using computer mouse, touch screen and intercom system, report writing as necessary, carrying mail bag to my assignment, sorting and passing mail to each specified cell, counting inmates twice per shift and filling out count slips."

On September 27, 2010, Petitioner presented to Dr. Brown. Dr. Brown noted Petitioner had worked as a correctional officer at Pinckneyville since 1998, and that her job entailed opening and closing steel doors and opening and closing locks repeatedly throughout the day. Dr. Brown noted that Petitioner estimated she typed on a computer two to three days a week up to eight hours a day. According to Dr. Brown's notes, Petitioner brought a hand-written job description with her to the appointment. Petitioner reported a year history of progressive numbness and tingling in both her hands associated with volar wrist pain. Dr. Brown noted Petitioner was treated with a wrist splint with no improvement in her symptoms. On physical examination Petitioner had good active range of motion of both elbows, both wrists, and all digits of both hands. Petitioner had a negative Tinel's sign over the ulnar nerve at the right and left cubital tunnels. Direct compression test/elbow flexion test was negative bilaterally. Petitioner had a positive Tinel's and direct compression test over both carpal tunnels. Phalen's test was positive bilaterally. Dr. Brown found that Petitioner had symptoms and findings on examination consistent with bilateral carpal tunnel syndrome. Dr. Brown advised he wanted Petitioner to undergo nerve conduction studies and prescribed Titan wrist splints for the right and left wrists and nonsteroidal anti-inflammatory medication. He felt she could continue working full duty with no restrictions.

That same day Petitioner presented to Dr. Daniel Phillips for electrical diagnostic studies. (PX4) Dr. Phillips noted a history of Petitioner having one year of sharp aching right wrist pain with intermittent numbness involving preferentially the middle and ring fingers, and numbness in

the left thumb that was global and intermittent. Petitioner denied cervical radicular pain. Dr. Phillips reported an impression of significant moderate sensory motor median neuropathy across the right carpal tunnel and milder median sensory neuropathy across the left carpal tunnel. Dr. Phillips also noted that there might have been a radicular component to her symptoms that could be further evaluated by a cervical MRI. Dr. Phillips noted Petitioner had a limited cervical range of motion, but neural foraminal findings were denied.

On September 27, 2010, Dr. Brown wrote an addendum to his note. (PX3) Dr. Brown noted Petitioner's nerve conduction study revealed findings consistent with significant right carpal tunnel syndrome and left carpal tunnel syndrome. Dr. Brown diagnosed Petitioner with bilateral carpal tunnel syndrome and advised he would see her in follow-up in four weeks.

Petitioner signed her Application for Adjustment of Claim herein on September 30, 2010. (AX 2)

On September 30, 2010, Petitioner completed her Employee's Notice of Injury. (RX2) Petitioner described her injury as "[r]ecurring numbness in L thumb and index finger Pain/Numbness in both wrist, constant numbness R fingers." Petitioner had reported the injury on September 29, 2010.

In September and October of 2010 Petitioner treated with Dr. Wood for a right talus chip fracture. (RX 16)

On October 7, 2010 Petitioner's supervisor, Major Malcolm, completed a Supervisor's Report of Injury. He listed Petitioner's job duties as "primarily [a] pod officer, wing officer, and main gate officer." He noted she used a computer keyboard and was engaged in "computer keyboard entry, repetitive motion" at the time of her accident. (RX 3) That same day Major Malcolm completed a Demands of the Job form for a correctional officer. (RX 4)

On October 27, 2010, Petitioner returned to see Dr. Brown. (PX3) Petitioner reported that she'd had no improvement in her symptoms. Dr. Brown advised Petitioner that she had chronic bilateral carpal tunnel syndrome that had failed conservative treatment and he advised her that she was a candidate for a carpal tunnel release. Petitioner advised she wished to proceed with surgery. In the interim she was allowed to continue working without restrictions.

On November 2, 2010, a "Surgical Admissions Scheduling Form" was completed by Dr. Brown's office. (RX13) The forms indicated Petitioner was to undergo surgery on her right hand on January 7, 2011, and surgery on her left hand on January 21, 2011. (RX13)

From January 30, 2011 through June 20, 2012 Petitioner worked as a "Regular Officer" in "Control." (RX 5)

Lt. Jason Thompson performed a key usage study at Respondent's facility February 14, 2011 through February 17, 2011. (RX 6)

On August 23, 2011, Dr. James Williams conducted a records review of Petitioner's records at the request of Respondent. (RX9) Dr. Williams opined that he believed Petitioner's work involved significant rest, and that her job duties would not be a factor in the development of her carpal tunnel syndrome.

Effective June 24, 2012 Petitioner was working as a "Regular Officer" in "Tower 4." (RX 5)

On July 18, 2012, Petitioner completed a "Health History" questionnaire for Belleville Hand Surgery. Petitioner described her injury/illness as "[r]eoccurring pain/numbness in R wrist, elbo, sholder, neck. Pain/numbness in L wrist, elbo, pain R side of head, pain when closing R eye. Weakness in both arms & hands". [sic] (PX 5)

On July 20, 2012, Petitioner presented to Dr. Harvey Mirly for bilateral hand pain. (PX5) Dr. Mirly noted that Petitioner had some recurring pain and numbness in the right wrist, also some radiation up her arm to her shoulder and neck, and pain and numbness in the left side although less severe. Dr. Mirly noted he had been supplied with some outside records, including clinical notes from Dr. Brown and a nerve conduction study by Dr. Phillips. Dr. Mirly noted that concern of a possible cervical radicular component had been raised by Dr. Phillips, and that Petitioner had a limited cervical range of motion. Dr. Mirly further noted that he had discussed the diagnosis, anatomy, and treatment options of carpal tunnel and discussed cervical radiculopathy with Petitioner. Dr. Mirly advised Petitioner that those conditions could mimic each other. Petitioner had positive carpal tunnel provocative testing on that day, and she wished to proceed with a right open carpal tunnel release.

On July 27, 2012, Petitioner underwent a right open carpal tunnel release performed by Dr. Mirly. (PX5)

On August 10, 2012, Petitioner presented to Dr. Mirly for a two week follow-up after undergoing surgery. (PX5) Dr. Mirly noted Petitioner's primary care physician had removed her stitches the week before. Dr. Mirley gave Petitioner a slip to return to work light duty on August 16, 2012. Petitioner informed Dr. Mirly that she was interested in having her left hand done later in the year. Dr. Mirly advised Petitioner to contact him should she wish to proceed with the left hand in the future.

Petitioner stopped working in Tower 4 as of August 13, 2012. (RX 5)

As of September 1, 2012, Petitioner was working as a "Regular Officer" in "Armory 2." (RX 5). She remained in that position until February 28, 2013 when she was transferred to "Res. 2 Control." As of June 16, 2013 Petitioner was assigned as a "Relief Officer" in "Res 4 A Wing," "Res 4 Control," and Res. 4 C Wing." (RX 5)

From July 15, 2013 through August 8, 2013 Petitioner worked at the "Main Gate." (RX 5) On August 10, 2013 Petitioner was assigned to "Res 3 D Wing" as a "Regular Officer." (RX 5)

On October 31, 2013, Petitioner presented to Dr. Anthony Sudekum for a Section 12 examination at the request of Respondent. (RX11) Dr. Sudekum opined that it was his opinion within a reasonable degree of medical certainty that Petitioner's job activities as a correctional officer at Pinckneyville Correctional Center did not cause or aggravate her carpal tunnel syndrome. (RX 11, p. 46)

On April 25, 2014, Petitioner presented to Dr. Reyes with complaints of neck pain. (RX16) Petitioner indicated her discomfort was located in the posterior of her neck, and that it was moderate in intensity, constant, and throbbing. Dr. Reyes noted Petitioner's associated symptoms included headache, neck stiffness, and upper extremity parasthesias. As a result Dr. Reyes ordered a cervical MRI and prescribed Norflex for Petitioner.

On May 1, 2014, Petitioner underwent an MRI of the cervical spine without contrast. (RX16) Dr. Aaron Settler noted an impression of: 1) moderate cervical spondylosis including a small right paracentral disc protrusion at C5-6; 2) mild spinal canal stenosis at C4-5 and C6-7; and 3) uncovertebral hypertrophy contributing to mild foraminal narrowing at C6-7.

On May 14, 2014, Petitioner completed a patient intake questionnaire for The Orthopaedic Institute of Southern Illinois. (PX16) Petitioner reported her chief complaint was "tingling/numbness back of neck and arm R" which had been ongoing for several years. She denied any significant injury noting that she had had right carpal tunnel syndrome which had been addressed and seemed to help her fingers; however, her arm complaints continued. . When asked what body part was involved Petitioner wrote "Neck & Arm" and circled "Right". Petitioner stated that her symptoms began "? few years ago". Petitioner reported that she had similar symptoms in her left arm, but they were not as bad.

That same day Petitioner was seen by Dr. Kevin Koth at the request of Dr. Reyes. (RX16) Petitioner presented with a history of right-sided neck pain, right-sided pain in her arm and tingling radiating into her arm. Dr. Koth noted this had been ongoing for several years. Petitioner denied any significant injury, and reported that she'd had carpal tunnel surgery on her right hand and it seemed to help her fingers but her arm symptoms continued. Petitioner advised Diclofenac and Ibuprofen did not help her. Dr. Koth noted the MRI was significant for degenerative changes and multilevel degenerative changes in the cervical spine. Dr. Koth stated there was multilevel disc bulging at C4-5, C5-6, and C6-7 with some minor encroachment on the cord anteriorly. Additionally there was a disc protrusion and right-sided foraminal stenosis at C4-5 which was encroaching on the C5 nerve root. Dr. Koth diagnosed Petitioner with stenosis of the cervical spine, degenerative disc disease, and radiculopathy. Dr. Koth advised Petitioner the tingling she was experiencing was likely secondarily related to her foraminal stenosis at C4-

5. Dr. Koth advised if Daypro and a Medrol Dosepak did not help her, then at some point she might benefit from surgical intervention at C4-5 in the form of an ACDF.

Petitioner has undergone no further treatment since May 14, 2014.

On December 19, 2014, Dr. Mirly testified via evidence deposition. (PX10) Dr. Mirly testified that he reviewed clinical notes from Dr. Brown and a nerve conduction study performed by Dr. Phillips on Petitioner. Dr. Mirly testified that after her surgery Petitioner reported a significant improvement in her pre-operative symptoms. Dr. Mirly testified that Dr. Phillips had expressed some uncertainty in Petitioner's diagnosis, in that she might have some neuroforaminal, or neck issues. Dr. Mirly testified that a person could have both neck and hand problems, commonly referred to as a "double crush syndrome." Dr. Mirly testified that Petitioner had other non-occupational risk factors as well, such as her gender, age, and high blood pressure. Dr. Mirly testified that he felt Petitioner's job duties would be of a contributory nature to her carpal tunnel syndrome. Dr. Mirly explained his opinion by testifying "...there's certainly a significant number of claims from people in the profession; therefore – and higher than I think in the general population, and therefore I think there is a contributory nature to it." (PX10, pp. 35-36)

On cross-examination Dr. Mirly admitted he did not recall talking to Petitioner at length about her job duties, and that he did not know what shift Petitioner worked or what job assignments Petitioner had. Dr. Mirly acknowledged that he took no information from petitioner regarding her job duties because she wasn't claiming that her injury was work-related when she presented to him desiring to go forward with surgery. He was, however, provided with documents to review vis a vis Petitioner's attorney. Those documents included the following: (1) Depositions of Robert Schuchert, Melanie Welch, Donna Jones, Jaelene Bryan, Jason Thompson, and Jimmy Phillips; (2) a Job Analysis (a/k/a JSA) from Corvel (Visits 1 and 2); (3) a medical opinion from Dr. Williams; (4) a medical opinion from Dr. Sudekum; (5) two letters from Dr. Williams; (6) a work history timeline prepared by Petitioner; and a (7) a longhand job description prepared by Petitioner. According to Dr. Mirly, there was information in the depositions about electronic controls and how the doors didn't always respond to the electronic control, didn't lock, and they would have to check them to make sure that they had engaged the lock. (PX 10, p. 24) When asked if he knew how many times Petitioner was keying during a shift Dr. Mirly said he reviewed the key estimates but admitted he did not have a "personal specific or accurate knowledge on that." On cross-examination Dr. Mirly testified that the activities of being in the control room and using a touchscreen or keyboard would be "much less strenuous or contributory than others."

When asked if any of the job duties Petitioner had listed on her job description could contribute or aggravate carpal tunnel syndrome, Dr. Mirly never succinctly answered the question; instead, he summarized her paragraph long narrative noting a "very relatively low intensity to mark if a person's in a room" and that didn't seem intensive and when Dr. Mirly

engaged in extensive longhand writing he would have to stop and shake his hand to give it a break (the doctor himself having had carpal tunnel syndrome) but he didn't know how long Petitioner's reports were, and she handled mail but he didn't know the weight or how many pieces so he didn't know if it was high intensity or high weight. Having said all that, the doctor testified, "…those would be the type of activities in her one paragraph that would be the type of activities contributory." (PX 10, pp. 28-30)

Dr. Mirly admitted on cross-examination that cervical radiculopathy can manifest as numbness, tingling, and parasthesia in the upper extremities. (PX 10)

Dr. Mirly was also asked who he finds to be the best person to tell him the details of what someone's job entails on a day to day basis and he replied that it is "overall a blend of all the sources." (PX 10, p. 34) His "best" is actual observation and performance of the activity such as touring plants and facilities and handling the tools. He also relies upon his patient. (PX 10, pp. 34-35)

On cross-examination Dr. Mirly acknowledged that he didn't go into a great deal of detail regarding Petitioner's job. (PX 10, p. 41) He was unfamiliar with her shift or the days of the weeks she worked. He didn't know what specific jobs/assignments Petitioner had as a correctional officer. On further cross-examination Dr. Mirly did mention that in Petitioner's one page job description there was some "talk of using on the computer" but it was more in the area of the pod. When asked if the activities of being in the control room where one is "simply using a touchscreen or a keyboard," would predispose one to or aggravate carpal tunnel syndrome, Dr. Mirly replied, "[T]hose activities would be much less strenuous or contributory than others. Again, not personally observing them, but unless you're doing a significant amount of mouse work, typing….. But again, I think using a touchscreen would be of a minimal but negligible contributing activity for carpal tunnel. (PX 10, pp. 58-59)

On January 15, 2015, Dr. Sudekum testified via evidence deposition. (PX12) Dr. Sudekum testified that he reviewed records from Dr. Reyes going back to 1999, a cervical MRI taken in 2000, a staff assignment history, Illinois Form 45, Employee's Notice of Injury, the Supervisor's Notice of Injury, Dr. Brown's records, Dr. Phillips' records, Corvel job analysis, Corvel dvds, key estimation study, the position description of a correctional officer at Pinckneyville Correctional Center, and Dr. Mirly's records. Dr. Sudekum testified that he has personally toured Menard Correctional Center and Big Muddy Correctional Center, and while there he was able to perform some of the job duties that a correctional officer would perform. Dr. Sudekum testified that he keyed open and closed doors, pushed buttons, pushed touchscreens in pods, cuffed and uncuffed an individual, manipulated property boxes, went into a tower, opened and closed gates, and used various keys, including a Folger Adams key, while touring.

Dr. Sudekum testified that Petitioner advised him she began experiencing significant numbness and tingling in her right, ring, and middle fingers while working in the health care

unit. (PX12) Dr. Sudekum testified that, as he understood it, Petitioner spent most of her time working in the control center in the pods, and working in housing units at various times. Dr. Sudekum testified that while working in the housing units he understood Petitioner's job to involve monitoring and counting inmates, intermittently cuffing and uncuffing inmates, and intermittently opening and closing chuckholes. Dr. Sudekum testified that he understood the control pods at Pinckneyville Correctional center to have four screens, and that there was a keyboard and mouse that could be used for entering data and scrolling to different areas, and then usually a touchscreen where a finger would be used to select a door to open or close.

Dr. Sudekum testified that Petitioner had many co-morbid factors that could have contributed to the development of her carpal tunnel syndrome regardless of her employment activities. (PX12) Dr. Sudekum testified that these factors were Petitioner's age, gender, postmenopausal status, hypertension, cervical arthritis, cervical disc disease, possible cervical radiculopathy, as well as arthritis in Petitioner's hands which was indicated in the x-rays he took. Dr. Sudekum testified that cervical problems can cause many of the same symptoms as carpal tunnel syndrome, including pain, paresthesias, weakness, numbness, and tingling. Additionally, Dr. Sudekum testified that the findings on her cervical MRI of cervical arthritis, disc bulging, and narrowing of the foramina are the mechanisms by which those symptoms occur because those spinal nerves are pinched or the central canal is compressed. Dr. Sudekum testified that not only could this "...cause the problem primarily, meaning that being the source of these problems, those being the symptoms associated with carpal tunnel syndrome, but it can also potentiate the carpal tunnel syndrome." (PX12, pg. 23) Dr. Sudekum explained this phenomena is called the "double crush" phenomena "...whereby if a patient has cervical radiculopathy, there can be a relatively greater likelihood of developing carpal tunnel symptoms as a result of that. The nerve is irritated proximally within the neck let's say, and that's the same nerve that exits in the palm as it crosses through the carpal tunnel." (PX12, pg. 23-24) Dr. Sudekum testified that if Petitioner had been his patient he would have recommended she obtain an MRI as Dr. Phillips mentioned. Dr. Sudekum testified he would do so because her symptoms were "atypical" and not just the "garden variety carpal tunnel symptoms." (PX 12)

Dr. Sudekum testified that did not believe within a reasonable degree of medical certainty that Petitioner's upper extremity conditions were causally related to her job duties at Pinckneyville Correctional Center. Dr. Sudekum testified that his opinion was based upon his understanding of Petitioner's job as well as her pathology. Dr. Sudekum testified that he charged $4,000.00 for his report, $785.00 for x-rays, $665.00 for his NeuroMetrix test, and $2,000.00 per hour for his deposition, bringing his charges to $8,000.00 to $9,000.00 in Petitioner's case. He has made over $1.1 million dollars performing medical/legal work for Respondent. Dr. Sudekum admitted that the medical journal articles referenced in his report are 10 to 15 years old, that there were more recent studies he could have cited, and that his report "probably should be updated." (RX 12, pp. 35, 36, 47).

Although Dr. Sudekum believed Petitioner's condition was likely due to risk factors such as her hobbies of sewing, weight lifting, and gardening, he admitted that he had no idea how often or how long Petitioner engaged in these activities. He testified that because he did not have this knowledge, he could not "rule them in;" but he also could not rule them out. Petitioner's job duties, however, were ruled out in their entirety. (RX 12, pp. 53-54)

On February 4, 2015, Dr. Williams testified via evidence deposition regarding the records review he performed on the Petitioner. (RX10) Dr. Williams testified that for his records review he reviewed the Employer's First Report of Injury, the Employee's Notice of Injury, the Supervisor's Notice of Injury, Petitioner's job description, the Roster Management Schedule, Dr. Brown's records, the nerve study performed by Dr. Phillips, the job site analysis, the CorVel dvds, various post descriptions, and the key turning analysis. (RX 10, pp. 10-12)

Dr. Williams testified that Petitioner had several co-morbid factors which would predispose her to the development of carpal tunnel syndrome, including Petitioner's post-menopausal state, age, gender, and hypertension. (RX 10, p. 14) Additionally, Dr. Williams testified that the potential cervical component that Dr. Phillips identified could affect Petitioner's development of carpal tunnel syndrome. Dr. Williams testified that Petitioner could have a "double crush syndrome" (being that she had both carpal tunnel as well as some type of cervical radiculopathy) or her problems could all be coming from her neck. Dr. Williams further testified that double crush syndrome could actually aggravate carpal tunnel syndrome and make the symptoms worse. Dr. Williams testified that if Petitioner continued to have symptoms in her right arm, shoulder, and neck following a right carpal tunnel release then it is because the symptoms are coming from another etiology than her carpal tunnel (such as her neck). In that scenario, one could not rule out the possibility that the nerve problems in her neck could have contributed to her carpal tunnel syndrome. (RX 10, pp. 15, 21-22)

Dr. Williams testified that he personally toured Respondent's facility in July of 2011 for 2 ½ to 3 hours. Dr. Williams also testified that he performed certain job duties that correctional officers performed, such as: opening and closing a chuckhole in segregation, opening and closing a cell door, lifting property boxes, cuffing and uncuffing an individual, opening and closing padlocks, lifting a food tray, utilizing small keys as well as Folger Adams keys. He also saw a control room and control panels, and he went up into a tower. (RX 10, pp. 18-19)

Dr. Williams testified that based upon the information he had at his disposal he did not believe the job duties for Respondent were realted to her condition and, therefore he did not believe the condition of Petitioner's upper extremities was related to her job duties at Pinckneyville CC. He did not believe that typing 2-3 days/week up to 8 hours a day would be contributory. (RX 10, pp. 21, 31-32)

Dr. Williams testified on cross-examination during his deposition that he did not have the opportunity to see Petitioner or perform a physical examination. (RX10, p.24). He testified that

90% of his medical/legal work was performed at the request of employers, and that he has made nearly $700,000.00 doing this type of work for the State of Illinois. (RX 10, p. 27). Dr. Williams testified that he was not provided with Petitioner's full job history and therefore did not know what positions she worked outside January 2011 to April of 2011. (RX 10, pp. 28, 29). Dr. Williams testified that his causation opinion could change if the information provided to him by Respondent was incomplete or incorrect. (RX 10, p. 31)

Dr. Williams further testified that he was unaware of Dr. Sudekum's involvement in the case and that NeuroMetrix tests are "horrible" adding "And personally I think they're worthless. That's my opinion of a NeuroMetrix machine. (RX 10, pp. 33-34) He acknowledged that there can be a "latency period" with carpal tunnel syndrome. (RX 10, p. 37)

At the arbitration hearing Petitioner testified that she began her career with Respondent in September of 1998 as a Correctional Officer, and was not employed in any other position or at any other facility until her retirement in May of 2015. Prior to her employment with Respondent, she served as a Correctional Officer/Matron for the Perry County Sheriff's Department. Petitioner testified that 70% of her time as a Pinckneyville Correctional Officer was spent as a pod/control officer, and 25% was spent as a wing/gallery officer. The remaining 5% was "here and there."

Petitioner testified that as a pod officer, her shift was comprised of 7.5 hours and she spent 90% of her time extending and using her right hand to operate a mouse using pressure to search for and open doors for Correctional Officers working on the wings. Petitioner described the layout of her station as an octagon with glass panes all the way around and four computers, each facing the wing that it relates to. Petitioner sits in the middle of these computers and operates the wing doors that they control by applying pressure to a mouse. When asked to detail the motions she engaged in to search for the various doors on the screens and open them, she testified she had to grab the mouse, "scroll" through several screens, and "hold" buttons down. Petitioner testified that she would get lost in the screens at times because it was difficult to find doors. Petitioner testified that she is right-handed and always had the mouse in her right hand.

Petitioner testified that she also used her wrist to "push away" from one wing computer to another. Petitioner explained that she wanted to follow the officers. She would sit in a chair at the wing computer (which would be facing the wing) and she would follow the officer. She would then push away from the counter to go over to another wing computer. According to Petitioner she was constantly pushing away from one counter to go to another counter. Petitioner testified that the chair did not roll easily and would often move in the wrong direction because the rollers would "gum up" and not move freely. Petitioner testified that this resulted in grabbing and pushing with her wrists constantly in order to move to the appropriate work station. The alternative was for Petitioner to stand up for 7.5 hours during her shift which she felt was "impossible."

Petitioner also testified that she was responsible for keeping log books, handing out keys, and sorting mail, which consumed the remaining 10% of her time. Petitioner testified that she was unable to open doors for each and every officer, because officers are busy and she simply could not get to the door in time. Petitioner also testified that the screen calibration is off. Petitioner testified that even when the facility was new and the screens worked properly, they were always going out. Petitioner testified that she pushed more than the 500 buttons per shift estimated in the study performed by Major Thompson. (T.52, 53).

Petitioner testified that she was not claiming that her injury was due, in any way, to repetitive keyboarding.

Petitioner was also a wing officer and she testified that as a wing officer in the gallery housing units, she opened chuckholes made of heavy metal with large Folger Adams keys. Petitioner testified that upon turning the key clockwise, the lock is "supposed to" release and the chuckhole door should drop down; however, she stated that this did not always occur, because the chuckholes were "gummed up," rusty and old. She testified that deterioration occurred as a result of the humidity on the wing and food spilled in the chuckholes. Petitioner stated that when the chuckholes would not close, she would try to slam it shut with her hand and wrist as best as she could, because the chuckholes could not be left open. She testified that some of them were broken and the locksmith would have to be called. Petitioner used other keys to open doors such as cell doors, the door to the laundry room, and the cleaning closet. Petitioner testified that she "open[ed] cell doors all the time." She testified that wing officers were responsible for opening individual inmate cell doors.

Petitioner testified that she performed wing checks every 30 minutes, during which she pulled on doors with her right upper extremity to make sure they were closed. She testified that she performed shakedowns, which required her to cuff and remove inmates from cells and rigorously search through the cells and all contents within, including the mattresses, for contraband.

Petitioner testified that half of her time as a wing officer was spent working in the infirmary. She testified that working in the infirmary was also hand-intensive, because the doors were not easy to open and everything remained locked. Petitioner testified that the doors were not easy to open. The Infirmary doors stay locked. The doors in the laundry room, closet, bio hazard room, the break room in the back, every door, the shower room, and bathroom stay locked. According to Petitioner, one would have to follow the workers around and key them in and out and stay with them. She would also have to key the nurse in and out.

Petitioner testified that in the years 2009 and 2010, she worked an average of 4 overtime shifts per pay cycle, because Respondent was short-staffed. Petitioner also testified that she was typically assigned to the control room or a control pod when she worked overtime. Petitioner testified that she worked both the day shift and the second 3 to 11 shift, and stated that there was

the same amount of movement on both shifts. Petitioner also testified that staff was not rotated every 90 days as indicated in the analyses.

When asked if she began developing symptoms in her hands and arms during the course of her employment, Petitioner responded in the affirmative. Petitioner testified that she believed her duties as a pod officer contributed to her problem the most. Petitioner testified that the problem was finding the actual door that needed to be opened and getting the mouse to do that and position. Hitting the button was not a problem as it would open the door right away; however, she had to hold the mouse down while getting the arrow just where you needed it and it would take a little time. Petitioner testified that she had to apply pressure to the mouse button while the pointer is over the arrow on the sidebar to scroll through the screens. The Arbitrator notes that Petitioner's wrist was in a fixed position while utilizing the mouse.

Petitioner denied being previously diagnosed with carpal tunnel syndrome nor had she undergone electrodiagnostic studies. She acknowledged that in 2008 she was treated for tendonitis in her thumb and the top part of her wrist. She didn't file a workers' compensation claim for it and didn't believe she ever saw a specialist for the condition.

Petitioner testified that right before her surgery she was having so many problems doing anything with her right wrist and hand that she began compensating for her left hand as much as possible. She couldn't sweep or "nothing," even at home. Her hand was constantly numb. She couldn't hold on to anything. Petitioner also testified that she required no significant treatment in her left upper extremity.

Petitioner testified that she does not suffer from diabetes, gout, hypothyroidism or rheumatoid arthritis. Petitioner weighs 125 pounds. Petitioner testified that she infrequently rides a motorcycle and does minimal gardening; the Arbitrator notes, however, that Petitioner's symptoms are predominantly right-sided.

Petitioner testified that September 27, 2010, was the first time she had ever received electrodiagnostic testing, and the first time that she was diagnosed with carpal tunnel syndrome. (T.29, 30).

On cross-examination Petitioner agreed that inmate movement was minimal after 9:30 – 11 pm when the inmates were locked up for the evening, so there was very little opening of cell doors during that time.

On cross-examination Petitioner admitted that as the control pod officer she was also responsible for keeping the log books, handing out keys, and sorting mail. Petitioner also agreed that as a control pod officer she opened the cell doors for mass movement for the chow lines, yard lines, and med lines. Petitioner admitted there were only four buttons that she was required to click to open the cells for a mass movement on a wing. Petitioner also admitted that the

computer screens were touch screen and worked when the facility first opened, but Petitioner testified that over time they starting going out.

On cross-examination Petitioner admitted that when an individual cell was opened typically a wing officer would open it. Petitioner testified that sometimes she would assist a wing officer and open an individual cell, but that the majority of the time the wing officer was supposed to key open the door themselves.

On cross-examination Petitioner testified that she reviewed Respondent's Exhibit 6, Major Thompson's key estimation study, three to four years prior to her arbitration hearing. Petitioner was asked if she agreed with Major Thompson's estimate that when working as a control pod officer in R1 – R4 she would be required to push approximately 500 buttons per shift. Petitioner testified that she disagreed with that estimate and testified she would estimate the number of buttons she pushed to be much higher than that.

On cross-examination Petitioner agreed that when she worked as a control pod officer she did not cuff inmates, use Folger Adams keys to open chuckholes, perform wing checks, or perform shakedowns.

Petitioner testified that she worked the 3 – 11 pm shift and that she believed there was the same amount of movement on that shift as the day shift.

On cross-examination Petitioner agreed the majority of the time she would be using a chuckhole as a wing officer in general population would be when the facility was on lockdown. Petitioner agreed that on the 3 – 11 pm shift she did not pass food or medication through the chuckhole. Petitioner estimated only 1 – 2% of chuckholes were problematic on the wings. Petitioner agreed that Pinckneyville CC employed a full time locksmith and that if a lock, chuckhole, or key needed repaired or replaced she could put in a work order for the locksmith to fix it. Petitioner estimated when she worked as a wing officer she would only submit one work order a month, but if she wasn't working in a wing you wouldn't be doing that.

On cross-examination Petitioner testified that she agreed with Major Thompson's key estimation that a wing officer working in R1 – R4 would use 55 large keys and 45 small keys on the 3 – 11 pm shift.

On cross-examination Petitioner testified that she would be required to shake down two cells per wing, and that on average it would take her twenty minutes to perform a shakedown.

On cross-examination Petitioner testified that she agreed with Major Thompson's key estimation study that stated she would be required to use 10 large keys, 20 small keys, and push 50 buttons while working in the infirmary on the 3 – 11 pm shift.

On cross-examination Petitioner testified that she was assigned to outer patrol several times. Petitioner agreed that as an outer patrol officer she would drive a vehicle on smooth

blacktop pavement around the outer rim of the facility. Petitioner testified that she would perform that activity for half of her shift. Petitioner testified that during the other half of the shift she would work in the tower. Petitioner testified that while working in the tower she was required to watch the perimeter of the grounds, and that one time per shift she would have to unload and reload four rounds in the weapon. Petitioner agreed that while working as an outer patrol officer and the tower officer she would not be cuffing inmates, keying chuckholes, or doing wing checks.

On cross-examination Petitioner testified that she completed a patient intake questionnaire prior to seeing Dr. Brown. Petitioner was asked how she knew her condition was work related at that time. Petitioner testified that she knew it was work related because that was where she was when she started hurting.

Petitioner testified that in 2008 she had some symptoms in her hand, but she was told it was tendonitis. Petitioner testified that her symptoms in 2008 were located in her thumb and the top part of her wrist. Petitioner testified that she did not file a claim for that and didn't believe she ever saw a specialist for her symptoms then. On cross-examination Petitioner testified that she was involved in a motor vehicle accident in 2008 and underwent a cervical MRI at that time.

On cross-examination Petitioner admitted that when she saw Dr. Phillips he told her she might want to obtain a cervical MRI because there could potentially be a cervical component from her neck. Petitioner agreed that when she saw Dr. Mirly two years after seeing Dr. Brown her symptoms had changed. Petitioner testified that Dr. Mirly didn't discuss with her that there could be a cervical component to her problem. Petitioner testified that the reason she was having more problems was because it had been so long. Petitioner was asked about Dr. Mirly's note dated July 20, 2012, where Dr. Mirly stated he discussed with Petitioner the fact that cervical radiculopathy and carpal tunnel could mimic each other. Petitioner testified she did not recall that.

On cross-examination Petitioner acknowledged that starting in 2014, she presented to the Southern Illinois Orthopedic Center for treatment of her cervical spine. Petitioner agreed that she completed a patient intake questionnaire on May 14, 2014, advising Dr. Koth that she was being seen for her neck and right arm and that the problem began a few years earlier. Petitioner was asked if it was accurate that she told Dr. Koth that she'd had an ongoing problem for several years and that her carpal tunnel release helped her fingers but that her arm symptoms continued. Petitioner testified that she did not believe that she'd told Dr. Koth that she had problems with her arm. Petitioner was asked if she had any reason to dispute why Dr. Koth noted she had right-sided pain that also went in to her arm, and Petitioner testified that she didn't know why he said that. Petitioner admitted that she was told that at some point she might benefit from surgery on her neck.

On cross-examination Petitioner admitted she takes a blood pressure pill for hypertension and that she was told she had arthritis in her hands.

On cross-examination Petitioner admitted she was diagnosed with left carpal tunnel syndrome. Petitioner denied receiving any conservative treatment to her left hand. However, she admitted she had been given wrist splints for her left hand as well as her right hand.

Petitioner testified that prior to her right carpal tunnel release, her right hand and wrist were constantly numb and she couldn't do anything with her hand. Petitioner testified that surgery helped and she didn't have any numbness now, but that she doesn't believe one is ever 100% after surgery. Petitioner testified she still has weakness in her right hand and loss of grip strength.

Major Jason Thompson was called to testify for Respondent. Major Thompson testified he was hired by the Department of Corrections in 1996, and then in July 1998, he transferred to Pinckneyville CC where he worked until December 2011. In December 2011, Major Thompson started working at DuQuoin, which is a satellite of Pinckneyville, and he worked there until March 2013, at which time he transferred to Jacksonville Correctional Center. Major Thompson testified that he has worked as a correctional officer, lieutenant, and shift supervisor for the Department of Corrections.

Major Thompson testified that he performed an estimation of key usage at Pinckneyville CC which was marked as Respondent's Exhibit 6. Major Thompson testified that he came up with the estimation both through physical observation and compiling movement totals for a month and then averaging. Major Thompson testified he came up with the approximation of buttons pushed and/or used by pod officers by physically observing them and then averaged the entire month to come up with an average daily usage.

Major Thompson testified that he worked with the Petitioner as her supervisor. Major Thompson testified that it was his job to supervise and observe everyone in the housing units. Major Thompson testified that he heard Petitioner's testimony that she disagreed with his estimation that a control officer would push 500 buttons per shift in general population, and that she believed the actual number pushed was higher. Major Thompson was asked if he disagreed with Petitioner's testimony, and Major Thompson testified that the total number he came up with was actually 400 from observation. He added 20 percent to 25 percent to everything he did to account for fluctuations, and arrived at the number 500. Major Thompson testified that he felt he was very generous with the key usage and button usage in his study.

Major Thompson testified he disagreed with Petitioner's testimony that there was no rest in between her job duties. Major Thompson testified that at certain times of the day everybody was busy, but at certain points of the day nobody was busy. Major Thompson testified that there is intermittent rest in between everything they do and one is not constantly opening doors explaining that that is not how a prison works. The doors stay locked for a reason.

On cross-examination Major Thompson testified that Petitioner would not have to have her hand on the mouse manipulating it the entire time that in an extreme situation Petitioner might press 100 buttons in five minutes, and then she might go an hour without pressing a single button. Major Thompson testified that one's hand isn't on that mouse seven and a half hours a day as nothing else would get done if that was the case. Major Thompson testified that he thought she spent maybe 40 to 50 percent of her time on the buttons, but that would be high.

On cross-examination, he testified that since the touchscreens started breaking and Respondent could not get replacement parts, Respondent opted to go to using a mouse rather than undertake the expense of buying brand new touch screens. Major Thompson testified that Petitioner was an "ace in the pod."

On re-direct Major Thompson testified it only took a fraction of a second to open a cell door. Major Thompson testified it took five key strokes to do a mass open of the cells for a mass movement.

Petitioner was recalled for rebuttal after Major Thompson's testimony. Petitioner testified the problem wasn't pushing the button, but was finding the actual door that you need to open with the mouse and getting it to work and positioning. On cross-examination Petitioner estimated that it might take 15 seconds to open a door. Petitioner agreed that it would take approximately 1 minute and fifteen seconds to do a mass movement on a wing because she was pushing five buttons. Petitioner agreed that to do a mass movement on all four wings it would take approximately five minutes. Petitioner estimated that there would be four mass movements per wing on the 3 – 11 pm shift. Petitioner agreed that when opening individual cell doors correctional officers were supposed to open those themselves.

The Arbitrator concludes:

1. Accident and Causal Connection.

   Petitioner failed to prove she sustained an accident on September 27, 2010, that arose out of her employment with Respondent. Petitioner failed to prove that her condition of ill-being in her bilateral hands and/or arms is causally related to her alleged accident of September 27, 2010.

   With regard to any claim of bilateral arm complaints, the Arbitrator notes Petitioner's lack of testimony regarding the development of same. Furthermore, no doctor rendered an opinion regarding any arm complaints and their relationship to Petitioner's job duties for Respondent.

With regard to Petitioner's bilateral hand complaints, the Arbitrator's determinations herein are based upon a failure of proof in that the opinion of Petitioner's treating physician, Dr. Mirly, was not persuasive. Furthermore, there were inconsistencies in Petitioner's testimony regarding the onset of her complaints (especially on the left side) and she was not forthright with her doctors concerning the onset of her right hand/wrist problems.

The causation and "arising out of" components of this case center around Petitioner's job(s) for Respondent. However, one of the problems with that in this particular case is that the focus was on the job of a "correctional officer" generically rather than the job of Petitioner as a "correctional officer." As a correctional officer what one does can vary greatly and what one might do in segregation or the infirmary can be as different and unique as what one does as a control pod officer. Yet, both are referred to as "correctional officers." Furthermore, over the length of one's employment as a correctional officer one can be assigned to various locations and have different job responsibilities and duties. The responsibilities of a wing officer and a control room/pod officer are very different.

When Petitioner originally reported her alleged injury to Respondent she claimed the following job tasks resulted in her injury: (1) keying locks to open and close heavy doors; (2) clipping and unclipping large heavy key rings and radios from duty belt; and (3) operating 4 wing computers. (RX 2) However, no one ever obtained the exact details regarding these tasks, how she performed them, how often she performed them, and how her hands and arms were utilized in performing specific tasks. Petitioner's testimony regarding her job duties provided the best evidence of what she did as a corrections officer. Her supervisor, Major Malcolm, completed a Supervisor's Report and indicated Petitioner was primarily a control pod officer. Respondent's job roster assignment sheet shows that from 2009 to 2011 Petitioner's primary job assignment was in the Control Room. Petitioner indeed focused her testimony on the lay-out and manner in which she performed the control pod duties and, yet, none of her treating physicians was aware of these details nor did they provide persuasive causation opinions based upon her description as provided at the arbitration hearing.

Petitioner testified that seventy percent of her time with Respondent was split as a control officer and twenty-five percent of her time was as a wing officer. Dr. Sudekum possessed the most knowledge regarding the lay-out of the control room but none of the depositions focused on the manner in which Petitioner performed the job she did seventy percent of her time. While there is brief mention in the depositions about a touch screen, Petitioner testified to using a mouse, not a touch screen. She denied that repetitive keyboarding itself played any role in her injury. While her attorney testified that she described how she used the mouse to Dr. Mirly, Dr. Mirly never corroborated that. In addition to how

she held and utilized the mouse, Petitioner took issue with the pushing and pulling she did with her hands and arms as she moved between computers within the control room. No doctor was aware of that.

In addition to the treating doctors lacking a full understanding of Petitioner's job duties as a control room/pod officer, the Arbitrator also notes that Petitioner was not forthright in her histories as provided to these doctors. Petitioner had right upper extremity complaints prior to September 15, 2010 and had sought treatment for them. However, Petitioner denied any prior treatment when she initially presented to Dr. Brown and suggested only a one year history of progressive bilateral numbness and tingling. Petitioner's right-sided complaints and problems, however, date back to 2000. In 2008 Petitioner was scheduled to see Dr. Young for right wrist problems. Those records weren't introduced nor did Petitioner provide any explanation concerning her care and treatment at that time.

Petitioner has alleged bilateral arm and hand problems. It is clear from her testimony that her duties as a control room/pod officer primarily required her to use her right hand. This would not explain how her left hand, wrist and/or arm complaints came to be and when she initially presented to Dr. Brown, she had bilateral complaints and was diagnosed with bilateral carpal tunnel syndrome. Petitioner testified that her left hand/wrist began bothering her just prior to her surgery when she was overcompensating for her right wrist by using her left hand/wrist more. However, that testimony isn't corroborated by the medical records. While Petitioner also denied receiving any treatment to her left hand, the medical records indicate otherwise. She received conservative treatment to her left hand/wrist and, at one point, was scheduled to undergo surgery with Dr. Brown.

It is axiomatic that in a repetitive trauma case the unique facts of each case must be closely analyzed and considered and, in appropriate cases, compensation should be given to an individual who proves her injury, while gradual in nature, is nonetheless linked to her work. In this case, none of the physicians who treated Petitioner provided opinions based upon the unique facts of Petitioner's job. Dr. Brown was not deposed. Dr. Mirly provided an opinion; however, he clearly acknowledged that Petitioner's job duties were not a topic of conversation between them as she did not claim her problem was work-related and his notes contain no description or summary of her job duties. When asked if any of the job duties Petitioner had listed on her job description could contribute or aggravate carpal tunnel syndrome, Dr. Mirly never succinctly answered the question; instead, he summarized her paragraph long narrative noting a "very relatively low intensity to mark if a person's in a room" and that didn't seem intensive and when Dr. Mirly engaged in extensive longhand writing he would have to stop and shake his hand to give it a break (the doctor himself having had carpal tunnel syndrome) but he didn't know how long Petitioner's reports were, and she handled mail but he didn't know the weight or how many pieces so he didn't know if it was high intensity or high weight.

Having said all that, the doctor testified, "...those would be the type of activities in her one paragraph that would be the type of activities contributory." (PX 10, pp. 28-30)

However, Dr. Mirly went on to acknowledge that he didn't go into a great deal of detail regarding Petitioner's job. (PX 10, p. 41) He was unfamiliar with her shift or the days of the weeks she worked. He didn't know what specific jobs/assignments Petitioner had as a correctional officer. On further cross-examination Dr. Mirly did mention that in Petitioner's one page job description there was some "talk of using on the computer" but it was more in the area of the pod. When asked if the activities of being in the control room where one is "simply using a touchscreen or a keyboard," would predispose one to or aggravate carpal tunnel syndrome, Dr. Mirly replied, "[T]hose activities would be much less strenuous or contributory than others. Again, not personally observing them, but unless you're doing a significant amount of mouse work, typing..... But again, I think using a touchscreen would be of a minimal but negligible contributing activity for carpal tunnel. (PX 10, pp. 58-59) Dr. Mirly simply did not have an informed opinion as to Petitioner's job or the tasks she felt accounted for her injury.

Petitioner bears the burden of proof on the issues of accident and causal connection. Petitioner failed to meet her burden of proof herein and her claim is denied. No benefits are awarded. All other issues are moot.

****

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Lori Crowder,
Petitioner,

vs.

NO: 14WC 15569

16IWCC0656

City of Springfield,
Respondent,

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 8, 2015, 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: OCT 14 2016
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CJD/jrc
049

Joshua D. Luskin

Ruth W. White

DISSENT

I must respectfully dissent from the Decision of the majority. The majority agreed with the Arbitrator who found that the Petitioner failed to prove she sustained an accidental injury that arose out of and in the course of her employment by respondent on 2/14/14.

There is no question that Petitioner was on Respondent's premises when she fell, or that despite the walk having previously been plowed, snow and ice had accumulated when Petitioner was walking. (Rx1) The evidence is also clear that Petitioner sustained a broken ankle requiring surgery as a result of her fall. (Px2 and Px4)

Accidental injuries sustained on an employer's premises within a reasonable time before and after work are generally deemed to be in the course of the employment. However, the fact that an injury is in the course of the employment is not sufficient to impose liability; to be compensable, the injury must also "arise out of" the employment. For an injury to arise out of the employment its origin must be in some risk connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury. Sisbro, Inc. v. Industrial Comm'n, 207 Ill.2d 193, 203 (2003), Caterpillar Tractor Co, v. Industrial Comm'n, 129 Ill.2d 52, 62 (1989).

If an employee is exposed to a risk common to the general public to a greater degree than other persons, the accidental injury is also said to arise out of her employment. However, if the injury results from a hazard to which the employee would have been equally exposed apart from the employment, or a risk personal to the employee, it is not compensable. Caterpillar Tractor Co, v. Industrial Comm'n, 129 Ill.2d 52, 58 (1989).

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. Petitioner was on her break when she fell while walking to get coffee at a Starbucks. Petitioner exited through the west entrance, which was the same entrance used for ingress and egress by members of the public. Although Petitioner testified she could have walked out the east exit to get to the Starbucks, it would have taken her longer and she might not have made it back to the premises before the end of her break. (Tr. p. 18, 40) When an injury to an employee takes place in an area which is the usual route to the employer's premises, and the route is attendant with a special risk or hazard, the hazard becomes part of the employment. Petitioner could have gone out the back door, but she was sure it would have been snowy too. (Tr. p. 18) Petitioner takes two breaks per day and will usually go outside, walk around and get a snack or go to the coffee shop. She typically exits the front door. It's rare she uses the back. (Tr. p. 13-14) Special hazards or risks encountered as a result of using a usual access route satisfy the "arising out of" requirement of the Act. See Bomarito v. Industrial Comm'n, 82 Ill.2d 191, 195 (1980); see also Mores-Harvey v. Industrial Comm'n, 345 Ill. App.3d 1034, 1040 (2004).

Petitioner's injuries also arose out of her employment under the personal comfort doctrine. The personal comfort doctrine is relevant to the determination of whether an

employee's injury occurred "in the course of" her employment. Circuit City Stores, Inc. v. Illinois Workers' Compensation Comm'n, 391 Ill. App.3d 913, 921 (2009). According to the personal comfort doctrine, an employee, while engaged in the work of his or her employer, may do those things that are necessary to his or her health and comfort, even though personal to him or herself, and such acts will be considered incidental to the employment. Illinois Consolidated Telephone Co. v. Industrial Comm'n, 314 Ill. App.3d 347, 350 (2000). The Supreme Court has noted, however, that in lunch hour cases, "the most critical factor in determining whether the accident arose out of and in the course of employment is the location of the occurrence." Eagle Discount Supermarket, 82 Ill. 2d 331, 412 (1980). In the instant case, the accident clearly occurred on Respondent's premises.

Based on the above, I would find that Petitioner sustained a compensable accident that arose out of and in the course of her employment and that she is entitled to medical expenses, temporary total disability, and permanency benefits.

Charles J. DeVriendt

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CROWDER, LORI
Employee/Petitioner

Case# **14WC015569**

CITY OF SPRINGFIELD
Employer/Respondent

16IWCC0656

On 9/8/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.27% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1909 ACKERMAN LAW OFFICE
JAMES W ACKERMAN
1201 S 6TH ST
SPRINGFIELD, IL 62703

0332 LIVINGSTONE MUELLER ET AL
DENNIS O'BRIEN
PO BOX 335
SPRINGFIELD, IL 62705

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

LORI CROWDER,
Employee/Petitioner
v.
CITY OF SPRINGFIELD,
Employer/Respondent

Case # **14** WC **15569**

Consolidated cases: ______

16IWCC0656

An *Application for Adjustment 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 **7/30/15**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **2/14/14**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

In the year preceding the injury, Petitioner earned $**36,291.84**; the average weekly wage was $**697.92**.

On the date of accident, Petitioner was **43** 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 $**00.00** for TTD, $**00.00** for TPD, $**00.00** for maintenance, and $**00.00** for other benefits, for a total credit of $**00.00**.

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

ORDER

Petitioner has failed to prove by a preponderance of the credible evidence that she sustained an accidental injury that arose out of and in the course of her employment by respondent on 2/14/14. Petitioner's claim for compensation is denied.

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

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

Signature of Arbitrator

8/21/15
Date

ICArbDec p. 2

SEP 8 - 2015

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 43 year old administrative zoning secretary, alleges she sustained an accidental injury that arose out of and in the course of her employment by respondent on 2/14/14, when she slipped and fell.

Petitioner works for respondent in the Municipal Center West, a building at 7th and Monroe. There are two entrances and exits. The front exit is considered the main entrance. This door faces 7th Street, and faces towards downtown. Also outside the building on this side is a fountain. This door is not locked during regular business hours and is the door in which the public mostly enter and exit the building. The second entrance/exit is out the back of the building and towards the respondent owned parking lot, that is restricted to employee-only parking during business hours. One can only get in this entrance if they use an employee badge. The public can only get in if they go in with an employee or are let in by someone inside the building. Anyone can exit the building from that door.

The Municipal Center West is a City owned building where some of the City's departments are located. CWLP has an office in that building where the public can pay bills. The zoning department is in the building, and people get building permits in the building. The City Clerk's Office is also in the building, as well as the City Council Chambers and the Springfield Hall of Fame. The public has access to the building and mostly uses the front door for entering and exiting the building.

There is a sidewalk that runs around the block. There is also a walkway that goes from the sidewalk on 7th Street to the west door of the Municipal Center West. That same walkway goes around the fountain in front of the building on the 7th Street side. This walkway is used by both employees and the general public to enter and exit the building. The walkway is owned and maintained by respondent.

Petitioner testified that she would usually use the east entrance to enter the building each day as she parked in the employee parking lot. Petitioner used her employee badge to gain access through the east door. Without it, the door would be locked. Petitioner testified that whenever she wanted to go to Starbucks or downtown she would exit the west door, and walk down the walkway from the building to 7th Street.

Petitioner gets two 15 minutes per day, as well as an hour lunch. Often petitioner used her morning break to go and get coffee from Starbucks. She would leave the Municipal Center West through the west door to walk down the walkway to the sidewalk on 7th Street and then north one block to the Hilton where she would get a coffee from Starbucks. Petitioner agreed that whether she went out the east door or the west door the distance to Starbucks was essentially the same.

On 2/14/14 at approximately 9:11 am, petitioner and a friend, Barb Jones, headed out of the west door of Municipal Center West, and started walking down the walkway towards 7th Street enroute to Starbucks to get a coffee. Snow started falling at approximately 7:27am. The snow was accumulating and at 8:56 am the walkway was shoveled. As petitioner and Jones exited the door and started walking down the walkway petitioner slipped and fell injuring her left foot/ankle. Petitioner was taken to St. John's Hospital via ambulance.

At the emergency room petitioner gave a consistent history of the accident. She had pain and was unable to bear weight. Petitioner was examined and x-rays were taken. She was diagnosed with a left bimalleolar ankle fracture, and displaced ankle fracture. Petitioner underwent a closed reduction of the left ankle.

On 2/20/14 petitioner presented to Dr. Stevens at Springfield Clinic regarding her left ankle. Petitioner reported that she was nonweightbearing and off work. Dr. Stevens examined petitioner and assessed an ankle fracture. He recommended surgical intervention.

On 2/27/14 petitioner underwent an open reduction and internal fixation of the left malleolus, open reduction and internal fixation of the left medial malleolus, and open reduction with manipulation without internal fixation of the posterior malleolus. Petitioner's post operative diagnosis was left trimalleolar ankle fracture subluxation. This procedure was performed by Dr. Benjamin Stevens. Petitioner followed-up post-operatively with Dr. Stevens. This treatment included physical therapy.

Petitioner followed-up with Dr. Stevens on 3/13/14, 4/10/14, 5/22/14, 7/21/15, 10/23/14, and 1/22/15. On 5/22/14 Dr. Stevens released petitioner to light duty desk work. When petitioner last followed-up with Dr. Stevens on 1/22/15 she was doing well. She had occasional stiffness and pain, and quite a bit of swelling with strenuous activity. A physical examination revealed left lower extremity neurovascularly intact, mild edema, tibiotalar motion without crepitus, nontender palpation, and nonantalgic gait. Dr. Steven's assessment was stable approximately 1 year postop course status post left ankle open reduction internal fixation. Dr. Stevens recommended that petitioner continue activity as tolerated, and to follow-up as needed.

Petitioner underwent a physical therapy initial evaluation on 4/16/14 at St. John's Hospital. On 6/2/14 petitioner was discharged from physical therapy after 12 visits for her left ankle rehabilitation. Therapist Wombles noted that petitioner progressed very well with her left ankle rehabilitation program with reports that she had transitioned into her athletic shoes "full time" with no significant difficulty or complaints.

Petitioner testified that currently still experiences problems with her left foot. She testified that it hurts every day. She stated that she does not have full mobility due to the hardware in her ankle. When going up and down steps, petitioner takes one step at a time. Petitioner testified that her foot swells almost every day, and

walking great distances aggravates it. Petitioner limits her walking and no longer takes morning break walks to Starbucks because of the pain. Petitioner is still wearing tennis shoes because she feels that she needs it for stability. Petitioner testified that sandals do not give her the support she needs. Petitioner takes OTC medication for pain in the morning and night, if needed. She stated that her left foot/ankle is sensitive to weather changes and it hurts more when the weather is bad. Petitioner also wears compression socks at time.

C. DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT BY RESPONDENT?

The risk of injury must be inherent in, incidental to or reasonably related to the work of the petitioner. If the accident is the result of a hazard or activity to which the general public is equally exposed, then the injury does not arise out of the employment. There are three types of risks which an employee might be exposed to, namely: 1) risks distinctly associated with the employment; 2) risks which are personal to the employee; and 3) "neutral risks which have no particular employment or personal characteristics." *Illinois Institute of Technology Research Institute v. Industrial Commission,* 314 Ill. App.3rd 149, 162, 247 Ill. Dec. 22, 731 N.E. 2d 795 (2000). Generally, accidents arising from inherent risks are usually compensable while injuries arising from personal risks more than likely are not compensable.

Inherent risks are distinctly associated with the employment and are risks to which the general public is not equally exposed. Since both petitioner and the general public can exit and enter the west entrance to the Municipal Center West at any time the door is open, and petitioner's decision to exit the west entrance to go to Starbucks for a latte during her morning break does not benefit the respondent economically, the arbitrator finds the petitioner was not exposed to an inherent risk. The arbitrator bases this on the fact that petitioner testified that she was not required to go to Starbucks for coffee on her break, and there was coffee available in the Municipal Center West. Additionally, the petitioner admitted that whether she went out the east exit or the west exit of Municipal Center West the distance to Starbucks was essentially the same. The petitioner also admitted that she always entered and exited the east entrance of the building each day to go to and from her car and this exit was only accessible if she used her employee badge. Whereas, the west entrance was where the general public enters and exits the building for City business.

Personal risks are chances of injury brought into the workplace by the employee. Accidents resulting from personal risks are usually not compensable because the risk of injury is placed into the workplace by the employee, is particular to the employee, and is of no benefit to the employer. Although petitioner had access to coffee in the Municipal Center West, and could use either the east or west exit to get to Starbucks in approximately the same amount of time, the petitioner decided to go to Starbucks via the entrance accessed

equally by the general public and slipped on a snow covered walkway that had been shoveled just 15 minutes prior. Due to the snow on the ground and petitioner's decision to go to Starbucks for her coffee and use the west exit, when coffee was readily available within the building, the arbitrator finds the petitioner's risk was not reasonably related to her work duties. The arbitrator further finds petitioner unreasonably increased her risk by leaving the building to go get coffee within one hour of arriving at work when it was clear that the weather conditions outside were less than desirable. The arbitrator finds the petitioner voluntarily exposed herself to an unnecessary danger entirely separate from the activities and responsibilities of her job, and was performing an act of a personal nature solely for her own convenience, an act outside any risk connected with her employment, when she decided to go to Starbucks when it was clearly snowing heavily outside. The arbitrator finds the petitioner's injury resulted from this personal risk.

Neutral risks are those risks of injury which are neither peculiar to the employment nor personal to the employee. Given the fact that going for a latte at Starbucks within one hour of beginning her work day was personal to the petitioner since coffee was available in the Municipal Center West, the arbitrator finds the petitioner's risk of injury was not a neutral risk.

Based on the above, as well as the credible evidence the arbitrator finds the petitioner has failed to prove by a preponderance of the credible evidence that she sustained an accidental injury that arose out of and in the course of her employment by respondent on 2/14/14. The arbitrator finds the petitioner's injury resulted from a personal risk, and that the general public was exposed to the identical risk.

J. WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY? HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES?
K. WHAT TEMPORARY BENEFITS ARE IN DISPUTE?
L. WHAT IS THE NATURE AND EXTENT OF THE INJURY?

Having found petitioner has failed to prove by a preponderance of the credible evidence that she sustained an accidental injury that arose out of and in the course of her employment by respondent on 2/14/14, the arbitrator finds these remaining issues are moot.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Michael Burks,
Petitioner,

vs. NO: 12WC 31111

Southern Illinois University Carbondale,
Respondent,

16IWCC0657

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, liability for medical expenses, nature and extent and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 3, 2015, 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: OCT 14 2016
o100416
CJD/jrc

Charles J. DeVriendt

Joshua D. Luskin

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BURKS, MICHAEL
Employee/Petitioner

Case# **12WC031111**

12WC031763

SOUTHERN ILLINOIS UNIVERSITY CARBONDALE
Employer/Respondent

16IWCC0657

On 8/3/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.14% 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:

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

AUG 3 = 2016

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

Michael Burks
Employee/Petitioner

v.

Southern Illinois University Carbondale
Employer/Respondent

Case # **12** WC **31111**

Consolidated cases: **12 WC 31763**

16IWCC0657

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

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [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 **June 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 not*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**41,845.61**; the average weekly wage was $**804.72**.

On the date of accident, Petitioner was **37** 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, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**0**.

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

ORDER

The Arbitrator finds that the Petitioner has failed to sustain his burden in connecting that alleged injury to his current condition of ill being.

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

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

Signature of Arbitrator

7-30-15
Date

AUG 3 - 2015

STATE OF ILLINOIS)
)SS
COUNTY OF WILLIAMSON)

16IWCC0657

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

MICHAEL BURKS,
Employee/Petitioner

v.

Case No: 12 WC 31111
consolidated with
12 WC 31763

STATE OF ILLINOIS – SOUTHERN ILLINOIS UNIVERSITY CARBONDALE,
Employer/Respondent

This matter proceeded to hearing on July 16, 2014, before Arbitrator Brandon Zanotti in Herrin, Illinois. Prior to issuing written Arbitration Decisions, Arbitrator Zanotti resigned from his position as an Arbitrator. The case was then re-assigned to Arbitrator Jessica A. Hegarty who will issue the written decisions in this matter.

ADDENDUM TO THE DECISION OF ARBITRATOR

FINDING OF FACTS

12 WC 03111

The only disputed issues in this case are causal connection, medical expenses and the nature and extent of the injury.

Petitioner alleges a work related injury on June 12, 2012 when he was cleaning out horse barns at Southern Illinois University. (Tr. 9, 12). He testified he was carrying five gallon buckets of cleaning supplies and stepped on some straw that was covering up some oil on the concrete. According to his testimony, he slipped, fell and experienced pain in his left knee.

Petitioner presented at SIU Healthcare on June 12, 2012 and had x-rays taken of his left knee, which revealed no fractures or dislocation. (PX3). Petitioner took off a couple of days of work and then returned to his normal job duties until his second work accident on August 9, 2012.

Petitioner testified that on August 9, 2012, he was at work, opening one of the SIU buildings at 6:00 A.M. According to his testimony, it was dark in the building and he thought he was at the bottom of a flight of stairs when he missed that last step falling and injuring his left knee again.

On August 9, 2012, Petitioner presented to Robin Gallo, PA-C at Logan Primary Care. (PX2). Petitioner indicated that he had fallen down one step and landed on his left knee. (PX2). He rated the severity of his pain as a five on a one out of 10 scale. (PX2). His knee exam revealed no crepitus, joint line tenderness, or joint effusion. (PX2). He had a negative draw sign and Lachman test; however, he did experience pain with patella ballottement. (PX2).

On August 10, 2012, Petitioner presented to Dr. Mark Smith at Logan Primary Care. (PX2). Dr. Smith took Petitioner off work for one week and ordered one week of physical therapy. (PX2).

On August 16, 2012, Petitioner followed-up with Dr. Smith who noted that Petitioner's left knee was a little better. (PX2). Dr. Smith indicated that Petitioner could return to work on the following Monday without restrictions. (PX2).

On August 27, 2012, Petitioner followed-up with Dr. Smith. (PX2). Petitioner indicated that his left knee was a little better. (PX2).

On September 18, 2012, Dr. Smith ordered an MRI of Petitioner's left knee. (PX1). The MRI showed:

1) Intact menisci;

2) Sprain/intra ligamentous injury involving the distal fibers of the anterior cruciate ligament with intact fibers clearly identified. No abnormal translation of the tibia relative to the femur; and

3) Mild patellar and moderately severe distal quadriceps tendinosis. Minimal lateral subluxation of the patella with low grade sprains involving the medial and lateral patellar retinacula. Nonspecific subcutaneous edema anteriorly. (PX1).

Dr. Smith referred Petitioner to Dr. Treg Brown at the Orthopaedic Institute of Southern Illinois. (PX5).

On October 2, 2012, Petitioner presented to Dr. Brown at the Orthopaedic Institute of Southern Illinois who reviewed the MRI, indicating it showed slight increased signal in the subcutaneous tissues anterior to the patellar tendon, perhaps mild patellar tendinopathy, no lateral meniscus tear, and no effusion present. (PX5). Dr. Brown diagnosed Petitioner with patellar tendonitis and thought it likely Petitioner had a contusion over this area that was slowly resolving. (PX5). Dr. Brown prescribed

Petitioner a Cho-Pat strap, ibuprofen, Voltaren gel, and physical therapy one to three times per week for three weeks. (PX5). Dr. Brown indicated that Petitioner could continue to work full duty and would see him back in six weeks. (PX5).

On November 6, 2012, Petitioner followed-up with Dr. Brown. (PX5). On examination, Dr. Brown noted Petitioner had no true medial or joint line tenderness, but did have pain over the patellar tendon. (PX5). Petitioner was also noted to have full range of motion from zero to 130 degrees. (PX5). Dr. Brown reiterated the MRI showed intact menisci, but recommended a diagnostic ultrasound with possible steroidal injection around the area in question and also an examination of the medial and lateral menisci as Petitioner stated that at some point he was told he had a torn meniscus. (PX5). Petitioner was to continue physical therapy and full duty work. (PX5).

On November 16, 2012, Petitioner was discharged from physical therapy for noncompliance as he had not shown for two appointments and cancelled three appointments. (PX5).

On November 29, 2012, Petitioner underwent an ultrasound of his left knee. (PX5). The medial and lateral menisci were imaged and no type of tear was indicated. (PX5). The impression of the ultrasound was of a small area of focal patellar tendinitis and lateral aspect of the proximal tibial insertion site. (PX5).

On December 13, 2012, Petitioner followed-up with Dr. Brown. (PX5). On physical examination, Dr. Brown noted that Petitioner had mild patella tendinitis. (PX5). Dr. Brown specifically noted "I certainly would expect him to have less pain than what he is complaining of today, which is purely subjective. I do feel there is some symptom magnification on his exam." (PX5). Dr. Brown recommended a Flector Patch, home exercise program, a Cho-Pat strap, and continued full duty work status. (PX5). Dr. Brown opined that Petitioner was rapidly approaching MMI and would see him in two months and release him at that time. (PX5).

On January 10, 2013, Petitioner voluntarily resigned from Southern Illinois University Carbondale. (RX8).

On February 14, 2013, Petitioner followed-up with Dr. Brown. (PX5). On exam, Dr. Brown found Petitioner did not have any crepitus, effusion, or swelling. (PX5). Petitioner had full range of motion both passively and actively and his quad tone was 5/5. (PX5). Dr. Brown noted "I believe likely there is some symptom magnification on the patient's part. Whether he is still having any significant pain or not seems to be in questions...but we are releasing him today full duty, no follow up, and he is considered MMI by our standards." (PX5).

On June 3, 2013, Petitioner then presented to his family doctor, Dr. Anad Salem. (PX4). Petitioner was following up regarding his ADD and complained of continued left knee pain. (PX4).

On October 3, 2013, Petitioner presented to Dr. Angela Freehill, whom he was referred to by Dr. Salem. (PX6). Dr. Freehill noted Petitioner "has marked guarding with the knee and is very hesitant to move it...I cannot actually get a good exam with him due to his guarding." (PX6). Dr. Freehill gave Petitioner a Depo-Medrol injection and recommended additional physical therapy. (PX6). Dr. Freehill did not consider Petitioner a surgical candidate. (PX6).

On October 5, 2013, Petitioner presented to the Herrin Hospital emergency room complaining of a headache and left knee pain at the injection site. (PX1). Petitioner was given a prescription for Reglan and Motrin and sent home. (PX1).

On October 8, 2013, Dr. Freehill reviewed the MRI of Petitioner's left knee, finding a very small ACL tear with most of the fibers entirely intact and some buckling at the PCL, but with intact fibers. (PX6). Dr. Freehill also found no meniscus tear. (PX6). She opined Petitioner's ACL and PCL did not appear to be surgical in terms of their treatment. (PX6).

On December 3, 2013, Petitioner followed up with Dr. Freehill. (PX6). Dr. Freehill's impression of Petitioner was patellofemoral pain and patellar tendonitis. (PX6). She recommended additional physical therapy. (PX6). Petitioner sought no further medical treatment after that time.

Petitioner testified that he no prior problems with his left knee before the June 12, 2012 accident. (Tr. 22). Petitioner testified that his left knee still pops and grinds and that it is an annoying pain. (Tr. 14).

Respondent called Jennifer Batson as a witness. Ms. Batson is the workers' compensation and disability coordinator for SIUC. (Tr. 29). Ms. Batson testified that she has access to and is familiar with Petitioner's personnel file. (Tr. 29). Ms. Batson testified that Petitioner did not miss any work after the June 12, 2012 accident and returned to work full duty the following day. (Tr. 30). Ms. Batson testified that Petitioner received TTD for his time off from the August 9, 2012 accident until he returned full duty on August 20, 2012. (Tr. 30).

Respondent entered into evidence a deposition of Dr. Luke Choi. (RX10). Dr. Choi performed an independent medical examination on Petitioner on May 2, 2014. (RX10, pg. 7). Dr. Choi testified that Petitioner had no soft tissue swelling or ecchymosis and no visible findings of acute trauma. (RX10, pg. 9). Dr. Choi testified Petitioner had a negative Lachman's test and had full range of motion. (RX10, pg. 9). Dr. Choi further noted that Petitioner demonstrated significant guarding and his subjective complaints were out of proportion. (RX10, pg. 9). Dr. Choi opined that Petitioner had a left knee patellar contusion and knee sprain from his June 12, 2012 and August 9, 2012 accidents that has resolved, required no further treatment, and that such diagnoses are temporary in duration without long-standing sequelae and would be resolved in up to three months. (RX10, pg. 12-13, RX9).

CONCLUSIONS OF LAW

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

Petitioner testified that he had not had prior problems with his left knee before the June 12, 2012 accident. (Tr. 22). However, the Arbitrator takes note that Petitioner was referred to an orthopedic surgeon for left knee pain in 2006. (RX11). At that time, he gave a history of problems with his left knee for four years that had gotten worse in the last two months. (RX11). Petitioner was diagnosed with patellofemoral pain and given a knee brace and prescribed physical therapy. (RX11). Further, Petitioner testified that he was diagnosed with a torn meniscus. (Tr. 20). However, the medical records from Dr. Treg Brown and Dr. Angela Freehill, as well as the IME report from Dr. Luke Choi, all indicate that Petitioner has intact menisci. (PX5, PX6, RX9).

On November 29, 2012, Petitioner underwent an ultrasound of his left knee. (PX5). The medial and lateral menisci were imaged and no type of tear was indicated. (PX5). The impression of the ultrasound was of a small area of focal patellar tendinitis and lateral aspect of the proximal tibial insertion site. (PX5).

Petitioner testified that his left knee still pops and grinds and that it is an annoying pain. (Tr. 14). However, Petitioner's subjective complaints were deemed out of proportion with the objective physical examinations and imaging studies performed by his treating doctor and the Section 12 examiner. (PX5, RX9). Every doctor who has examined Petitioner's left knee noted that Petitioner demonstrated significant guarding and symptom magnification. (PX5, PX6, RX9).

Dr. Angela Freehill diagnosed Petitioner with patellofemoral pain and patellar tendonitis. Dr. Luke Choi diagnosed Petitioner with the left knee patellar contusion and a knee sprain. All three of the Orthopedic specialists felt that he had injured his left patella but was not a surgical candidate.

Based on the foregoing, the Arbitrator finds that the Petitioner did suffer a left knee sprain and patellar contusion on August 9, 2012, which is causally connected to his current condition. With respect to the June 12, 2012 injury, the Arbitrator finds that the Petitioner has failed to sustain his burden in connecting that alleged injury to his current condition of ill being.

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?

On November 16, 2012, Petitioner was discharged from physical therapy for noncompliance as he had not shown for two appointments and cancelled three

appointments. (PX5). The Arbitrator finds that the medical records indicate that Petitioner was not compliant with recommended conservative treatment. Further, the Arbitrator finds Respondent's Section 12 examiner, Dr. Luke Choi, is credible in his opinion that Petitioner's left knee patellar contusion and knee sprain would have been resolved in three months' time. Petitioner's original treating doctor released Petitioner from care and at MMI on February 14, 2013. As such, the Arbitrator finds that Respondent shall pay all medical bills dated prior to and including February 14, 2013 as outlined in Petitioner's Exhibit #7. Petitioner's claim for payment of medical bills dated after February 14, 2013 as outlined in Petitioner's Exhibit #7 is hereby denied.

<u>Issue (L):</u> What is the nature and extent of the injury?

Since the accidents occurred after September 1, 2011, Section 8.1(b) of the Act applies. As neither party presented an AMA rating, the Arbitrator relies on the remaining four factors: (i) the occupation of the injured employee; (ii) the age of the employee at the time of the injury; (iii) the employee's future earning capacity; and (iv) evidence of disability corroborated by the treating medical records.

(i) Occupation: Petitioner was employed as a laborer at Southern Illinois University Carbondale. He testified that he resigned his position. At the time of his resignation, Petitioner was working full duty.

(ii) Age: Petitioner was 37 years old at the time of his injury.

(iii) Earning Capacity: There is no direct evidence of diminished future earning capacity in the record.

(iv) Disability: Petitioner testified that his left knee still pops and grinds and that it is an annoying pain. Petitioner did not testify that he is currently taking any pain medication for his left knee. Both Petitioner's treating doctor and the Section 12 examiner indicated that Petitioner displayed symptom magnification.

Based upon the foregoing, The Arbitrator finds that Petitioner has sustained injuries on August 9, 2012 that resulted in the 1% loss of use of his left leg. Respondent shall pay Petitioner permanent partial disability benefits of $482.83/week for 2.15 weeks, because the injuries sustained caused the 1% loss of use of the left leg, as provided in §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 WILLIAMSON	)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
			☐ PTD/Fatal denied
		☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Michael Burks,
Petitioner,

vs. NO: 12WC 31763

Southern Illinois University Carbondale,
Respondent,

16IWCC0658

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, liability for medical expenses, nature and extent and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 3, 2015, 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: OCT 1 4 2016
o100416
CJD/jrc

Charles J. DeVriendt

Joshua D. Luskin

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BURKS, MICHAEL
Employee/Petitioner

Case# **12WC031763**

12WC031111

SOUTHERN ILLINOIS UNIVERSITY CARBONDALE
Employer/Respondent

16IWCC0658

On 8/3/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.14% 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:

1167 WOMICK LAW FIRM CHTD
CASEY VANWINKLE
501 RUSHING DR
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CERTIFIED as a true and correct copy pursuant to 820 ILCS 305 / 14

AUG 3 - 2015

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

Michael Burks
Employee/Petitioner

v.

Southern Illinois University Carbondale
Employer/Respondent

Case # 12 WC 31761

Consolidated cases: **12 WC 31111**

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

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [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 **August 9, 2012**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**41,845.61**; the average weekly wage was $**804.72**.

On the date of accident, Petitioner was **37** 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 $**230.01** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**230.01**.

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

ORDER

Based upon the foregoing, the Arbitrator finds that Petitioner has sustained injuries that resulted in a 1% loss of the left leg. Respondent shall pay Petitioner permanent partial disability benefits for 2.15 weeks, because the injuries sustained caused a 1% loss of the left leg, as provided in §8(d)2 of the Act.

Respondent must pay for all reasonable and necessary related medical bills as outlined in the Memorandum of Decision of Arbitrator.

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

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

Signature of Arbitrator

7-30-15
Date

AUG 3 - 2015

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

William Logue,
Petitioner,

vs. NO: 13WC 6025

State of Illinois, Department of Transportation,
Respondent,

16IWCC0659

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 11, 2015, 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: OCT 14 2016
o100516
CJD/jrc
049

Charles J. DeVriendt

Joshua D. Luskin

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

LOGUE, WILLIAM
Employee/Petitioner

Case# **13WC006025**

SOI DEPARTMENT OF TRANSPORTATION
Employer/Respondent

16IWCC0659

On 8/11/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.24% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2028 RIDGE & DOWNES LLC
JOHN E MITCHELL
415 N E JEFFERSON AVE
PEORIA, IL 61603

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

0988 ASSISTANT ATTORNEY GENERAL
BRETT D KOLDITZ
500 S SECOND ST
SPRINGFIELD, IL 62706

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

1430 CENTAL MGMGT SERVICES
WORKERS' COMP MANGER
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

AUG 11 2015

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

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

William Logue
Employee/Petitioner

Case # 13 WC 6025

v.

16IWCC0659

State of Illinois, Department of Transportation
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Anthony C. Erbacci**, Arbitrator of the Commission, in the city of **Rock Island**, on **June 11, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of 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 **January 8, 2013**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**49,179.00**; the average weekly wage was $**945.75**.

On the date of accident, Petitioner was **55** years of age, ***single*** with **1** dependent children.

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

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

Respondent shall be given a credit of $**11,625.15** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**11,625.15**.

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

ORDER

Respondent shall pay medical expenses for treatment provided the Petitioner by Burt Clinic Chiropractic, Orthopaedic Specialists, Mississippi Valley Surgery Center, Radiology Group, and Genesis Imaging Center through October 9, 2013 and subject to the limitations of the Medical Fee Schedule provided for in the Act. Respondent is entitled to a credit for any medical bills paid through its group medical plan under Section 8(j) of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $**630.50**/week for **27 3/7** weeks, commencing **April 1, 2013** through **October 9, 2013**, as provided in Section 8(b) of the Act. Respondent shall be given a credit of $**11,625.15** for temporary total disability benefits that have been paid.

Respondent shall pay Petitioner permanent partial disability benefits of $**567.45**/week for **12.5** weeks, because the injuries sustained caused the **2.5%** 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

August 7, 2015
Date

AUG 1 1 2015

FACTS:

On January 8, 2013 the Petitioner was employed by the Respondent as a seasonal highway maintainer. The Petitioner testified that he worked from November through March of each year and that he had been employed in that manner for 7 years. The Petitioner described that his job duties included plowing snow, driving and maintaining trucks, fixing roads, and removing trees and brush.

The Petitioner testified that on January 8, 2013, while he was performing the regular duties of his employment, he was struck on the right side of his body by a tree limb which was being moved by a back hoe. The Petitioner testified that he became "airborne" and landed on his left side. He testified that he was helped up from the ground by his co-workers and that he noticed that he was extremely stiff and sore. It is not disputed that the Petitioner sustained accidental injuries that arose out of and in the course of his employment with the Respondent. It is also not disputed that timely notice of the accident was provided to the Respondent.

The Petitioner testified that he first sought medical treatment following his injury on January 14, 2013 when he saw Chiropractor Chad Burt. The records of Burt Chiropractic demonstrate that the Petitioner was seen there on January 14, 2013 with complaints of low back pain, which radiated to the right buttock and right thigh, upper back pain, neck pain and headaches, and knee pain. The chiropractic assessment included sciatica to the right leg, lumbar and SI sprain/strain, and possible disc lesion. The Petitioner continued chiropractic treatment with Dr. Burt and, on February 4, 2013, he underwent a lumbar MRI. That MRI was reported to demonstrate L5-S1 degenerative disc disease with bilateral small disc herniations causing stenosis and impingement on the right S1 nerve root sleeve.

On February 14, 2013 the Petitioner saw Dr. Michael Dolphin on referral from Dr. Burt. The Petitioner's chief complaint was noted to be right leg pain and low back pain and it was noted that the right leg pain developed acutely on January 8, 2013 when he was struck by a backhoe. After examination and review of the MRI, the assessment was lumbar degenerative disc disease and lumbar radiculitis. The Petitioner was given an epidural steroid injection and continued on light duty work. On March 12, 2013 the Petitioner was given another epidural steroid injection. The Petitioner also continued to treat with the chiropractor.

The Petitioner returned to Dr. Dolphin on March 27, 2013 and another epidural steroid injection was prescribed. On April 24, 2013 the Petitioner returned to Dr. Dolphin and it was noted that he was 50-60% better. The Petitioner was referred for physical therapy and hs also continued to treat with the chiropractor. The Petitioner continued to follow up with Dr. Dolphin in June, July, September, and October and was noted to be improving on each of those occasions. The Petitioner last saw Dr. Dolphin on October 9, 2013 and the assessment was low back pain and degenerative disc disease at L5-S1. At that time, Dr. Dolphin released the Petitioner to return to work with instructions to avoid tree trimming and brush clearing work. The Petitioner testified that he returned to work for the Respondent in the middle of November 2013.

The Petitioner testified that currently he continues to have constant discomfort in his low back and into his buttocks. He testified that he has to change positions every 30 to 40 minutes and he has to sleep on the floor as sleeping in a bed causes increased pain.

At the request of the Respondent, the Petitioner was examined by Dr. Lawrence Li on July 14, 2014. Dr. Li opined that as a result of being struck by the backhoe on January 8, 2013, the Petitioner sustained a lumbar contusion/strain which resolved within four months of the injury. Dr. Li indicated that the Petitioner had pre-existing degenerative disc disease with no compression of the nerve roots and that those findings were unrelated to the work injury. Dr. Li opined that the Petitioner was not in need of any further medical treatment as a result of his injury and that the Petitioner had reached maximum medical improvement from his work injury. Dr. Li further reported that the Petitioner had a whole person impairment rating of 1% based upon the AMA Guides for Evaluation of Permanent Impairment, Sixth Edition.

In a letter report dated December 10, 2014 and directed to the Petitioner's attorney, Chiropractor Chad Burt opined that the Petitioner's symptoms and subsequent care were directly related to the injuries he sustained in his work accident. Chiropractor Burt indicated that the Petitioner now has chronic back and buttock symptoms that are the result of his work accident and that he will likely have permanent or recurrent symptoms associated with his condition. Chiropractor Burt further indicated that the Petitioner would likely require further care for management of his complaints.

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:

Dr. Li, the Respondent's examining physician, opined that the Petitioner sustained a lumbar contusion/strain as a result of his work accident which would have resolved within four months of the injury. Chiropractor Burt opined that the Petitioner's injury was "more complex" than the lumbar contusion diagnosed by Dr. Li and was directly related to the Petitioner's work injury. The Arbitrator notes the opinions of Dr. LI and Chiropractor Burt and finds that as a result of the work injury of January 8, 2013, the Petitioner sustained a lumbar strain/sprain injury which resulted in an aggravation of his pre-existing degenerative disc disease. The Arbitrator further finds that the Petitioner reached maximum medical improvement from his injuries by October 9, 2013, the date he was released to return to work by Dr. Dolphin.

Based upon the foregoing, and having considered the totality of the credible evidence adduced at hearing, the Arbitrator finds that the Petitioner's condition of ill-being through July 14, 2014 was causally related to the work injury of January 8. 2013. The Arbitrator further finds that the Petitioner reached maximum medical improvement from his injuries by October 9, 2013, and that his condition of ill-being thereafter is not causally related to the work injury of January 8. 2013.

In Support of the Arbitrator's Decision relating to (J.), Were the medical services that were provided to Petitioner reasonable and necessary/Has Respondent paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds and concludes as follows:

The Arbitrator's findings and conclusions relating to the issue of causation are adopted and incorporated herein.

The Petitioner introduced evidence of medical expenses for treatment provided to him by Burt Clinic Chiropractic (Chiropractor Burt), Orthopaedic Specialists (Dr. Dolphin), Mississippi Valley Surgery Center (Dr. Miller), Radiology Group, and Genesis Imaging Center. The Arbitrator finds that the treatment rendered to the Petitioner for his lower back and right buttocks complaints by the above providers from January 14, 2013 through October 9, 2013, the date he has been found to have reached maximum medical improvement, was reasonable, necessary and causally related to the Petitioner's work injury and that the Respondent is liable for payment of those expenses subject to the limitations of the Medical Fee Schedule provided for in the Act. The Arbitrator finds that the care and treatment rendered to the Petitioner after October 9, 2013, the date he has been found to have reached maximum medical improvement, was not causally related to the Petitioner's work injury and that the Respondent is not liable for payment of the expenses related to that treatment.

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

The Petitioner claimed to be entitled to Temporary Total Disability benefits from March 31, 2013 through October 9, 2013, a period of 27 3/7 weeks. The parties stipulated that the Respondent has paid $11,625.15 in Temporary Total Disability benefits and is entitled to credit for that amount.

The Petitioner was employed by the Respondent as a seasonal worker and he testified that he worked from November through March of each year. The Petitioner testified that following his work injury, he continued to work restricted duty until the end of his contract on March 31, 2013. He testified that he had not been released to return to regular duty work when his contract ended and that he did not return to work until the middle of November 2013, after he had been released to return to work on October 9, 2013. The Petitioner testified that he did not look for any other work during 2013.

Although the Petitioner went off work as a consequence of the ending of his seasonal contract, the Petitioner was still subject to work restrictions at that time and he had not yet reached maximum medical improvement from his injuries. Thus, the Arbitrator concludes that the Petitioner is entitled to Temporary Total Disability benefits from April 1, 2013 through October 9, 2013, a period of 27 3/7 weeks. The Respondent is, however, entitled to credit for the $11,625.15 in Temporary Total Disability benefits that it has paid to the Petitioner.

16IWCC0659

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 Petitioner's alleged accident occurred after September 1, 2011. Therefore, Section 8.1(b) of the Act requires consideration of the following criteria in determining the level of permanent partial disability:

* The reported level of impairment based upon the most current edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment;
* 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.

No single enumerated factor shall be the sole determinant of disability but the relevance and the weight of any additional factors used must be explained.

In the instant case, the Petitioner suffered a lumbar strain/sprain injury which resulted in an aggravation of his pre-existing degenerative disc disease. The Petitioner reached maximum medical improvement from those injuries by October 9, 2013 and he was released to return to work with instructions to avoid tree trimming and brush clearing work.

With regard to the reported level of impairment pursuant to Section 8.1(b), the level of impairment reported by Dr. Li, the Respondent's examining physician, pursuant to the American Medical Association's Guides to Evaluation of Permanent Impairment is 1% of the whole person. No impairment rating was reported by any other physician. While the Arbitrator notes that impairment does not equate to permanent partial disability under the Workers' Compensation Act, the Arbitrator finds the reported level of impairment to be a significant factor in determining disability in the instant matter.

With regard to the occupation of the injured employee, the Petitioner's occupation is that of a seasonal highway maintainer, which the Arbitrator notes can be strenuous work. The Arbitrator concludes that the Petitioner's ability to perform the duties of his employment will be more adversely affected by his permanent partial disability than would the ability of an individual who performs lighter work. Thus, the Arbitrator concludes that the Petitioner's occupation is also a significant factor in determining disability in the instant matter.

With regard to the age of the employee at the time of injury, the Petitioner's age at the time of injury was 55 years old. The Arbitrator considers the Petitioner to be an older younger individual and concludes that the Petitioner's age is also a significant factor in determining disability in the instant matter.

With regards to the employee's future earning capacity, the Arbitrator notes that the Petitioner's future earning capacity appears to be unaffected by the injury. Thus, the Arbitrator concludes that the Petitioner's future earning capacity is not a factor in determining disability in the instant matter.

With regard to the evidence of disability corroborated by the treating medical records, the Petitioner testified that he currently continues to have constant discomfort in his low back and into his buttocks. He testified that he has to change positions every 30 to 40 minutes and he has to sleep on the floor as sleeping in a bed causes increased pain. These complaints are corroborated in the medical records of Chiropractor Burt and the Petitioner's complaints as supported by the medical records, evidence a disability as indicated by Commission decisions regarded as precedent pursuant to Section 19(e).

The determination of permanent partial disability is not simply a calculation but an evaluation of all 5 factors as stated in the Act. In making this evaluation of permanent partial disability, consideration is not given to any single enumerated factor as the sole determinant. Therefore, having considered the factors enumerated in Section 8.1(b) of the Act, 820 ILCS 305/8.1(b), the Arbitrator finds that as a result of his accidental injuries the Petitioner has sustained a 2.5% disability to his whole person.

STATE OF ILLINOIS)
) SS.
COUNTY OF McLEAN)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Barbara Harris-Calcote,
Petitioner,

vs. NO: 11 WC 24478

Kelly Services,
Respondent.

16IWCC0660

DECISION AND OPINION ON REVIEW

Timely Petition for Review under Section 19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, casual connection, temporary total disability, permanent partial disability, medical expenses, prospective medical expenses and notice and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission does note that the Decision includes boilerplate 19(b) language noting that a subsequent hearing for further medical benefits or disability is not barred by this decision. Because the claimant failed to prove accident, causal relationship, and notice, the boilerplate language is inapposite. The Commission therefore strikes that sentence from the Decision. All other findings and conclusions are affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that other than noted above, the Decision of the Arbitrator filed August 28, 2015, is hereby affirmed and adopted.

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

DATED: OCT 1 4 2016

Joshua D. Luskin

Charles J. DeVriendt

o-10/05/16
jdl/wj
68

Ruth W. White

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

HARRIS-CALCOTE, BARBARA Case# **11WC024478**
Employee/Petitioner

KELLY SERVICES
Employer/Respondent

16IWCC0660

On 8/28/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.20% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in 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

2674 BRADY CONNOLLY & MASUDA PC
NOAH HAMANN
705 E LINCOLN ST SUITE 313
NORMAL, IL 61761

STATE OF ILLINOIS)
)SS.
COUNTY OF McLean)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Barbara Harris-Calcote
Employee/Petitioner

v.

Kelly Services
Employer/Respondent

Case # 11 WC 24478

Consolidated cases: ____

16IWCC0660

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **McCarthy**, Arbitrator of the Commission, in the city of **Bloomington**, on **6/29/2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

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

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

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

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

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

G. [ ] What were Petitioner's earnings?

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

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

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

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

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

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

N. [ ] Is Respondent due any credit?

O. [ ] Other ____

FINDINGS

On the date of accident, **3/3/11**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident *was not* given to Respondent.

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

In the year preceding the injury, Petitioner earned $**8,447.04**; the average weekly wage was $**301.68**.

On the date of accident, Petitioner was **44** years of age, *married* with **1** dependent children.

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

Respondent shall be given a credit of $**N/A** for TTD, $**N/A** for TPD, $**N/A** for maintenance, and $**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

Petitioner failed prove she sustained any work injury arising out of or in the course of employment. She failed to prove a casual connection between her work duties and her left foot condition and she failed to timely report any alleged work injury. All benefits are denied.

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

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

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

D. Dylan McCarthy
Signature of Arbitrator

Aug. 17, 2015
Date

ICArbDec19(b)

AUG 28 2015

FINDINGS OF FACT

The petitioner alleges a left foot injury as a result of repetitive trauma. She claims an accident date of March 3, 2011. She was employed by Kelly Services, which is a temporary staffing agency. She was placed by Kelly Services at Illinois Wesleyan University as a janitor. She worked for the respondent at Illinois Wesleyan in this role from August 19, 2010 to March 28, 2011.

Testimony of the Petitioner

The petitioner testified that she worked as a janitor at Illinois Wesleyan. She was responsible for cleaning the first and third floors of a university building. She testified that her job duties included vacuuming, mopping floors, sanitizing the shower and carrying supplies up the stairs to the third floor. She explained that in order to get to the third floor, she had to climb four flights of stairs. The stairs were concrete. She testified that she climbed the stairs eight to ten times each day to restock supplies. The petitioner testified that she worked 40 hours a week, and was on her feet for six hours a day.

The petitioner testified that she had no prior left foot symptoms, and no prior treatment related to her left foot. The petitioner testified that she began noticing left foot pain on or about early March 2011. On March 3, 2011 she sought treatment with her primary care physician, Dr. Joseph Liu. Dr. Liu referred her to physical therapy in March 2011. She testified that she did not initially report any injury to her employer because she thought her condition was minor and that it would improve.

On March 28, 2011 the petitioner testified that she was instructed to leave work at Illinois Wesleyan for a meeting with her supervisor at Kelly Services, Jhane Melton. At that meeting the petitioner was terminated for failing to disclose a felony drug manufacturing and delivery conviction. The petitioner maintains she did disclose the felony at the time she applied for work.

The petitioner says during the March 28, 2011 meeting, she reported her left foot pain as work-related. The petitioner claims her supervisors at Illinois Wesleyan were aware of a left foot work injury prior to March 28, 2011. No witnesses testified on behalf of the petitioner.

The petitioner testified that in January of 2011, while working for the respondent, she got cleaner in her eye and she reported that injury to the respondent the same day. She also confirmed that she had filed workers' compensation claims in the past.

Since the alleged work injury, the petitioner testified that she worked at Labor Ready in 2012 and as a receptionist in 2013; however, she claims she was unable to maintain these jobs due to foot pain. She testified that she has reapplied with Kelly Services several times since her termination in 2011, most recently in November of 2014.

At trial the petitioner complained of being unbalanced because of her foot. She reported sharp pain to her left foot and she says she needs a cane to ambulate. She is not working. She testified her pain is worse now than it was when she was working for the respondent.

Testimony of Jhane Melton

Jhane Melton testified on behalf of Kelly Services. She is a district manager for the respondent and she was the petitioner's supervisor. Ms. Melton testified that all employees are required to participate in an orientation session at the time of hire. During that orientation, each employee is given instructions about the policies and procedures for reporting work injuries. She testified that employees are taught to immediately report work injuries to Kelly Services. Ms. Melton testified that if an employee is injured, the employee would report it to Ms. Melton. Ms. Melton testified that the petitioner participated in this training when she was hired in August 2010.

Ms. Melton refuted the petitioner's claims that notice of the work injury was reported on March 28, 2011. Ms. Melton testified that notice was not given until April 18, 2011. Ms. Melton claims the only discussion that took place on March 28, 2011 concerned termination of the petitioner for failing to

disclose the felony. Ms. Melton testified that no work injury was reported by the petitioner on March 28, 2011.

Ms. Melton testified that on April 18, 2011, the petitioner walked into the Kelly Services office and stated that she had treated with her doctor for work related left foot pain and that Ms. Melton should expect a bill. Ms. Melton testified that the injury was then reported to Kelly Services. The trial exhibits contain a Form 45 dated April 20, 2011. (RX4).

Medical Treatment

The petitioner first treated for left foot pain on March 3, 2011. On that date she was seen by her primary care physician, Dr. Joseph Liu. (PX2). This visit was a follow up for a vitamin D deficiency and hip pain. At this visit she mentioned left heel pain from walking up and down stairs. (Id.). She did not describe her employment and she did not make any work-related allegations. She was diagnosed with plantar fasciitis. (Id.). Thereafter she continued to follow up with Dr. Liu on March 28, 2011 and March 31, 2011 for her heel and foot pain. (Id.). She was referred by Dr. Liu for physical therapy. (PX9).

The petitioner participated in physical therapy at OSF Medical Center from April 5, 2011 through April 26, 2011. (PX13). She did not describe any work-related allegations in the therapy records until April 18, 2011. (Id.).

The petitioner presented to orthopedic surgeon Dr. Joseph Norris at McLean County Orthopedics for evaluation of her left heel and foot pain. She was seen on April 27, 2011. She self referred to Dr. Norris. An MRI was ordered and the petitioner was prescribed a short leg walking boot. (PX10). The MRI was performed on May 5, 2011. It showed findings compatible with moderate plantar fasciitis. (PX4).

The petitioner presented to podiatrist Dr. Gerald Paul at McLean County Orthopedics on May 9, 2011. She reported left heel pain for the past two months. (PX10). In the record, she reported she was on her feet all day for her job. (Id.). This record reflects that the petitioner was required to walk on concrete stairs six hours

each day and that she had to carry supplies as well. This record reflects the petitioner had retained an attorney. The petitioner was diagnosed with plantar fasciitis of the left foot. She underwent a cortisone injection. (Id.).

The petitioner continued to treat with Dr. Liu and on May 12, 2011, was again recommended to undergo physical therapy. (PX9). The petitioner underwent physical therapy from May 17, 2011 through May 31, 2011. (PX13). On May 31, 2011, the petitioner's therapy was placed on hold due to a lack of progress. (Id.).

The petitioner returned to Dr. Paul on May 25, 2011. Dr. Paul thought she may have a nerve-related problem. (PX10). So, he referred the petitioner to physiatrist, Dr. Won Jhee at OSF Healthcare. (Id.). Dr. Jhee performed an EMG on June 6, 2011 that showed relatively prolonged distal latency and relatively diminished aptitude likely presenting early stage left tarsal tunnel syndrome. (PX12).

On July 12, 2011, the petitioner returned to Dr. Norris and underwent a cortisone injection in her left foot. (PX10).

On August 1, 2011, the petitioner presented to Dr. Jhee for a follow up. (PX12). The record indicates no exam was performed and that the petitioner was there to ask for a legal causation opinion from the doctor. According to the record, the petitioner claimed the doctor told her at a prior visit that the condition might be work related. According to the August 1, 2011 record, Dr. Jhee refused to give the petitioner a causal connection opinion. The record reflects that the petitioner became upset. The record indicates the petitioner accused the doctor of not being truthful and she was quoted as saying, "you are in the wrong country," before leaving the appointment (Id.).

On August 3, 2011, the petitioner asked Dr. Paul for a referral to another podiatrist. (PX10). She specifically asked to be seen by Dr. Scott O'Connor. (Id.). The petitioner was seen by podiatrist Dr. O'Connor at Premier Podiatry on September 8, 2011. (PX14). She was diagnosed with possible lateral band plantar fasciitis, possible lateral calcanel nerve damage, and possible impingement of the lateral plantar nerve or Baxter's neurolitis. (PX14). It was noted that Dr. O'Connor was unsure if there was enough proof for workers' compensation. (Id.).

The petitioner returned to Dr. Liu on September 22, 2011 and was given a referral to another podiatrist, Dr. Todd Snoeyink. She saw Dr. Snoeyink on October 28, 2011. (PX11). He diagnosed her with possible entrapment of the distal tarsal tunnel. (PX11). Dr. Snoeyink discussed the petitioner's possible options, including surgery. He did not render a causation opinion. (Id.).

The petitioner presented for a Section 12 examination with orthopedic surgeon Dr. George Holmes on November 16, 2011. (RX1). Dr. Holmes diagnosed petitioner with tarsal tunnel syndrome. He opined that the petitioner's condition was not related to her work activities. He opined that there is no medical scientific evidence linking walking to the condition of ill-being. (Id.).

The petitioner continued treating with Dr. O'Connor. On January 3, 2012, the petitioner asked Dr. O'Connor if her condition was work-related. (PX14). Dr. O'Connor stated it was difficult for him to know if petitioner's condition was work-related, as he did not see her until six months after the case was ongoing. (Id.). He did opine that petitioner's work could have exacerbated her condition. (Id.). The petitioner underwent a cortisone injection with Dr. O'Connor on February 20, 2012. (Id.).

The petitioner had a follow up exam with Dr. Liu in April 2012. She also saw Dr. O'Connor in April 2012. She was a no-show for two appointments with Dr. O'Connor in June. There are no treatment records from April 2012 to January 2013.

On January 30, 2013, the petitioner presented to orthopedic surgeon, Dr. Blair Rhode for evaluation. (PX15). This record indicates she was referred by Dr. Liu. The petitioner also testified that Dr. Rhode was recommended by her husband. She was diagnosed with foot pain, plantar fasciitis, and tarsal tunnel syndrome. (Id.). The petitioner did not want to undergo surgery, so she was recommended to undergo a functional capacity evaluation. (Id.).

The petitioner underwent a functional capacity evaluation on February 27, 2013. (PX7). A majority of the tests were limited by the petitioner's complaints of pain in her left foot and also to some extent her left upper

extremity. (Id.). The test had some inconsistencies, which the evaluator attributed to pain. No specific restriction recommendations were made by the therapist. (Id.).

She followed up with Dr. Rhode on March 13, 2013. (PX15). Dr. Rhode placed the petitioner on permanent modified light duty, and placed the petitioner at maximum medical improvement. (Id.). She has not been treated by Dr. Rhode since March 13, 2013.

The petitioner did not treat again with any provider until April 29, 2014 when she returned to Dr. Liu. She had diffuse complaints of pain to her left foot, left wrist, back and neck. She was referred to Illinois Regional Pain Institute. She has been receiving pain management consisting of prescription pain medications through early 2015. (PX17). At trial, the petitioner stipulated that her back and neck complaints are not related to the work accident or injury.

On August 20, 2014 the petitioner presented to orthopedic foot surgeon, Dr. Nirain D'Souza, based on a referral from Illinois Regional Pain Institute. (PX21). Her left foot was examined. He opined surgery was an option, but it could exacerbate petitioner's condition. Dr. D'Souza did not provide any causation opinion.

<u>Depositions</u>

The deposition of Dr. Blair Rhode was taken February 21, 2014. (PX1). Dr. Rhode causally connected the petitioner's tarsal tunnel syndrome and plantar fasciitis to her job duties for the respondent. (Id., pg. 10).

The deposition of Dr. George Holmes was taken July 7, 2014. (RX3). Dr. Holmes diagnosed the petitioner with tarsal tunnel syndrome. (Id., 4, 11). Dr. Holmes testified that it was his opinion that the petitioner's left foot condition was not related to her job duties, but was rather idiopathic in nature. (Id., pg. 11-12). Dr. Holmes explained that medical literature and in particular, a study by Dr. Gregory Guyton, finds no causal connection within a reasonable degree of medical certainty, between walking and the development of tarsal tunnel syndrome. (Id. pg. 14). He also testified that individuals like the

petitioner who have a past history of bilateral carpal tunnel syndrome, are more likely to get compressive neuropathy in other areas, such as the feet. (Id. pg. 17).

CONCLUSIONS OF LAW

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

The Arbitrator does not find that the petitioner timely reported her alleged injury to the respondent. The Arbitrator finds Jhane Melton's testimony more credible than the petitioner's concerning notice. The Arbitrator recognizes that the Form 45 is dated April 20, 2011. (RX4). The Form 45 is much closer in time to the April 18, 2011 meeting Ms. Melton described as opposed to the March 28, 2011 meeting described by the petitioner. The petitioner offered no explanation as to why Ms. Melton would not have reported a work injury if one had been alleged on March 28, 2011. The Arbitrator believes the petitioner did not report a work incident until after her termination on March 28, 2011. This is further supported by the medical records that show the petitioner did not give a work-related history to her providers until after her termination on March 28, 2011.

The Arbitrator recognizes the petitioner claims she reported the injury to an individual at Illinois Wesleyan. However, the Arbitrator finds it significant that she presented no witnesses to corroborate her testimony. Ms. Melton's testimony is thus more credible than the Petitioner as to when the accident was reported.

Finally, the Arbitrator recognizes that the petitioner admitted reporting a prior work injury while employed by Kelly Services. The petitioner testified that she reported this prior injury immediately after it occurred. The petitioner also admitted reporting other workers' compensation cases previously. The Arbitrator finds the petitioner knew how to report an injury and thus it is significant to impeach her credibility that she did not do so until April 18, 2011 in this case.

Did the Petitioner sustain an accident arising out of her employment causally related to her condition of ill being?

In repetitive trauma claims, the issues of accident and causation are intertwined to the point where they need to be analyzed together. The petitioner treated with several physicians who were unable to specially relate petitioner's condition to her work activities with the respondent. Specifically:

a. Dr. Liu rendered no causation opinion. (PX2, 9).
b. OSF Physical Therapy rendered no causation opinion. (PX13).
c. Dr. Norris rendered no causation opinion. (PX10).
d. Dr. Paul rendered no causation opinion. (PX10).
e. Dr. Jhee rendered no causation opinion and on August 1, 2011, when he refused to give the petitioner one upon her request, she insulted Dr. Jhee. (PX12).
f. Dr. O'Connor rendered no causation opinion. Moreover, on January 3, 2012, he specifically opined that there may not be enough facts for the petitioner to prove causation.
g. Dr. Snoeyink rendered no causation opinion.
h. Dr. D'Souza rendered no causation opinion.

The Arbitrator finds it significant that the petitioner treated with eight different doctors, two of whom were podiatrists and two of whom were orthopedic surgeons, and that none provided causation opinions. Additionally, the petitioner specifically asked Dr. Jhee and Dr. O'Connor for causation opinions and they did not give her one. This is a significant indication that there is no causal connection.

The petitioner's only causation opinion comes from Dr. Rhode. Dr. Rhode examined the petitioner nearly two years into her treatment. He testified that he had incomplete medical records available for review and that he relied largely on the petitioner's subjective history to form his causation opinion. He based his opinion on the fact that the petitioner temporally associated her foot symptoms to her activities at work. He said that he sees the condition in runners and people in highly repetitive job exposures, again relying on her history of carrying supplies eight to ten times a day up multiple flights of stairs. (PX 1 at 13) He also testified that he is a general orthopedic surgeon, he does not specialize in the treatment of feet and he has no specialized training with treatment of the feet.

The petitioner testified to her activity level on the job. In contrast, Ms. Melton testified that the job required her to work on only her assigned floor. She said that occasionally the petitioner helped on

another floor. When that occurred, the petitioner was required to take her mop and bucket. Supplies were kept on each floor. As stated above, the Arbitrator found Ms. Melton more credible than the petitioner with respect to the conversation between the two of them on March 28, the day the petitioner was fired. Accordingly, the Arbitrator believes Ms. Melton to be more credible on the extent of stair climbing done by the petitioner, and, as such, finds that Dr. Rhode's opinion was based on erroneous facts.

The Arbitrator also does not find Dr. Holmes persuasive on the issue of causation. He defined tarsal tunnel as an entrapment of the posterior tibial nerve. He said that if the nerve gets swollen or there is any impingement, the nerve gets constricted. (RX 3 at 11) He said the condition could occur if a lesion presses on the nerve. (Id at 12) While admitting that could happen due to a tumor, a ganglion cyst or a bone spur, he refused to acknowledge that it could also happen from swelling of the tibial tendon or other soft tissue adjacent to the nerve. He acknowledged that it could occur, but would be extremely rare. (Id at 37) Instead he suggested that a meta study done by Guyon suggested that cumulative trauma was not causative of the condition. He seemed to say that unless there was scientific support to the proposition, it could not have been present to a reasonable degree of medical certainty. If he had explained why a lesion on the nerve from a tumor, etc. could cause the condition but nerve pressure from swollen soft tissue or a tendon would not, his opinion would have been more convincing.

While the petitioner was exposed to walking on concrete steps and hard surfaces at work, there is no evidence to suggest that traversing these stairs caused or exacerbated her left foot condition. Dr. Holmes also testified that individuals like the petitioner who have a past history of bilateral carpal tunnel syndrome, are more likely to get compressive neuropathy in other areas. (RX3, pg. 17).

The Arbitrator also notes the petitioner worked for the respondent for only eight months and after she stopped working for the respondent, her pain worsened. This is not indicative of a causal relationship between the condition and employment.

The Arbitrator also finds the petitioner is not credible. As already discussed, she did not report an injury until after she was terminated and the medical records do not make reference to allegations of a work-related condition until after her termination. The timing of her reporting negatively impacts her credibility.

In summary, the Arbitrator did not find either medical expert convincing on the issue of causation. The petitioner, however, has the burden of proving causation exists by a preponderance of the evidence. For the foregoing reasons, the Arbitrator finds that the petitioner failed to meet her burden, and the claim is therefore denied. All other issues are moot.

STATE OF ILLINOIS	)	☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
	) SS.	☒ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
COUNTY OF WILLIAMSON (MADISON)	)	☐ 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

Tawny Jaylynn Adams (Jay),
Petitioner,

vs. NO: 14 WC 22022

City of Carbondale,
Respondent.

16IWCC0661

DECISION AND OPINION ON REVIEW

Timely Petition for Review under Section 19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, casual connection, temporary total disability, medical expenses, prospective medical expenses and notice and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission hereby 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).

In so affirming, we should specifically note that we share our colleague's concerns regarding the claimant's credibility. At best, Petitioner skewed the truth regarding the extent of her physical activities outside of the workplace during her presentation to the Section 12 examiner; at worst, she misrepresented or outright lied about them. The documentary record is abundantly clear that the petitioner engaged in rigorous upper body physical training in the weeks and months leading up to the treatment and diagnosis of right shoulder pathology in April 2014 – activities in which she specifically denied participating during her examination by Dr. Mirken. See RX3, RX4. Were it not for independent evidence demonstrating the quite strenuous nature of her workplace duties, the claimant's lack of candor and credibility would likely be enough to warrant a finding that there was insufficient credible evidence of a workplace accident or a causal relationship between such and her current condition of ill-being. As it is, we believe that the independent evidence does support a finding that her rigorous and repetitive job duties were a contributing cause of her right shoulder rotator cuff tear.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 17, 2015, is hereby affirmed and adopted.

16IWCC0661

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

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

DATED: OCT 14 2016

o-10/04/16
jdl/wj

Joshua D. Luskin

Charles J. DeVriendt

DISSENT

I respectfully dissent from the majority opinion in this matter. I appreciate that the majority shares my concerns about Petitioner's credibility. However, I believe the magnitude of her misrepresentations casts serious doubt as to whether her condition of ill-being was indeed related to her work activities rather than her outside activities. Therefore, I would have reversed the Decision of the Arbitrator, found that Petitioner did not sustain her burden of proving accident or causation, and denied compensation.

Petitioner alleged repetitive trauma accident manifesting a condition of ill-being of her right shoulder on April 14, 2014. Petitioner testified she began working for Respondent in mid-December of 2013. Prior to that, on November 26, 2013, Petitioner began working with athletic trainer/physical therapist, Steve Middleton, head of rehabilitation services at Access, Treat, & Condition. On that date, she told Mr. Middleton that she was experiencing bilateral shoulder pain. She reported weight lifting as a hobby.

Petitioner continued to work with Mr. Middleton and complained to him of shoulder pain on December 23, 2013, January 28, 2014, January 30, 2014, and February 3, 2014. On February 12, 2014, she informed him that she had begun a "boot camp class" which was described as very upper-body intensive. Thereafter, Petitioner complained to Mr. Middleton of problems regarding her shoulders on March, 10, 2015, March 12, 2014, March 30, 2014, April 3, 2014, April 8, 2014, and April 10, 2014. On two such occasions, she indicated her right shoulder was "killing her." Finally, on April 14, 2014, Petitioner told Mr. Middleton that she thought her shoulder was getting worse. On that date, she also reported that that she worked out hard every day with free weights.

Mr. Middleton told Petitioner he did not think she should continue working and should see her primary care physician for treatment. Petitioner went to her doctor, Dr. Graham, on April 17, 2014 for evaluation of her right shoulder pain. He opined that the precipitating event seemed to be "frequent overhead activity with arms, frequent heavy lifting, and weight lifting." He took her off work and told her to stop lifting weights.

At Respondent's direction, Petitioner was seen by Dr. Mirkin for an examination pursuant to Section 12 of the Act on June 17, 2014. At that examination, she related that she thought it was impossible weight lifting could have caused her shoulder pain because she had not done any upper extremity exercises for two years, an assertion obviously at odds with the record before us. In addition, Petitioner was not forthright with Dr. Davis, her treating orthopedist, about the extent of her exercise regimen.

Based on the history Petitioner provided, Dr. Mirkin opined that her right shoulder condition was caused by her repetitive work activities as a solid waste collector. However, after he was informed about her weight-lifting activities he changed his opinion and then posited that her frequent weight-lifting activity was the most likely factor causing the condition of ill-being of her right shoulder.

In my opinion, Petitioner's obvious misrepresentation about her weight-lifting activities to Respondent's Section 12, as well as her treating orthopedist, not only raises great concern about her credibility in general, it raises great doubt about the very crux of her claim. If she felt the need to affirmatively hide her weight-lifting activities from these doctors, she very likely believed that her work activities were not actually the cause of her right shoulder condition.

For the reasons stated above, I would have reversed the Decision of the Arbitrator, found that Petitioner did not sustain her burden of proving accident or causation, and denied compensation. Therefore, I respectfully dissent from the majority opinion

Ruth W. White

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

ADAM JAYLYNN, TAMMY (JAY)
Employee/Petitioner

Case# 14WC022022

CITY OF CARBONDALE
Employer/Respondent

16IWCC0661

On 9/17/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.26% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

0180 EVANS & DIXON LLC
MARILYN C PHILLIPS
211 N BROADWAY SUITE 2500
ST LOUIS, MO 63102

STATE OF ILLINOIS)
)SS.
COUNTY OF **Williamson (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
19(b)

Tawny Jaylynn Adams (Jay)
Employee/Petitioner

Case # **14** WC **022022**

v.

Consolidated cases: _____

City of Carbondale
Employer/Respondent

16IWCC0661

An *Application for Adjustment 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 (tried in Collinsville)**, on **6/17/15**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

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

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

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

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

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

G. [ ] What were Petitioner's earnings?

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

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

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

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

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

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

N. [ ] Is Respondent due any credit?

O. [ ] Other _____

FINDINGS

On the date of accident, **4/14/14**, 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 $**8,755.93**; the average weekly wage was $**486.44**.

On the date of accident, Petitioner was **37** years of age, ***married*** with **1** dependent children.

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

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

Respondent is entitled to a credit of $**any paid through carrier** under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical services 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.

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

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

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

Signature of Arbitrator

9/17/15
Date

ICArbDec19(b)

SEP 1 7 2015

STATE OF ILLINOIS)
) SS
COUNTY OF MADISON (WILLIAMSON))

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Tawny Jaylynn Adams (Jay)
Employee/Petitioner

v.

Case # 14 WC 022022

City of Carbondale
Employer/Respondent

16IWCC0661

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

At the time her injuries manifested, Petitioner was a 37-year-old, right-hand dominant Solid Waste Collector for Respondent at the City of Carbondale's Refuse and Recycling Division. (T. 9-10, 17-18, 25-27; PX12). Petitioner began working with the City of Carbondale in June of 2013 as a member of their Forestry Department. (T. 26). Petitioner testified that between September and October of 2013, the work in the Forestry Department slowed, and she sought other employment. *Id.* Witness Robert Hardin, who oversaw both the Forestry and Refuse and Recycling Departments as the Maintenance and Environmental Service Manager for the City of Carbondale, testified at trial that he noticed that Petitioner was a good worker and invited her to interview for an opening in the Refuse and Recycling Department during December of 2013. (T 16-17). Petitioner went through the interview process, and on December 16, 2013, she began working as a Solid Waste Collector. (T 26). Petitioner was the only woman working in the Refuse and Recycling Department at the time. (T. 10, 20, 26).

As a Solid Waste Collector, Petitioner performed the task referred to as the "thrower." (T. 28). Petitioner's main duties were to hold on to the railing with one arm and ride on the back of the trash truck, grab approaching trash_cans on the street with the opposite arm, and dump the contents of trash_cans into the trash compactor located on the back of the truck. (T. 26-30). Witnesses Loren Polley and Robert Hardin, Petitioner's Supervisor and Manager respectively, both testified that the trash_cans Petitioner would handle ranged in weight from 0-50 lbs. (T. 9-10, 20, 28). Petitioner testified that, while a 50 lb. weight limit was in place for these trash_cans, she would "almost guarantee that over half the stuff [they] picked up was 50 plus [pounds]." (T. 28). Petitioner would handle these trash_cans continually from around 7:00 a.m. until around 12:00 p.m. *Id.* After lunch, Petitioner's job changed from handling trash_cans to handling dumpsters. (T. 29). Petitioner would pull out the dumpsters, affix them to the arms of the truck, dump them, and take the contents to the landfill. (T 29).

Petitioner testified that she immediately developed soreness in her upper body upon beginning her work as a Solid Waste Collector. (T 30.) Petitioner is right-hand dominant and primarily relies on her right arm for handling the trash_cans. (T. 29-30). Petitioner acknowledged that she would occasionally resort to using her left arm in order to alleviate symptoms, but noted that, being predominantly right-handed; her tendency to make use of her right arm remained. (T. 29). Petitioner stated:

> I would get very sore from doing the exact same motion so one of the guys had suggested to me when you're on the left side of the road try to push with your left. When you're on the right try to push with your right to kind of balance out so you're not always lifting with your right hand so I would try to do that but of course when you're predominantly right-handed that's what you tend to do… (T. 29-30).

Petitioner testified that at first, she attributed her symptoms of soreness and fatigue to her beginning a new, physically demanding job. (T. 30). However, Petitioner testified that her condition persisted and even deteriorated to the point where she began to feel pain in her right shoulder. (T. 30). Petitioner candidly testified at trial that she experienced these symptoms of soreness and fatigue in her right shoulder shortly after she began working as a Solid Waste Collector. (T. 40-49). She also candidly testified that she exercised regularly as a hobby. (T.40-49).

Although Petitioner testified to some prior shoulder complaints incidental to running in poor shoes, which were noted by Dr. Middleton (T.40; RX4, 11/26/13); Dr. Middleton's records clearly document shoulder pain as a direct result of her work activities. (T.42; RX4, 12/13/13). Petitioner testified that after working as a Solid Waste Collector for a number of weeks, she developed localized pain. (T. 29-31). This testimony is corroborated by Dr. Middleton, who states on January 23, 2014, a month after her position as a Solid Waste Collector began, that Petitioner was feeling pain in her right shoulder. (RX4).

Petitioner testified that she continued to present to Dr. Middleton with upper body soreness and tiredness through February 12, 2014. *Id.* Petitioner was taken off work by Dr. Patricia Parks at Southern Illinois Hospitals Medical Group (SIH), on April 14, 2014. (PX3). On this date, Dr. Parks thoroughly examined Petitioner, noting symptoms of right shoulder pain, popping, and loss of strength. *Id.* After cataloguing Petitioner's symptoms, Dr. Parks ordered Petitioner off work for a period of four days, beginning April 14, 2014 and ending April 18, 2014. *Id.*

During her time off, Petitioner was able to see her primary care physician, Dr. Eric Graham at Graham Family Medicine. (PX5). Dr. Graham examined Petitioner's shoulder and expressed concern that Petitioner had torn her rotator cuff. *Id.* Dr. Graham therefore ordered an MRI for Petitioner's shoulder and restricted her from all strenuous activity. *Id.* The MRI on April 23, 2014 at Cedar Court Imaging revealed "moderate supraspinatus tendinopathy with an intrasubstance tear." (PX6).

Petitioner came under the care of Dr. J.T. Davis at The Orthopedic Institute of Southern Illinois on May 7, 2014. (PX8, 5/7/14). After reviewing Petitioner's MRI and performing his own examination, Dr. Davis's stated:

> Given her young age and high activity level if this is in fact a full tear, surgery would be highly recommended. Since it is inconclusive upon my review of the MRI scan, we are going to approach this conservatively, continuing with her therapy over the next month. We will like proceed with a diagnostic and therapeutic corticosteroid injection at that time. Ultimately if these measures fail to improve her, we will likely discuss going to surgery for biceps tenodesis subacromial decompression, rotator cuff debridement versus probable repair. *Id.*

Dr. Davis ordered continuing physical therapy and returned Petitioner to work on light duty with a 3-5 pound lifting limit. *Id.* Petitioner was not able to return to work, as her restrictions excluded her from any positions. Petitioner continued physical therapy through December 2014 with little to no improvement in her strength, range of motion, or pain level. (PX4; PX7; PX8).

After the prolonged period of conservative treatment failed to improve Petitioner's condition, Dr. Davis performed a right shoulder rotator cuff repair surgery on December 30, 2014, at the Southern Illinois Orthopedic Center. (PX8; PX9). Objective findings during surgery revealed partial-thickness tearing of the supraspinatus. *Id.*

Following surgery, Petitioner completed more physical therapy and continued to see Dr. Davis for regular check-ups. (PX8). Petitioner was released to work by Dr. Davis on April 15, 2015 with a 2-3 lbs. lifting restriction. *Id.*

Petitioner testified at trial that both the surgery and the physical therapy improved her condition. (T. 36-37). Despite improvement from surgery, Petitioner continues to require medical attention including check-ups from Dr. Davis and physical therapy. (PX8; T. 37).

Respondent had Petitioner evaluated by Dr. Peter Mirkin pursuant to § 12 of the Act on June 13, 2014. (RX1). Dr. Mirkin stated in his note that, "If the patient's history is correct (in that she has not had any type of workout with her upper extremities for the last two years), then I think her condition is more likely due to lifting trash." (RX1). Dr. Mirkin, upon finding that Petitioner worked out with kettle bells, altered his opinion to say "it is more likely the patient developed a degenerative rotator cuff tear from repetitive use of lifting kettle bells and other work out activities." (RX3). However, later in the report, Dr. Mirkin admitted that "It is also possible that her work activities in March/April 2014 could have aggravated her condition." *Id.*

Dr. Davis testified by way of deposition that Petitioner's "work injury and tasks are the direct cause or contributor[s] to the rotator cuff tear that she experienced as well as the subsequent treatment rendered." (PX11, p.14). Dr. Davis stated that Petitioner's bilateral use of kettle bells was not the cause of her injury. Dr. Davis stated that equal use of these kettle bells on both sides would expectedly generate equal symptoms, but that Petitioner never presented with symptoms in her left shoulder. Dr. Davis stated in his testimony that 99 percent of his practice was dedicated to surgery and clinical evaluation, while only 1 percent was spent on independent medical examinations or depositions. (PX11, p.5).

CONCLUSION

Issue (C): Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
Issue (F): Is Petitioner's current condition of ill-being causally related to the injury?

The purpose behind the Workers' Compensation Act is best served by allowing compensation where an injury is gradual but linked to the employee's work. *Durand v. Indus. Comm'n*, 224 Ill.2d 53, 862 N.E.2d 918, 926 (Ill. 2006) citing *Peoria Cnty. Belwood Nursing Home v. Indus. Comm'n*, 115 Ill. 2d 524, 505 N.E.2d 1026 (Ill. 1987). The Court expressly stated:

> 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. *Durand v. Indus. Comm'n*, 862 N.E.2d at 926.

The Arbitrator notes that in Illinois, employment need not be the sole, primary or prevailing cause of a claimant's condition; it only need be ***a*** factor. *Land & Lakes Co. v. Indus. Comm'n*, 359 Ill.App.3d 582, 834 N.E.2d 583 (2d Dist. 2005); *Fierke v. Indus. Comm'n*, 309 Ill.App.3d 1037, 723 N.E.2d 846 (3rd Dist. 2000). The Arbitrator finds that if Petitioner's occasional hobbies would be a factor, her repetitive employment would also be a factor.

Respondent's physician, Dr. Mirkin stated in his June 13, 2014 note that "If the patient's history is correct (in that she has not had any type of workout with her upper extremities for the last two years), then I think her condition is more likely due to lifting trash." (RX1). Dr. Mirkin, upon finding that Petitioner worked out with kettle bells, altered his opinion to say "it is more likely the patient developed a degenerative rotator cuff tear from repetitive use of lifting kettle bells and other work out activities." (RX3). However, later in the report, Dr. Mirkin admitted that "It is also possible that her work activities in March/April 2014 could have aggravated her condition." *Id.* The Arbitrator notes that Dr. Mirkin was initially willing to admit to the feasibility of Petitioner's injury being work related. Dr. Mirkin was also willing to admit that Petitioner's work conditions could aggravate her symptoms. The Arbitrator notes that if the relatively minor use of kettle bells, which weigh between 5-10 lbs., could cause injury, then certainly the extensive and daily lifting of trash cans, which could weigh over 50 pounds would cause injury.

The Commission reached a similar conclusion in *Samuel Burns v. Pinckneyville Corr. Ctr.*, 14 I.W.C.C. 0482 (2014). The Commission recognized that although the claimant was involved in martial arts activity outside of his employment with Respondent, given the amount of time Petitioner performed intensive activities as a Correctional Officer versus the amount of time he engaged in his martial arts hobby, it "defied logic" to conclude that the claimant's work activities would not also be such a factor. *Samuel Burns v. Pinckneyville Corr. Ctr.*, 14 I.W.C.C. 0482

(2014). Both of these testimonies support the conclusion that Petitioner's working conditions were at least ***a*** factor in her injury.

Petitioner's treating doctor, Dr. Davis, who is a board certified orthopedic surgeon with a specialty in shoulders, knees, and elbows, stated that Petitioner's "work injury and tasks are the direct cause or contributor to the rotator cuff tear that she experienced as well as the subsequent treatment rendered." (PX11, p.14). Dr. Davis stated that Petitioner's bilateral use of kettle bells was not the cause of her injury. Dr. Davis stated that equal use of these kettle bells on both sides would expectedly generate equal symptoms. The Arbitrator finds it significant that Petitioner experienced symptoms only in her right shoulder, the shoulder with which she predominately handled the trash cans. The Arbitrator also notes that although Petitioner has an extended history of upper extremity exercising, she never had any significant complaints until she began working as a "thrower." (T. 39).

The Arbitrator therefore relies on the credible causation opinion of Dr. Davis and finds that Petitioner's job duties were a causal factor in her development of a right shoulder rotator cuff tear.

<u>Issue (D)</u>: What was the date of the accident?
<u>Issue (E)</u>: Was timely notice of the accident given to Respondent?

The method for determining the manifestation date for repetitive injuries is flexible and liberally construed depending upon the facts of the case. *Durand v. Industrial Commission*, 224 Ill.2d 53, 862 N.E.2d 918 (Ill. 2007).

Although a claimant is aware of symptoms and carries a suspicion that these are work-related, the Supreme Court has stated, "The 'fact of injury' is not synonymous with the 'fact of discovery'" *Durand*, 862 N.E.2d at 927. In short, claimants are not charged with filing a claim as soon as they believe they *may* have a work-related condition, nor are they penalized for failing to realize a condition is work-related when the employer feels that he or she should have. In *Oscar Mayer & Co. v. Indus. Comm'n*, the Commission stated that, "Requiring notice of only a *potential* disability is a useless act since it is not until the employee actually becomes disabled that the employer is adversely affected in the absence of notice of the accident." *Oscar Mayer & Co. v. Indus. Comm'n*, 176 Ill. App. 3d 607, 611, 531 N.E.2d 174, 176 (1988). The Supreme Court in *Durand* noted that the manifestation date is typically set on the date the employee requires medical treatment or the date on which the employee can no longer perform work activities. *Durand*, 862 N.E.2d at 929. Courts consistently note that claimants who file repetitive trauma claims have the same burden or "standard of proof" as claimants who file traumatic injury claims have. *Durand*, N.E.2d at 924 citing *AC & S v. Industrial Comm'n*, 304 Ill.App.3d 875, 879, 710 N.E.2d 837 (1999); *Nunn v. Industrial Comm'n*, 157 Ill.App.3d 470, 480, 510 N.E.2d 502 (1987). Hence, the principal upheld by the Supreme Court for nearly a century that "compensation may be allowed where a workman's existing physical structure, whatever it may be, gives way under the stress of his usual labor" remains valid where injury occurs as a result of repetitive trauma. *Laclede Steel Co. v. Indus. Comm'n*, 6 Ill. 2d 296, 300, 128 N.E.2d 718, 720 (Ill. 1955) citing *E. Baggot Co. v. Indus. Comm'n*, 290 Ill. 530, 125 N.E. 254 (Ill. 1919).

Oscar Mayer v. Indus. Comm'n is instructive. In *Oscar Mayer*, the claimant acknowledged that it was clear from the record that he knew of his injuries and their relationship to employment prior to his manifestation date. *Oscar Mayer v. Indus. Comm'n*, 176 Ill.App.3d 607, 609, 531 N.E.2d 174 (4th Dist. 1988). However, he argued that the date of "collapse" should still be considered a viable date for determining injury in repetitive trauma cases. *Id.* The Appellate Court agreed, noting that the appropriate date of injury can be "where the employee's existing physical structure gives way under the stress of his usual labor and he is suddenly disabled." *Id.* In fact, the Supreme Court noted that requiring Petitioner to do as the Arbitrator suggests would not only prejudice him, but would essentially be ineffectual for the very purpose that notice serves:

> By their very nature, repetitive-trauma injuries may take years to develop to a point of severity precluding the employee from performing in the workplace. An employee who discovers the onset of symptoms and their relationship to the employment, but continues to work faithfully for a number of years without significant medical complications or lost working time, may well be prejudiced if the actual breakdown of the physical structure occurs beyond the period of limitation set by statute. *Id.* Similarly, an employee is also clearly prejudiced in the giving of notice to the employer if he is required to inform the employer within 45 days of a definite diagnosis of the repetitive-traumatic condition and its connection to his job since it cannot be presumed the initial condition will necessarily degenerate to a point at which it impairs the employee's ability to perform the duties to which he is assigned. Requiring notice of only a *potential* disability is a useless act since it is not until the employee actually becomes disabled that the employer is adversely affected in the absence of notice of the accident. *Id.* citing *Oscar Mayer v. Indus. Comm'n*, 176 Ill.App.3d 607, 609 (4th Dist. 1988). (Emphasis in original).

The Arbitrator notes that the date of accident entered by Petitioner is April 14, 2014, the same date on which Petitioner was first taken off work by a physician. (PX3). The Arbitrator finds that this was effectively Petitioner's "date of collapse." After Petitioner was taken off work, she filed a report of incident with Respondent on April 21, 2014, only one week after her injury manifested. (PX12).

The Arbitrator thus finds that Petitioner met her burden of proof on the issues of manifestation date and notice.

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

<u>Issue (K)</u>: Is Petitioner entitled to any prospective medical care?

The Act requires employers to provide all reasonable and necessary medical care required to diagnose, relieve, or cure the effects of an injury that is causally related to a work accident.

Plantation Mfg. Co. v. Indus. Comm'n, 294 Ill.App.3d 705, 691 N.E.2d 13 (2nd Dist. 2000); *F & B Mfg. Co. v. Indus. Comm'n*, 325 Ill.App.3d 527, 758 N.E.2d 18 (1st Dist. 2001).

Based upon the above findings as to causal connection, the Arbitrator finds that Petitioner is entitled to prospective medical care. Even Dr. Mirkin admitted that Petitioner was not at MMI. (RX3). Petitioner completed physical therapy and four months after her surgery was released to return to work by Dr. Davis, albeit with stringent restrictions. (PX8). Petitioner was told there were no positions within her restrictions and therefore was never able to return to work. The Arbitrator notes that Dr. Davis never placed Petitioner at MMI and he continues to see Petitioner for follow-up appointments. Also, Petitioner continues to complete physical therapy.

Respondent is liable for all medical expenses contained in Petitioner's group exhibit and shall have credit for all expenses paid. Respondent shall indemnify and hold Petitioner harmless from any claims arising from the expenses for which it claims credit, pursuant to § 8(j) of the Act. Respondent shall authorize and pay for any prospective medical care which Petitioner may need to relieve the effects of her work-related injury.

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

Respondent disputes TTD between April 14, 2014, and June 17, 2015, a period of 61 2/7 weeks. The Arbitrator notes that Petitioner was released to work as early as May 7, 2014, by Dr. Davis, but that Petitioner's restrictions were so limiting that she was not able to find a position with Respondent. Petitioner continued under her restrictions until her surgery on December 30, 2014. Dr. Mirkin and Dr. Davis acknowledged the need for a four month period of rehabilitation. (PX8; RX3). Following these four months, Petitioner was released to work with a 2-3 lbs. lifting restriction. (PX8). The Arbitrator notes that Petitioner has not been able to work a position with Respondent since April 14, 2014. The Arbitrator also notes that Petitioner has not been paid since her date of injury, but has relied on the income of her husband. (T. 38). Based on these facts, the Arbitrator finds that Petitioner is awarded TTD for the period of April 14, 2014, to June 17, 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.

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 Accident/ Causal Connection	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify Choose direction	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

HARSHA KUDIGRAM,

Petitioner,

vs. NO: 14 WC 26658

16IWCC0662

CATERPILLAR, INC.

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission having considered the issues of accident and causal connection, and being advised in the facts and law, reverses the Decision of the Arbitrator for the reasons stated below.

On August 6, 2014, Petitioner filed an application for adjustment of claim alleging that on June 4, 2014, he sustained a repetitive traumatic injury that arose out of and in the course of his employment. Petitioner who was 45 years old at the time of the incident testified on direct examination that he worked for Respondent as a senior engineer for about two years. Petitioner described that he spent 90% of his work day at the computer using a mouse. He was required to reach forward with his right arm. Petitioner testified that his computer stand was at about waist level. Petitioner stated that as a full time employee he worked "at least 10 hours per day", ate lunch for 15 minutes at his desk, and took no scheduled breaks. Petitioner's work station is located at waist level and that his keyboarding work all occurred at waist level, never above the shoulder. There is no evidence that Petitioner sustained a traumatic injury at work.

16IWCC0662

In January of 2014, Petitioner testified that he felt increased pressure from his supervisor to increase the "velocity" of his work. As Petitioner attempted to comply with production expectations he started experiencing mild symptomatology in his neck and right shoulder in January that got progressively worse in May 2014. Petitioner testified that at this time he did not know the cause of his symptoms. Petitioner testified at trial that on average he worked a 10-14 hour workday with occasional weekend work.

Petitioner traveled to India for vacation in June 2014. While in India Petitioner first sought medical attention from a physician who told him that his shoulder symptoms could be associated with his job duties. There is no evidence that Petitioner made any complaint of shoulder discomfort to any medical provider prior to his vacation trip.

Upon Petitioner's return home from India he informed his supervisor, Paul Schweiger, and the human resources representative of his injury and filled in a Caterpillar Incident Report. Petitioner reported that he sustained a "painful arc syndrome from long hours of computer mouse work at my desk."

Petitioner was referred immediately to Caterpillar Medical where he was seen first by nurses and subsequently by Dr. O'Connor. Dr. O'Connor suspected Petitioner had an impingement of the right shoulder but also considered the possibility of a supraspinatus muscular tendon inflammation or injury. He referred the Petitioner to an orthopedic surgeon. Dr. O'Connor further ordered an ergonomic evaluation of Petitioner's desk and work site.

Petitioner testified at hearing that as a result of the ergonomic evaluation there were changes introduced to his work station. Petitioner's computer monitor was placed on a stand, he was provided with a new keyboard touchpad and a new mouse. A device referred to by Petitioner as a "surfboard" was also added to his work station. Petitioner testified that he experienced improvement in his symptoms as a result of the ergonomic changes that were made. Petitioner did not present any medical testimony establishing that the ergonomic changes made to his work station had any relation to his shoulder condition.

On July 7, 2014 Petitioner consulted Dr. Blair Rhode, an orthopedic surgeon. Petitioner reported that he was an engineer at Respondent Caterpillar who had developed lateral right shoulder pain secondary to prolonged "mousing". Petitioner further reported that he had recently experienced a significant increase in his work load. On examination Petitioner displayed a positive impingement sign. Dr. Rhode charted that Petitioner developed right rotator cuff tendonitis that progressed into a frozen shoulder secondary to his work exposure as an engineer.

Dr. Rhode recommended aggressive physical therapy for passive motion. He continued the Petitioner on full duty and recommended a range of motion test in two weeks.

Petitioner returned to Dr. O'Connor at Caterpillar Medical on July 17, 2014. Dr. O'Conner reviewed Dr. Rhode's clinical note. Petitioner's condition was essentially unchanged. Dr. O'Connor commented that Petitioner was not receiving physical therapy and that no x-ray of the right shoulder had been obtained. Dr. O'Connor informed Petitioner that the problems with Petitioner's right shoulder were being considered non- occupational by Respondent.

Petitioner next saw Dr. Rhode on November 19, 2014 reporting that he had not yet commenced physical therapy due to the time constraints of his position. Petitioner reported to Dr. Rhode that there are days that he will work "three straight shifts (24 hours) in his position as an engineer." This description of the duration of Petitioner's work day was contradicted by his supervisor, Paul Schweiger, who testified he was not aware of any employee working 24 hours in a day. Furthermore, the Petitioner's worksheets offered into evidence do not support Petitioner's representation to Dr. Rhode that he worked some 24 hour days. Petitioner reported that he would have the chance to begin physical therapy starting in two to three weeks. Dr. Rhode kept Petitioner on full duty pending follow-up.

Petitioner returned to Dr. Rhode on December 3, 2014. At this time Dr. Rhode prescribed Tylenol with codeine #4 and Mobic. Dr. Rhode placed Petitioner off duty commencing December 8, 2014 until December 20, 2014 to allow him to undergo aggressive, passive physical therapy. The physical therapy progress notes reflect that Petitioner was reporting improvement in symptoms and increased range of motion. The course of physical therapy ran from December 8, 2014 through March 2015.

Respondent's Section 12 examiner, Dr. Ira Kornblatt, performed an examination on Petitioner on December 22, 2014. Dr. Kornblatt reviewed the records of Dr. Rhode and noted Dr. Rhode's diagnosis of frozen shoulder and rotator cuff tendonitis. On examination Dr. Kornblatt charted significant limitation of range of motion of the right shoulder in all planes with pain at the extremes of motion. There is no history offered of traumatic injury to the right shoulder. X-rays demonstrated the right shoulder to be free of arthritis, new or old fracture, or calcifications. Dr.Kornblatt, in his Section 12 report of December 22, 2014 stated that, "There is no scientific evidence that would suggest that utilizing a computer mouse leads to adhesive capsulitis of the right shoulder. Adhesive capsulitis is an inflammatory disease process that can come on spontaneously. It does sometimes occur following trauma and as such I believe that he has spontaneous onset adhesive capsulitis of the right shoulder." Dr. Kornblatt indicated his familiarity with the medical literature regarding the shoulder over 30 years of medical practice and knows of no scientific evidence that suggests using a computer mouse leads to adhesive capsulitis.

On April 22, 2015, Dr. Rhode discharged Petitioner from care stating that he was at MMI and recommending 10 minute breaks from work when his arm is tired. He was to follow up on an as needed basis. On April 23, 2015 Petitioner had a restriction review with Dr. O'Connor. Petitioner was given a 10 lb. lifting restriction to his right arm and given 10 minute rest periods every 30 minutes.

No deposition or testimony from Dr. Rhode was offered into evidence. Dr. Rhode addressed Dr. Kornblatt's opinions concerning accident and causation in his clinical note of January 28, 2015. Dr. Rhode acknowledged that frozen shoulder can be idiopathic. In his opinion, however, the cause of petitioner's frozen shoulder was extensive use of the computer mouse in a forward reach position. This diagnosis apparently derives from Petitioner's self - reporting concerning his work activities. Dr. Rhode opined that as Petitioner developed pain at the end of his range of motion, he avoided the end range resulting in a frozen shoulder.

Dr. Kornblatt testified by evidence deposition that "I don't believe repetitive activity leads to an inflammatory process involving the shoulder, and certainly not where all of the work is below shoulder level."

In essence both Drs. Rhode and Kornblatt agreed that petitioner had adhesive capsulitis of the right shoulder. Both physicians agreed that the petitioner required extensive passive physical therapy. The etiology of the Petitioner's condition and whether it arose out of and in the course of his employment with Respondent as well as causation, are at issue.

The arbitrator found that the Petitioner proved accident and causal connection. The Commission disagrees. The Petitioner's prima facie case rests upon the opinion of Dr. Rhode. Dr. Rhode bases his opinion at least in part upon the discredited statement made by Petitioner in seeking treatment on November 19, 2014 that "There are days that he will work 3 straight shifts (24 hours) in his position as an engineer." The time entries entered into evidence demonstrate that Petitioner in fact worked between 7 hours and 12.5 hours per day. Dr. Rhode, after reviewing Dr. Kornblatt's report, recognized that a frozen shoulder can be idiopathic.

For the foregoing reasons, the Commission finds that Petitioner failed to prove a work accident/causal connection, and denies the claim.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 17, 2015, is hereby reversed and Petitioner's claim is denied.

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

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

DATED: OCT 14 2016
o-9-08-16
SJM/msb
44

Stephen Mathis

David L. Gore

Mario Basurto

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

KUDIGRAM, HARSHA
Employee/Petitioner

Case# **14WC026658**

16IWCC0662

CATERPILLAR
Employer/Respondent

On 12/17/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.58% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in 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

5411 CATERPILLAR INC
AMANDA J WATSON
100 N E ADAMS ST
PEORIA, IL 61629

/

STATE OF ILLINOIS)
)SS. **16IWCC0662**
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
CORRECTED

Harsha Kudigram
Employee/Petitioner
v.
Caterpillar
Employer/Respondent

Case # **14**WC **26658**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed out to each party. The matter was heard by the Honorable **GREGORY DOLLISON** Arbitrator of the Commission, in the city of **Peoria, Illinois on September 23, 2015.** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the 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 **6/04/14**, 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 her employment.

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

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

In the year preceding the injury, Petitioner earned $91,524.00; the average weekly wage was $1,760.07.

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

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

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

Respondent shall be given a credit of **$0.00** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and $0.00 for other benefits, for a total credit of $0.

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

ORDER

Respondent shall pay reasonable and necessary medical services of $43,009.60, as provided in Section 8(a) of the Act. The medical bills are to be paid pursuant to the medical fee schedule contained to the Act.

Respondent shall pay Petitioner permanent partial disability benefits of **$721.66**/week for 15 weeks, because the injuries sustained caused the loss of use of 3% **man 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

11/18/15
Date

ICArbDec p. 2

DEC 1 7 2015

FINDINGS OF FACTS

Petitioner testified that on/or about June 4, 2014, he was employed by Respondent as a Senior Performance Engineer. Petitioner testified that he started working for Caterpillar on May 28, 2013 developing new engine ratings for Caterpillar's natural gas and diesel engines. Petitioner testified that as a Senior Performance Engineer, he was required to perform data analysis, project management and engine testing. Petitioner testified that besides engine testing nearly all aspects of his job as data analyst and project management required him to use a computer. Petitioner testified that on his computer, he had a regular keyboard and a regular mouse. Petitioner testified that his computer monitor, the keyboard and the mouse were all located on his work station. Petitioner testified that his work station was approximately at waist level. Petitioner testified that nearly approximately 90% of his job required him to use computer, and every aspect of using the computer required the use a computer mouse. Petitioner testified that he worked for Respondent as a full time employee, working "at least 10 hours a day." Petitioner testified that he sometimes worked week-ends, which were project or deadline dependent. Petitioner testified that he would not take any scheduled lunch or breaks. Petitioner testified that the extent of his breaks would involve eating his lunch, which he did at his work station and using the washroom or walking to the vending machines.

As to the postural movements, Petitioner testified that when he uses his computer and uses the mouse, he has to reach forward with his right arm. Petitioner testified that essentially all aspects of his job duties required him to use the mouse. Petitioner testified that approximately around January of 2014 he had increased pressure from his supervisor to increase the "velocity" of his work. Petitioner testified that to increase the "velocity" of his work, he had to engage in more computer and mouse use. Petitioner testified that as he was attempting to increase the "velocity" he started experiencing problems with his right shoulder. Petitioner testified that his problems started sometime around January of 2014. Petitioner testified that he initially experienced mild symptomology with his right shoulder and that said symptomology got progressively worse in May of 2014. Petitioner testified that at that time he was unaware as to the cause of his symptoms. Petitioner testified that prior to 2014, he had never experienced any problems with his right shoulder.

Petitioner testified that in June 2014, while on vacation in India, he consulted a doctor and learned for the first time that the problems that he was experiencing with his right shoulder could have been associated with his job duties.

Petitioner testified that after learning the potential association between his right shoulder symptoms and his job duties, he notified his supervisor, Paul Schwriger. Petitioner testified that he also notified his HR person, Debbie Massrngill. Petitioner completed an Employee Incident Report indicating that he sustained a "painful arc syndrome from long hours of computer mouse work at my desk". Petitioner reported that the body parts affected were his shoulder, right upper arm and neck. (PX 2)

Petitioner testified that after notifying his supervisor and completing the incident report, he was sent to Caterpillar Medical. On June 16, 2014, Petitioner presented to Respondent's medical. The initial nursing assessment notes that Petitioner reported with pain to his right shoulder for approximately six months. Petitioner reported that his pain was getting progressively worse from sitting at a desk on a computer/mouse for long hours. It was noted that Petitioner had limited range of motion, was painful to dress and reach behind his head. Petitioner was referred to Dr. O'Connor at Caterpillar medical. (PX 2)

Petitioner saw Dr. O'Connor on June 17, 2014. The doctor recorded a history of right shoulder pain for "at least four months." Dr. O'Connor noted Petitioner reported he did desk work with the computer for up to 12 to 14 hours. Dr. O'Connor noted Petitioner frequently used the mouse with his right hand and arm and that his right hand was somewhat elevated at his desk which caused pain in his right shoulder. Dr. O'Connor assessed possible AC joint pathology and a possible impingement syndrome. Dr. O'Connor also stated that there existed findings especially on internal rotation and abduction that suggested Petitioner might have some deep pathology with the shoulder joint and that could involve the rotator cuff. He also indicated this could especially involve the supraspinatus tendon and muscle. Dr. O'Connor indicated Petitioner was going to need further evaluation of his work site and ordered an ergonomic evaluation of Petitioner's desk and work site. (PX 2)

Petitioner next followed up with Dr. O'Connor on June 23, 2014. At that time, Petitioner continued with his right arm pain complaint. Dr. O'Connor once again diagnosed impingement of the right shoulder. The doctor further expressed the possibility of supraspinatus muscular tendon inflammation or injury. He also referred Petitioner to an orthopedic doctor. (PX 2)

Petitioner next followed up with Dr. O'Connor on July 17, 2014. Dr. O'Connor noted that Petitioner had been evaluated by Dr. Rhode at Great Plains Orthopedics Group. Dr. O'Connor assessed that Petitioner's right shoulder was essentially unchanged. The doctor also advised Petitioner that his right shoulder pain was being considered as non-occupational by Caterpillar Medical. (PX 2)

Medical records submitted show Petitioner presented to Dr. Blair Rhode on July 2, 2014. Dr. Rhode recorded that Petitioner worked as an engineering performance analyst for Caterpillar. He had been at this position for approximately 13 months; he performs a significant amount of computer and mouse work. The doctor noted Petitioner reported recently experiencing a significant increase in work load and that he had developed lateral shoulder pain secondary to prolonged mousing. Dr. Rhode recorded that Petitioner described his mouse position as a forward reach static hold position. After taking a history and proceeding with a physical examination, Dr. Rhode assessed 1.) shoulder pain; 2.) rotator cuff sprain; and 3.) frozen shoulder. Dr. Rhode opined that Petitioner developed progressive lateral right shoulder pain secondary to his work exposure as an engineer. The doctor stated, "...He developed progressive lateral shoulder pain secondary to static forward reach position. He progressively lost motion. I believe that the patient developed rotator cuff tendonitis which has progressed into a frozen shoulder." Dr. Rhode recommended aggressive physical therapy for passive motion and returned Petitioner to full duty work. (PX 4)

At the request of Respondent, Petitioner attended a Section 12 Independent Medical Examiner with Dr. Kornblatt on December 22, 2014. In his reported dated December 22, 2014, Dr. Kornblattt opined that Petitioner had findings compatible with adhesive capsulitis of the right shoulder. Dr. Kornblatt stated that "There is no scientific evidence that would suggest that utilizing a computer mouse leads to adhesive capsulitis of the right shoulder." He explained that "[a]dhesive capsulitis is an inflammatory disease process that can come on spontaneously. It does sometimes occur following trauma. This patient has not had any trauma and as such I believe that he has spontaneous onset adhesive capsulitis of the right shoulder." The doctor felt Petitioner could return to full duty work. He also felt Petitioner had significant disability due to loss of motion of the right shoulder and needed aggressive physical therapy. He further indicated surgical treatment may eventually be necessary. (RX 2)

Petitioner returned to Dr. Rhode on January 28, 2015. The doctor recorded Dr. Kornblatt's opinion that Petitioner's work-related exposure cannot cause frozen shoulder. Dr. Rhode wrote, "I respectfully disagree. I agree that frozen shoulder can be idiopathic. That being said, idiopathic merely means that no [known cause exists]. It does not mean that there was not a cause. It just means that we have an inability to identify the cause.

In this instance we have identified a cause. The patient was exposed to a significant amount of mousing. He was required to operate a computer keyboard and mouse throughout his entire shift in a forward reach fashion. I believed he developed rotator cuff tendonitis and through an avoidance behavior, developed a frozen shoulder. This means that as he developed pain with end range, he avoided his end range. This resulted in a worsening loss of motion culminating in the diagnosis of a frozen shoulder. The patient has no pre-existing risk factors and has an appropriate exposure and causative mechanism. Therefore, it is my opinion that the frozen shoulder is work related." (PX 4)

Petitioner testified that he did not undergo the recommended aggressive physical therapy until December 2014. Petitioner explained that gap was "due to the amount of work needed to be done, I wanted to get it done." Medical records show Petitioner attended physical therapy through April 22, 2015. At that time, it was noted Petitioner reported some pain at the end range limits of motion. Petitioner also reported significant improvement with range of motion and strength overall. He was discharged from physical therapy at that time.

Petitioner last saw Dr. Rhode on April 22, 2015. The doctor discharged Petitioner indicating he was at maximum medical improvement. The doctor also recommended 10 minute breaks when his arm is tired. (PX 4)

Dr. Kornblatt testified via deposition in this matter. The doctor testified that he was very well-versed in the literature regarding the shoulder and knows of no scientific evidence that suggests utilizing a computer mouse leads to adhesive capsulitis of the shoulder. He provided that idiopathic adhesive capsulitis is very common.(RX 3, pp.9-10)

On cross-examination, Dr. Kornblatt provided that the only information regarding Petitioner's job duties were provided to him by Petitioner; he did not know what exactly Petitioner did or how long Petitioner did the job. Following is an excerpt from that dialogue:

> Q. And doctor what information were you provided regarding Petitioner's job duties?
>
> A. The Petitioner told me what his job duties were. I don't' recall if I had a description of the job, but the Petitioner told me what his job duties were. He told me that his job duties, you know, I don't know if I have any other information.
>
> Q. What were the job duties doctor?
>
> A. He was an engineer which involved doing a lot of work on a computer I am looking through to see if I have any other information that I might have seen but I don't think that there is. That's all I have. There was no job description. I came to my opinion based on what the claimant told me his job duties were.
>
> Q. Just to clarify, in the situation you were not provided with any formal job description from the Respondent themselves, correct?
>
> A. I don't' believe I was.

(RX 3, pp.14-15)

Dr. Kornblatt stated that he does not think that any repetitive activity, regardless of how long the duration or regardless of whether it is done on a correct or ergonomically incorrect work station, can lead to adhesive capsulitis. Following is an excerpt from that dialogue:

Q. And now doctor you mentioned a lot of computer use and mousing. Do you agree with me that in order for you to opine on causation would have been a condition and job duties, it is extremely important to know the exact nature of the work station?

A. I do not agree with you, no, not when it comes to adhesive capsulitis.

Q. Why not?

A. As you already asked me if I thought any type of repetitive activity leads to adhesive capsulitis, and I don't' believe it does. As I have described it before adhesive capsulitis is an inflammatory process, and I don't' believe that repetitive activity leads to an inflammatory process involving the shoulder, and certainly not here where all of his work is below shoulder level. I don't know how could you possibly tie adhesive capsulitis into repetitive activity basically down at a desk. It doesn't make any sense to me. After 30 years of practice.

Q. Doctor, do you know the duration of time that he was working at Caterpillar.

A. I believe I do. Let's see. I don't recall. No.

Q. Doctor, if that information is not within your report, then would there be any additional place that you would have written that information or taken that information and written it somewhere else?

A. I am looking at my handwritten notes and I did not write it down, so there would not be no place else where I would have written that. In my opinion that's not relevant. I don't care if --.

Q. Doctor that is not what I'm asking. I'm asking you a question, if you can stick to the answer that would be perfect. Doctor, you said that no repetitive job duties can cause adhesive capsulitis. Are you counting in ergonomically correct work stations when you talk about that, or are you saying that even if the work station is not ergonomically correct, it could never cause adhesive capsulitis?

A. In my opinion, even if the work station is not ergonomically correct, repetitive activity will not lead to adhesive capsulitis.

(RX 3, pp.16-17)

Petitioner's supervisor, Paul Schweiger, testified on behalf of Respondent. He agreed with the job duties described by Petitioner. He also noted the percentages of time spent on duties would vary depending on specific projects employees were working on at the time. Mr. Schweiger provided that Petitioner informed him of his shoulder complaint on or about June 16, 2014 and at that time he sent Petitioner to Respondent's medical department.

Mr. Schweiger testified that each employee is expected to work a minimum of 8 hours a day. He stated that sometimes an employee's work hours would increase depending on the assigned project. He stated dead-lines have to be met, the employees are accountable for the work and the amount of time an individual needs was based on that indvidual. He added that he was not aware of an employee working 24 hours in a day.

On cross-examination, Mr. Schweiger testified that he agreed with Petitioner's "overall" testimony regarding the hours he worked. Mr. Schweiger testified that an ergonomic evaluation was conducted of Petitioner's desk. He believed one of the suggestions was implemented, although his new desk was primarily the same. Mr. Schweiger could only recall Petitioner receiving a keyboard with a touchpad after the assessment. (T69-70)

Petitioner testified that after the ergonomic evaluation was performed, changes were made to his work station. Petitioner testified that his monitor was raised via a stand, he was provided with a new keyboard touchpad and a new mouse. Petitioner also testified that a service board was added to his work station. Petitioner testified that as a result of these ergonomic changes his symptoms improved.

CONCLUSIONS OF LAW

With respect to (C.) Did an accident occur that arose out of and in the course of the Petitioner's employment by Respondent and (F.) Is Petitioner's condition of ill-being causally related to the injuries, the Arbitrator finds as follows:

The term repetitive trauma was established by the Supreme Court in Peoria County Belwood . The court set the standard for the date of accident in a case which did not involve a single trauma. As the court later explained in its Durand decision, the standard of proof is the same as a single trauma case. Petitioner must simply prove that his work was a causative factor. The accident date is the date when the injury manifested itself; the date when both the fact of the injury and the causal relationship between the injury and the claimant's employment become plainly apparent to a reasonable person. Here, Petitioner is alleging the repetitive trauma accident date of on/or about June 4, 2014, the date when he first sought treatment in India and the date he learned that his job duties could be the cause of his condition of ill-being. The evidence establishes that on/or about June 4, 2014, Petitioner had knowledge that his injury might be related to his work duties at Respondent.

The Arbitrator finds that Dr. Rhode's opinion on causation is more persuasive than that of Dr. Kornblatt. Dr. Rhode had a clear and accurate understanding of what Petitioner did. He knew that Petitioner had been mousing for approximately 13 months working full-time at Caterpillar. Dr. Rhode knew that at the time of his index visit Petitioner recently experienced an increase in work load. Dr. Rhode was aware of the postures that involved Petitioner to engage in mouse work. Dr. Rhode opined credibly that as a result of the job duties Petitioner sustained a rotator cuff tendonitis which went untreated and resulted in an adhesive shoulder capsulitis. Unlike Dr. Rhode, Dr. Kornblatt did not know how long Petitioner worked for. He did not know the posture Petitioner engaged in while mousing. He did not know the specifics of Petitioner's job duties. He didn't know as to how long Petitioner would engage in mousing. Dr. Kornblatt simply denied causation and stated that no job duties can ever lead to adhesive capsulitis.

Based on the above, the Arbitrator finds that Petitioner sustained an accidental injury arising out of and in the course of employment with Respondent which manifested itself on on/or about June 4, 2014. The Arbitrator further finds that a causal relationship exists between Petitioner's right shoulder condition of ill-being and said accident.

With respect to (J.) Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds as follows:

Having found the requisite causal relationship, the Arbitrator awards the following medical bills contained Petitioner's Exhibit 5.

NAME OF PROVIDER	ACCOUNT NUMBER	DATE OF SERVICE	AMOUNT OF BILL
Orland Park Orthopedics	KUDHAR0001	11/19/14-04/22/15	$43,009.60
			$43,009.60

The medical bills are to be paid consistent with the rates as prescribed by the Illinois Workers' Compensation Commission fee schedule.

With respect to (L.) What is the nature and extent of the injury, the Arbitrator finds as follows:

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

(a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but are not limited to: loss of range of motion; loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment.

(b) Also, the Commission shall base its determination on the following factors:

(i) The reported level of impairment;
(ii) The occupation of the injured employee;
(iii) The age of the employee at the time of the injury;
(iv) The employee's future earning capacity; and
(v) Evidence of disability corroborated by medical records.

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

i. Neither party submitted an impairment rating. The Arbitrator accords no weight to this factor
With regards to paragraph (ii) of Section 8.1(b) of the Act:

ii. Petitioner returned to full duty work. He continued to work in the capacity until his employment with Respondent terminated. The Arbitrator accords some weight to this factor.

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

iii. Petitioner was 45 years old at the time of injury. Because of the length of time Petitioner will live with his permanent disabilities, the Arbitrator gives some weight to this factor

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

iv. There is no evidence that Petitioner's earning capacity has been affected. As such, the Arbitrator accords no weight to this factor.

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

v. Petitioner's adhesive capsulitis resolved through physical therapy, without injection, manipulation or surgery. Petitioner testified the only problem he still has is washing his back. This statement is consistent with the April 22, 2015 physical therapy documentation which noted Petitioner reported some pain at the end range limits of motion. Petitioner also reported significant improvement with range of motion and strength overall.

After considering all the above, the Arbitrator finds that Petitioner is permanently disabled to the extent of 3% under Section 8(d)2 of the Act.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

HERIBERTO PEREZ,

Petitioner,

vs. NO: 14 WC 8161

EL PALENQUE #2 & MICHAEL FRERICHS, Illinois State Treasurer as Ex-Officio Custodian of the Injured Workers' Benefit Fund,

16IWCC0663

Respondents.

DECISION AND OPINION ON REVIEW

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

The Commission corrects the order part of the Arbitrator's Decision to reflect, consistent with the Arbitrator's findings, a permanency award for partial loss of use of the left hand to the extent of 35% thereof.

Further, the Commission adds the following language to the Arbitrator's Decision:

"The Illinois State Treasurer as Ex-Officio Custodian of the Injured Workers Benefit Fund was named as co-Respondent in this matter. The Treasurer was represented by the Illinois Attorney General's Office. Award is hereby entered against the Fund to the extent permitted and allowed under Section 4(d) of the Act, in the event of the failure of Respondent-Employer, El Palenque #2, to pay the benefits due and owing to the

Petitioner. Respondent-Employer shall reimburse the Injured Workers' Benefit Fund for any compensation obligations of Respondent-Employer that are paid to the Petitioner from the Injured Workers' Benefit Fund."

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 22, 2016 is hereby corrected as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent El Palenque #2 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.

Bond for the removal of this cause to the Circuit Court by Respondent El Palenque #2 is hereby fixed at the sum of $75,000.00. No bond is required for removal of this cause to the Circuit Court by the Injured Workers' Benefit Fund. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: OCT 1 4 2016
d-9-29-16
SJM/msb
44

Stephen J. Mathis

Stephen Mathis

Mario Basurto

David L. Gore

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

PEREZ, HERIBERTO
Employee/Petitioner

Case# **14WC008161**

EL PALENQUE #2
Employer/Respondent

16IWCC0663

On 3/22/2016, 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 0.44% 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:

4239 THE LAW OFFICE OF JOHN ELIASIK
BRIAN C HERCULE
180 N LASALLE ST SUITE 3700
CHICAGO, IL 60601

0000 EL PALENQUE #2
406 WELLINGTON LN
BOLINGBROOK, IL 60440

5204 ASSISTANT ATTORNEY GENERAL
CHRISTOPHER FLETCHER
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

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

Heriberto Perez
Employee/Petitioner

v.

El Palenque #2
Employer/Respondent

Case # **14** WC **8161**

Consolidated cases: ______

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Jessica Hegarty**, Arbitrator of the Commission, in the city of **Geneva**, on **January 14, 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 **December 27, 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 $**14,040.00**; the average weekly wage was $**270.00**.

On the date of accident, Petitioner was **30** years of age, ***married*** with **3** dependent children.

Petitioner ***has not*** received all reasonable and necessary medical services.

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

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

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

ORDER

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $**270.00**/week for **18 and 1/7** weeks, commencing **January 29, 2014** through **June 5, 2014**, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of $**0.00** for temporary total disability benefits that have been paid.

Medical benefits

Respondent shall pay reasonable and necessary medical services of $**36,447.76**, as provided in Section 8(a) of the Act.

Respondent shall be given a credit of $0.00 for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Statutory loss: Index Finger

Respondent shall pay Petitioner $270.00/week for 43 weeks because the injuries sustained caused 100% loss of the left index finger as a whole as provided in Section 8(e)8 of the Act.

Statutory loss: Middle Finger

Respondent shall pay Petitioner $270.00/week for 38 weeks because the injuries sustained caused 100% loss of the left middle finger as provided in Section 8(e)8 of the Act.

Permanent Partial Disability: Left hand

Respondent shall pay Petitioner permanent partial disability benefits of **$270.00**/week for **71 and 5/7** weeks, because the injuries sustained caused the **35%** loss of the person as a whole, as provided in Section 8(d)2 of the Act.

Penalties

Respondent shall pay Petitioner penalties under Section 19(k) in the amount of $20,788.88. Respondent shall pay Petitioner penalties under Section 19(l) in the amount of $2,500.00. Respondent shall pay Petitioner attorney's fees under Section 16 in the amount of $16,564.05.

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

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

Jessica A. Hegarty
Signature of Arbitrator

3/21/16
Date

MAR 2 2 2016

16IWCC0663

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

HERIBERTO PEREZ, Employee/Petitioner v. EL PALENQUE #2 & Michael Frerichs, Illinois State Treasurer, as ex-officio custodian of the Injured Workers' Benefit Fund, Employers/Respondents.	))))))))))	14 WC 008161

ADDENDUM TO THE DECISION OF THE ARBITRATOR

This action was pursued under the Illinois Workers Compensation Act (the "Act") by the Petitioner who is seeking relief from Respondent-employer El Palenque #2 of Aurora, Illinois and the Injured Workers' Benefit Fund regarding Petitioner's work-related accident on December 27, 2013.

After investigation, Petitioner notified El Palenque #2 of the hearing by certified mail at the last known address, but the notice was not picked up and no one appeared on behalf of El Palenque.

On January 14, 2016 a hearing was held before Arbitrator Hegarty in Geneva, Illinois. The Illinois Attorney General filed an appearance on behalf of the Illinois State Treasurer, as *ex- officio* custodian of the Injured Workers Benefit Fund.

STATEMENT OF FACTS

Petitioner testified, through a qualified interpreter, that on the date of the accident, December 27, 2013, he was employed at El Palenque in Aurora, Illinois. El Palenque was a grocery store and butcher shop. Prior to the accident date, Petitioner had been employed there for 3 months.

On December 27, 2013, while using a meat saw, Petitioner injured the middle and index fingers of his left hand. He was transported via ambulance to the emergency room at Presence Mercy Medical Center where he underwent left hand x-rays and was diagnosed with a partial amputation and fracture of the middle phalanges of the second

and third fingers with tendon involvement. Petitioner testified, and his records indicate, that the tips of his fingers were surgically replanted and sutured and his fingers were placed in splints. Petitioner testified that he returned two more times to Presence Mercy Medical Center for follow-up care and to have his stitches removed. His medical records indicate that he was prescribed physical therapy during his follow-up visit of January 22, 2014.

On January 29, 2014, Petitioner reported to Dr. Bodem at Rehab Dynamix for physical therapy, which he participated in from January 29, 2014 to June 5, 2014.

On February 5, 2014, Petitioner was seen by Dr. Vargas at the Chicago Pain and Orthopedic Institute who noted complaints of stabbing, electric-like pain running from his fingers into his forearm. (PX 4) Dr. Vargas prescribed a course of NSAID's and referred Petitioner to Dr. Sclamberg for an orthopedic consult. Dr. Vargas also recommended an EMG/NCV. (Id.)

A functional capacity evaluation ("FCE") dated April 30, 2014 noted Petitioner at a medium duty level for his return to work and that he could lift up to 35 pounds.

Petitioner was told after his functional capacity evaluation to attend work conditioning. Petitioner did undergo work conditioning and ended his treatment on June 5, 2014.

The EMG/NCV performed on May 7, 2014 showed no electro-diagnostic evidence of a distal right upper extremity peripheral neuropathy and no evidence of a radial sensory nerve injury.

On May 12, 2014, Records from Rehab Dynamix reflect Petitioner's report of "doing well" but having trouble flexing his middle three fingers fully toward the distal aspects. He reported improved strength but pain with activities involved with gripping, grasping and carrying. On exam, DIP flexion of the 2nd and 3rd digits was noted to be reduced.

On June 5, 2014 Dr. Bodem released Petitioner with modified work restrictions of 30 pounds for lifting and carrying, 25 pounds with the left hand.

Petitioner testified that he was off work from January 29, 2014 until he was discharged from care on June 5, 2014. Petitioner's medical records indicate that he was also kept off of work by Dr. Vargas on February 5, 2014. He was given work restrictions of no lifting, pushing or pulling more than five pounds by Dr. Sclamberg on February 21, 2014. Dr. Sclamberg's record from April 11, 2014 indicates that Petitioner was to remain off work. He was ordered off of work again by Dr. Vargas on May 28, 2014. Petitioner testified that he gave all of his work status notes to his employer. Petitioner testified that he did not receive any TTD during this period of time.

Petitioner incurred bills for the aforementioned provided medical services. All of those bills remain unpaid. (PX 2, PX3, PX 4, PX5, PX6).

Petitioner testified that his condition improved significantly as a result of his treatment. However, he also testified that he still experiences pain and numbness in the middle and index fingers of his left hand along with limited range of motion and loss of grip strength. Petitioner demonstrated his loss of range of motion at the hearing. He testified that his pain increases with frequent use of his left hand or from lifting heavy objects. Petitioner testified that he has difficulty doing simple tasks around the house like washing dishes, mopping and sweeping floors and shoveling snow. The Arbitrator notes Petitioner has scarring across both fingers located where the distal and middle phalanges meet.

Concerning Petitioner's current ability to work, Petitioner testified he has done jobs for the owner of the building he lives in two or three times, such as carrying things that are not that heavy.

CONCLUSIONS OF LAW

Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Disease Act?

Petitioner testified he worked for Respondent-employer El Palenque #2 on December 27, 2013. Petitioner used an electric saw in the preparation of cow parts at El Palenque, which makes the employer subject to the Act under Section 3(8)(Any enterprise in which sharp edged cutting tools, grinders or implements are used…" 820 ILCS 305/3(8). Based upon the evidence presented, the Arbitrator finds that Respondent-employer El Palenque was operating under and subject to the coverage provisions of section 3 of the Act.

Was there an employee-employer relationship?

Petitioner was employed by El Palenque as a meat cutter. The Arbitrator finds by a preponderance of the evidence Petitioner worked for El Palenque as an employee under the Act.

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

Petitioner testified he was cutting cow parts when he cut his fingers on an electric saw. This Arbitrator finds Petitioner proved by a preponderance of the evidence than an accident arose out of and in the course of Petitioner's employment with El Palenque.

What was the date of accident?

Petitioner's testimony and the emergency room records establishes a date of accident of December 27, 2013.

Was timely notice of the accident given to Respondent?

Petitioner testified he notified the owner of the El Palenque, Jose, that he was injured. As his testimony was unrebutted, Petitioner has proven timely notice of the accident to the Respondent-employer.

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

The record establishes by a preponderance of the evidence that Petitioner's current condition of ill-being is causally related to his work injury. Petitioner testified he currently has ongoing pain in both of his injured fingers. Nothing in the testimony or medical records suggest there was some intervening cause of Petitioner's current pain.

What were Petitioner's earnings?

This Arbitrator notes Petitioner claims an average weekly wage of $270.0 for his tenure as an employee at El Palenque. The Arbitrator notes that while no testimony was elicited concerning the exact amount of Petitioner's wages from El Palenque, there was no evidence produced at the hearing to dispute Petitioner's claim as to his wages, contained on Arbitrator's Exhibit 1, The Arbitrator finds Petitioner's average weekly wage with respect to the accident at issue is $270.00.

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

Based on Arbitrator's Exhibit 1 and the supporting medical records which document Petitioner's date of birth, the Arbitrator determines Petitioner was 30 years of age on the date of the accident.

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

Based on Arbitrator's Exhibit 1 and the fact that Respondent presented no evidence to dispute Petitioner's marital status, the Arbitrator finds that Petitioner was married with three children at the time of the accident.

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

All of Petitioners medical records from his first date of treatment until he was released from care indicate that he suffered a partial amputation of the middle phalanges of the middle and index fingers of the left hand. Petitioner's testimony about the mechanism of injury was consistent with his medical records. Respondent has not presented any evidence purporting to show that the medical services provided to the Petitioner were not reasonable. All of Petitioner's bills for the medical services provided remain outstanding.

For these reasons, the Arbitrator finds that the medical services provided to the Petitioner were reasonable and necessary. The Respondent is liable to Petitioner for the following outstanding medical bills related to his injury, pursuant to the fee schedule:

Presence Mercy Medical Center	$3,004.78
Rehab Dynamix	$16,376.75
Chicago Pain & Orthopedic Institute	$1,204.73
Elite Physical Therapy	$1,600.00
Total	$36,447.76

TTD benefits in dispute?

Petitioner has claimed entitlement to TTD benefits from January 29, 2014 through June 5, 2014. This Arbitrator finds Petitioner has proved by a preponderance of the evidence he is entitled to this period of temporary disability. Respondent-employer shall be liable to Petitioner for TTD benefits for the period of January 29, 2014 through June 5, 2014.

What is the Nature and Extent of the Petitioner's Injury?

For injuries occurring on or after September 1, 2011, all permanent partial disability awards shall be established using the following criteria under Section 8.1b of the Act:

- The reported level of impairment pursuant to subsection (a)
- The occupation of the injured employee;

- The age of the employee at the time of the injury;
- Future earning capacity; and
- Evidence of disability corroborated by the treating medical records.

No single factor shall be the sole determinant of disability, the weight given to each factor must be explained in the written arbitration decision.

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, Petitioner was employed at a grocery store/butcher shop on the accident date. Petitioner was cutting cow legs using a large saw when he was injured. Based on the fact that Petitioner was engaged in what seems like somewhat heavy work that requires hand dexterity, the Arbitrator assigns *more* weight to this factor in her determination of a PPD award.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 30 years old at the time of the accident. The Arbitrator considers Petitioner to be *young* in age. He will have to live and work with his disabilities for a long time. The Arbitrator therefore finds this factor to be relevant in her PPD analysis and assigns *greater* weight to this factor.

With regard to subsection (iv) of §.1b(b), Petitioner's future earnings capacity, Petitioner asked to return to the workplace where he was injured. Respondent-employer refused.

Petitioner has worked three times in his building since the accident.

The FCE dated April 30, 2014 notes Petitioner was at a medium duty level for his return to work and that he can lift up to 35 pounds. He was released by his treating doctor with modified work restrictions. Although Petitioner has made significant improvement, he still suffers deficits with respect to his fingers and the overall function of his hand. The Arbitrator finds the above facts relevant in the determination of future earning capacity and therefore 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:

- The emergency room records from the accident date indicate Petitioner was diagnosed with a partial amputation and fracture of the middle phalanges of the second and third fingers with tendon involvement. The tips of his fingers were surgically replanted and sutured and his fingers were placed in splints.

- On February 5, 2014, Petitioner was seen by Dr. Vargas at the Chicago Pain and Orthopedic Institute. Petitioner testified and his records indicate that when he was seen by Dr. Vargas, he had symptoms of stabbing, electric like pain running from his fingers into his forearm. Dr. Vargas prescribed a course of NSAID's and referred Petitioner to Dr. Sclamberg for an orthopedic consult.

- The FCE dated April 30, 2014 notes Petitioner was at a medium duty level for his return to work and that he could lift up to 35 pounds. Petitioner was released to work by his doctor with a 30 pound lift restriction, 25 pound lift with left hand.

Given that the aforementioned records do support and corroborate Petitioner's testimony with respect to chronic pain and disability, the Arbitrator assigns *greater* weight to this factor.

The Arbitrator further notes that because Petitioner's medical records indicate that he suffered a partial amputation and fracture from the middle phalanges of the middle and index fingers with tendon involvement, the injury represents a loss of two phalanges of both digits, starting from the middle phalanx and including the distal phalanx. Based on the foregoing, **the Arbitrator finds that the Petitioner suffered a statutory loss of 100% of use of the left index finger and 100% of use of the middle finger. Accordingly, Respondent shall pay Petitioner $270.00/week for 43 weeks because the injuries sustained caused 100% loss of the left index finger as a whole as provided in Section 8(e)8 of the Act. Respondent shall pay Petitioner $270.00/week for 38 weeks because the injuries sustained caused 100% loss of the left middle finger as provided in Section 8(e)8 of the Act.**

Further, Petitioner's injuries required replantation surgery, stitches and extensive physical therapy. Petitioner made a good recovery, but continues to experience significant symptoms and loss of use of the hand as a whole. As Petitioner testified, he experiences pain and numbness in the affected fingers on a daily basis. Further, as Petitioner testified and as he demonstrated at the hearing, he has suffered a loss of range of motion in the affected fingers, as well as a loss of grip strength.

Based on the evidence contained in the record as a whole, including consideration of the criteria under Section 8.1b of the Act, **the Arbitrator finds that Petitioner has suffered a loss of use of the hand as a whole, and awards permanent partial disability in the amount of 35% loss of use of the left hand.**

Other Issues: Whether penalties under the Act should be imposed?

Petitioner is seeking penalties under the Act against Respondent-El Palenque only.

Petitioner testified that he did not receive any TTD neither for the periods of time that he was taken off of work nor for the periods of time that his employer did not accommodate his restrictions. Further, all of Petitioner's medical bills related to this matter remain unpaid. In fact, Respondent-employer has not appeared or participated in this case in any significant way and has not presented any legal justification for not paying Petitioner's TTD benefits and for not paying Petitioner's medical bills. The Arbitrator finds that Respondent's delay in payment is unreasonable and vexatious and has caused the Petitioner considerable hardship.

For the foregoing reasons, the Arbitrator further finds that the Respondent-employer El Paleque is liable for the following:

1. Penalties under Section 19(k) equal to 50% of the amount of compensation payable ($5,130.00 in TTD plus $36,447.76 in unpaid medical bills) or **$20,788.88.**

2. Penalties under Section 19(l) of **$2,500.00** (the maximum allowed under Section 19(l)).

3. Attorney's fees under Section 16 of **$16,564.05,** equal to 20% of the following:
    - 35% loss of use of the left hand or $19,372.50
    - Unpaid TTD of $5,130.00
    - Unpaid medical bills of $36,447.76

The Arbitrator finds, due to Respondent-El Palenque's egregious conduct and disregard for Petitioner's medical treatment, this Arbitrator imposes penalties under Sections 19(l), 19(k), and attorney's fees under Section 16.

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

Cindy Green,
Petitioner,

vs. No. 14 WC 21246

16IWCC0664

Walgreens,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under Section 19(b) having been filed by Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses including prospective care, and temporary total disability,[1] and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below. The Commission otherwise affirms and adopts the Decision of the Arbitrator, a copy of 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).

The Arbitrator's Decision is modified through the Commission's finding that Petitioner failed to prove that her left wrist injury is causally connected to the accident of September 25, 2013. Petitioner, a 45-year-old "split-case picker," alleged she injured her neck, both shoulders and left arm -- including elbow and wrist -- when she attempted to pull out a box that was wedged tightly between two boxes in an overhead position. (Tr. 9-10). She subsequently underwent treatment to her neck, left shoulder, and left elbow, including: anterior fusion surgery (January 2014); biceps tenodesis for labral tear in the left

[1] Respondent disputes causal connection, medical expenses and temporary total disability with respect to Petitioner's upper extremities only.

shoulder (December 2014); and medial and lateral epicondyle debridement of the left elbow (December 2014). (PX 5, PX 10). The left shoulder and elbow surgeries were performed by Dr. Nathan Mall. As of the date of the hearing (January 16, 2015), Petitioner was anticipating biceps tenodesis for the right shoulder from Dr. Mall. For her left wrist, Dr. Mall was recommending that Petitioner be seen by a hand specialist, but thought it likely that she would require surgery for her left wrist as well. (PX 11 at 21).

Regarding her left wrist injury, this injury was diagnosed in July 2014 by Dr. Mall as a scapholunate ligament tear based on an MRI arthrogram. Dr. Mall's diagnosis was consistent with the radiologist's impression of a full thickness scapholunate ligament tear. The Commission finds that the scapholunate ligament tear was not causally connected to the September 25, 2013 accident. In so finding, the Commission deems credible the opinion of Dr. Richard Rende. Dr. Rende explained that such a ligament tear occurs with wrist dislocation and is inconsistent with the mild mechanism of injury as alleged by Petitioner. (RX 1 at 21-22). Dr. Mall's opinion that her ligament tear "could very well be" caused by the trauma of the accident was based in large part on the fact that he did not have any reason to believe that Petitioner had left wrist pain predating the accident. (PX 11 at 21-22). With regard to prior left wrist pain, the Commission notes that Petitioner has a long history of ill-being in both upper extremities, prompting several surgeries including bilateral carpal tunnel releases (around 2003), bilateral ulnar nerve transpositions (around 2012) and surgery for DeQuervain's tenosynovitis in the left wrist (2009). (RX 4).

For the reasons stated, the Commission modifies the Arbitrator's Decision and finds that any condition of ill-being in Petitioner's left wrist is not causally connected to the accident. Accordingly, the Arbitrator's award of medical expenses for treatment for the left wrist, including prospective care, is vacated.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on August 6, 2015, is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $ 457.36 per week for 9-1/7 weeks, for the period commencing January 9, 2014 through February 11, 2014; and December 18, 2014 through January 16, 2015 as provided under § 8(b); Respondent shall be given credit for all temporary total disability benefits that have been paid and shall be given further credit for any non-occupational disability payments paid.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of medical benefits is modified. Respondent shall pay only the reasonable and necessary medical expenses incurred for treatment to the neck, shoulders and left elbow under § 8(a) of the Act and subject to the medical fee schedule.

IT IS FURTHER ORDERED BY THE COMMISSION that the award of prospective medical care to the left wrist is vacated. The prospective care relative to the right shoulder as awarded is affirmed.

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

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner 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. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: OCT 1 7 2016

o-08/16/16
jdl/ac
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Joshua D. Luskin

Charles J. DeVriendt

Ruth W. White

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

GREEN, CINDY
Employee/Petitioner

Case# **14WC021246**

WALGREENS
Employer/Respondent

16IWCC0664

On 8/6/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.16% 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:

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

0180 EVANS & DIXON LLC
ROBERT HENDERSHOT
211 N BROADWAY SUITE 2500
ST LOUIS, MO 63102

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Cindy Green
Employee/Petitioner

Case # **14** WC **21246**

v.

Consolidated cases: ______

Walgreens
Employer/Respondent

16IWCC0664

An *Application for Adjustment 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 **Herrin**, on **January 16, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the 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 25, 2013**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$35,673.69**; the average weekly wage was **$686.03**.

On the date of accident, Petitioner was **45** years of age, ***single*** with **1** dependent child.

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

Respondent shall be given a credit of **$2,221.46** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$2,221.46**.

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

ORDER

Respondent shall pay reasonable and necessary medical services of $201,527.15, as outlined in Petitioner's group exhibit 1, as provided in Sections 8(a) and 8.2 of the Act.

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

Respondent shall authorize and pay for any further reasonable and necessary medical care required by Petitioner.

Respondent shall pay Petitioner temporary total disability benefits of $457.36/week for 9 1/7 weeks, commencing 1/9/14 through 2/11/14 and 12/18/14 through 1/16/15, as provided in § 8(b) of the Act. Respondent shall be given a credit of $2,221.46 for temporary total disability benefits that have been paid and shall be given further credit for any non-occupational disability benefits paid.

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

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

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

Signature of Arbitrator

7/31/2015
Date

ICArbDec19(b)

FINDINGS OF FACT

Petitioner has worked for Respondent, Walgreen's Distribution Center, as a split case picker for 15 years. The Parties stipulated that Petitioner sustained accidental injury on September 25, 2013, when she attempted to dislodge a stuck container in an overhead position and felt immediate pain in her neck and upper extremities. Petitioner described it as a burning sensation with pain shooting into her shoulders and down her left arm. Petitioner testified she had no prior injuries or treatment for her neck, shoulders or left elbow. Respondent disputes causal connection, medical benefits, and temporary total disability with respect to Petitioner's upper extremities only. (T.4).

Petitioner was initially treated by Walgreens company doctor, Dr. Wood, and the onsite physical therapist. Dr. Wood's note of October 15, 2013 indicates that she presented with complaints of neck pain radiating into the left arm with left arm paresthesia. Her symptoms started acutely several weeks ago. She was diagnosed with cervical spondylosis with myelopathy. She was told to follow-up with an orthopedic surgeon for left C6 radiculopathy. (PX3, 11/13/13)

Petitioner was referred by the company doctor and Respondent's insurance carrier to Dr. Chabot. Dr. Chabot noted that Petitioner reported severe posterior neck pain, rated as 9 on a scale of 10, which radiated down into her left upper extremity with numbness, weakness and paresthesias in her left arm. Petitioner reported that her left arm fatigued easily and felt weak, and that left posterior shoulder pain kept her awake at night. *Id.* Dr. Chabot reviewed Petitioner's records and noted the above findings from Dr. Woods' notes. Physical examination demonstrated reduced range of motion in Petitioner's cervical spine by 50% in all directions, tension involving the posterior paraspinal and trapezius musculature, left worse than right, notable trigger points along the left posterior trapezius musculature, and positive Spurling's test inducing posterior neck and shoulder pain. *Id.* Petitioner's neurological examination revealed decreased sensation of the left lateral arm, left extensor and volar forearm and left 1st web space. *Id.* Dr. Chabot recommended an MRI of the cervical spine, prescribed a Medrol Dosepak, Soma, Ultram, and outpatient physical therapy. *Id.*

A cervical MRI of 13 November 2013 revealed a large, extruded disc herniation at C6-7 on the left side with bilateral neural compression, effacement of the thecal sac and narrowing of the left neural foramina. (PX3, 11/13/13; PX4, 11/13/13) Dr. Chabot recommended that Petitioner undergo a cervical epidural steroid injection and continue her current medications. (PX3, 11/13/13). When Petitioner returned on December 18, 2013, and reported no improvement in her complaints despite 3 weeks of physical therapy and an epidural steroid injection. (PX3, 12/18/13) Dr. Chabot recommended an anterior cervical discectomy and fusion at C6-7. *Id.* The surgery was performed on January 9, 2014. (PX5) In a letter addressed to Respondent and dated January 14, 2014, Dr. Chabot noted that Petitioner's complaints did not predate her accident and stated that Petitioner's complaints and need for surgery were causally related to her work injury on September 15, 2013. (PX3, 1/14/14) He stated that surgery was the most reasonable approach to resolution of Petitioner's complaints given the failure of conservative measures. *Id.*

Petitioner testified that the surgery improved her neck symptoms, but not those in her shoulders or her left arm. (T.11). On January 20, 2014, Petitioner returned to Dr. Chabot for reevaluation with complaints of paresthesia involving her left upper extremity. (PX3, 1/20/14) Physical examination revealed positive Tinel's sign over the left carpal and cubital tunnels which he believed to be most consistent with carpal tunnel disease

and ulnar neuropathy. *Id.* Dr. Chabot recommended a cock-up splint for Petitioner's left wrist. *Id.* On February 10, 2014, Petitioner complained of neck and left posterior shoulder aches and pains with numbness involving the ulnar 2 digits of the left hand and numbness with cramping involving the radial 3 digits of her left hand. (PX3, 2/10/14) Tension involving the posterior cervical paraspinal and trapezius musculature was also noted. *Id.* Tinel's sign and elbow flexion test were positive over Petitioner's left elbow, and Tinel's sign was positive over Petitioner's left wrist. *Id.* Petitioner's left elbow was also tender to palpation over the left lateral epicondyle, which he felt to be consistent with lateral epicondylitis. *Id.* Dr. Chabot recommended and performed an injection to the left ulnar nerve sheath and an injection to the left lateral epicondylar tendinous insertion. *Id.* Although Petitioner reached maximum medical improvement with respect to her cervical spine on April 11, 2014, Petitioner continued to suffer left upper extremity complaints. (PX3, 4/11/14) Dr. Chabot believed these upper extremity complaints were unrelated to Petitioner's cervical spine and referred Petitioner to Dr. Howard, his partner. (PX3, 3/10/14, 4/14/14).

Petitioner saw Dr. Howard on April 17, 2014, and Dr. Howard recommended an MRI of Petitioner's left elbow and a nerve conduction study. (PX3, 4/17/14) Petitioner's nerve conduction study showed mild neuropathy of the left wrist and was unimpressive for cervical radiculopathy or evidence of left focal ulnar or peripheral neuropathy. (PX3, 5/6/14) Petitioner's MRI also appeared to be unremarkable, although thickening and increased signal involving the insertional fibers of the distal lung of the biceps tendon at the radial tuberosity was noted. (PX3, 5/6/14; PX6, 5/6/14) Dr. Howard was unable to determine the cause of Petitioner's complaints, and released her from his care.

Petitioner testified that she continued to have undiminished pain in her left elbow and bilateral shoulders. (T.12, 13) At this point, Petitioner sought treatment from a doctor of her choosing for the first time. Dr. Mall examined Petitioner on June 18, 2014. Dr. Mall noted that Petitioner's neck surgery failed to mitigate Petitioner's shoulder pain. *Id.* Physical examination demonstrated limited range of motion secondary to discomfort. *Id.* Petitioner had pain with rotator cuff strength testing bilaterally, positive O'Brien's test bilaterally and AC joint pain bilaterally. *Id.* Physical examination of Petitioner's left upper extremity revealed left wrist swelling and pain with palpation over the intersection point of the second and third dorsal compartments, pain with resisted wrist extension in Petitioner's left forearm and left elbow and tenderness to palpation at the lateral epicondyle. *Id.* Dr. Mall assessed 1) right shoulder partial thickness rotator cuff tear, possible superior labral tear, versus rotator cuff tendinitis; 2) left shoulder partial thickness rotator cuff tear versus rotator cuff tendinitis; 3) lateral epicondylitis; and 4) intersection syndrome left forearm. *Id.* Dr. Mall recommended anti-inflammatory medications and physical therapy for the left wrist. In terms of the shoulders he felt she would benefit from cortisone injections and MRIs for the shoulders to make sure there is no rotator cuff tear or superior labral tear present. He felt he could treat Petitioner conservatively at first as he did not see any evidence of a full thickness, retracted rotator cuff tear that would require urgent surgical intervention. *Id.*

Dr. Mall administered an injection in each of Petitioner's shoulders. *Id.* Petitioner responded favorably to the cortisone injection into the subacromial space of her shoulders bilaterally, which he felt indicated that Petitioner's shoulders were a significant source of her pain. *Id.*

On June 27, 2014, Dr. Mall reviewed Petitioner's shoulder MRI films. (PX8, 6/27/14) Dr. Mall's assessment was 1) right shoulder SLAP tear with paralabral cysts and biceps tendonitis, 2) left shoulder SLAP tear and biceps tendonitis, 3) intersection syndrome, left forearm, 4) lateral epicondylitis, and 5) scapholunate

pain over the left wrist. (PX8, 6/27/14) Dr. Mall performed a second injection in each of Petitioner's shoulders. *Id.* Given Petitioner's positive response to injection in her shoulders, Dr. Mall believed that Petitioner's pathology was intraarticular pathology coming from the superior labrum and/or biceps within the shoulder joint or the undersurface of the rotator cuff and recommended surgery. (PX8, 7/7/14) He believed that Petitioner's need for surgery was causally connected to her work injury. *Id.*

Dr. Mall also recommended an MRI of Petitioner's left wrist and a new MRI of Petitioner's left elbow due to the poor quality of the first elbow MRI done in May. (PX8, 6/27/14, 7/7/14) The MRI of Petitioner's left wrist performed on July 7, 2014, revealed a full thickness tear in Petitioner's scapholunate ligament with some extensor carpi ulnaris tenosynovitis. (PX4, 7/7/14; PX8, 7/7/14) Dr. Mall recommended that Petitioner be evaluated by Dr. David Brown, a hand specialist, for her scapholunate injury. (PX8, 7/7/14) The MRI of Petitioner's left elbow on September 15, 2014, demonstrated lateral epicondylitis with partial tearing of the extensor carpi radialis brevis tendon, particularly of the posterior fibers, and medial epicondylitis with edema. (PX4, 9/15/14; PX8, 9/15/14) Since Petitioner's complaints persisted for some time despite conservative management through injections and physical therapy, Dr. Mall believed that Petitioner would likely require surgical intervention. (PX8, 8/11/14). The totality of Petitioner's injuries suffered were 1) bilateral SLAP and/or partial thickness rotator cuff tears, 2) left-sided medial and lateral epicondylitis, 3) left forearm intersection syndrome, 4) and left scapholunate tear of the wrist. (PX8, 10/27/14, 12/1/14) Dr. Mall recommended right shoulder biceps tenodesis, possible rotator cuff repair, medial and lateral epicondyle debridement of the left elbow, and left shoulder biceps tenodesis and possible rotator cuff repair. (PX8, 12/1/14) Dr. Mall believed that Petitioner's scapholunate tear should be addressed by a hand specialist such as Dr. Brown. *Id.*

Dr. Mall noted that Petitioner began having shoulder pain right after the accident. She stated that this was ignored by Dr. Chabot, but Dr. Mall pointed out there is a significant overlap between the shoulder and the neck. He felt it likely that some of her pain related to her neck was coming from her shoulders or vice versa. He indicated that if there was clear reason to proceed with cervical spine surgery then often times this is the more pressing intervention. He agreed with doing the cervical spine surgery first followed by any shoulder treatment that needed to be performed. Dr. Mall also pointed out that pulling a box from overhead is a classic mechanism for both superior labral and rotator cuff pathology. In light of the fact that Petitioner noted significant symptoms in the shoulders, arms, and wrists when the accident occurred and that the mechanism of injury is consistent with the type of pathology sustained, Dr. Mall felt that even if the pathology was not caused by this initial accident, it clearly aggravated a condition that was present in the shoulders but had been asymptomatic prior to the accident.

Respondent had Petitioner examined by Dr. Richard Rende on August 18, 2014. (RX1, p.5) Dr. Rende testified that he currently lives in Steamboat Springs, Colorado and comes to St. Louis once a month to perform medical legal examinations, 80% of which are for Respondents. *Id.* at 33, 34.

Petitioner gave Dr. Rende a consistent report of the injury and Dr. Rende reviewed the records of Dr. Chabot, Dr. Howard and Dr. Mall. *Id.* at 8-11. Dr. Rende also reviewed the MRI films of Petitioner's bilateral upper extremities. *Id.* at 11-13. Dr. Rende's physical examination findings were markedly different from those of Dr. Mall and Dr. Rende testified that he saw no clinical evidence of a SLAP tear in Petitioner's right or left shoulder. *Id.* at 14-17. Dr. Rende noted that there was no evidence of carpal tunnel syndrome or distal ulnar neuropathy. *Id.* at 17. His physical examination of Petitioner's left wrist only reflected Petitioner's ganglion cyst.

Id. at 18.

Dr. Rende testified that he did not appreciate any significant labral pathology on either of Petitioner's shoulder MRIs, which the Arbitrator notes is inconsistent with the interpretations of both the radiologist and Dr. Mall. Dr. Rende believed the findings were unreliable unless the MRI was performed with contrast. *Id.* at 19-20. Dr. Rende also testified that Petitioner's MRI arthrogram of the left wrist did not show evidence of carpal instability, and that the leaking of the dye adjacent to Petitioner's scapholunate ligament was merely evidence of an old injury. *Id.* at 21. He did not believe that Petitioner's work accident on September 25, 2013, was the sort of mechanism by which scapholunate or carpal instability could occur. *Id.* at 21, 22, 26, 27. He indicated that the cause of this condition "had to be either prior trauma or she was born that way." *Id.* at 27. He also believed that it would take years for Petitioner's ganglion cyst to develop. *Id.* at 22.

Dr. Rende believed that Petitioner's shoulder problems were related to her cervical spine as a residual of her work-related cervical injury. *Id.* at 23 The Arbitrator notes that this opinion is contrary to the opinion of Dr. Chabot, to whom the Respondent sent Petitioner, and the results of Petitioner's EMG study. Dr. Rende testified that Petitioner's shoulder symptoms, examination and MRI scans were not consistent with the work injury of September 25, 2013. *Id.* at 24. With respect to Petitioner's left elbow, although Dr. Rende agreed that Petitioner suffered from lateral epicondylitis, he did not believe this was related to the accident of September 25, 2013. *Id.* at 25, 26. He stated that lateral epicondylitis is a repetitive condition rather than one triggered by a traumatic event, and Petitioner did not have any further treatment options for this condition. *Id.* at 25, 26.

Dr. Rende acknowledged that Dr. Chabot diagnosed shoulder and elbow discomfort, but the pain diagram that Dr. Chabot had in his chart indicated that the shoulder pain was posterior and stated that labral tears don't present as posterior pain. *Id.* at 39, 40. He also acknowledged that seeing intra-operative photographs of Petitioner's shoulder could change is causation opinion. *Id.* at 45, 46.

Dr. Mall testified by way of deposition on December 5, 2014. (PX11) Dr. Mall testified that he is a board certified orthopedic surgeon who focuses his practice on advanced sports medicine and shoulder and knee procedures. *Id.* at 5. He testified that he performs 10 to 15 surgeries per week. *Id.* at 5. Dr. Mall reviewed the initial and supplemental reports of Dr. Rende. *Id.* at 6, 7. Dr. Mall testified that the results of Petitioner's EMG studies confirmed that Petitioner did not suffer from either acute or chronic cervical radiculopathy. Further, Petitioner's neck surgery had no effect on her upper extremity complaints. *Id.* at 10, 11. He noted that since cervical and shoulder complaints frequently overlap, Petitioner's upper extremity complaints were not addressed until the conclusion of her cervical spine treatment. *Id.* at 10-12.

With regard to Petitioner's left wrist, Dr. Mall testified that neither he nor the radiologist visualized a dorsal wrist ganglion, and that Dr. Rende mistook the dye leaking from Petitioner's scapholunate as a ganglion rather than appreciating the leakage as evidence of a scapholunate ligament tear. *Id.* at 13. Dr. Mall testified that even if a ganglion was present, since Petitioner's MRI was performed more than a year following her accident, it is impossible to prove that the ganglion existed prior to the accident. *Id.* at 13, 14. Dr. Mall further testified that while ganglions can be painful, they do not cause acute symptoms following an injury. *Id.* at 14. Dr. Mall also noted that there is no evidence of any shoulder complaints prior to the work accident. *Id.* at 14.

Dr. Mall testified that he recommended a biceps tenodesis over a superior labral repair because the

medical literature reports that in patients over the age of 35 or 40, the superior labrum repair results in excess stiffness and potentially may not heal. *Id.* at 15. He also recommended inspection of Petitioner's rotator cuff to address any problems that may be found there. *Id.* at 15.

When Petitioner presented to Dr. Mall following her examination with Dr. Rende, Dr. Mall discussed Dr. Rende's disagreements in light of the medical literature and evidence-based medicine in great length. *Id.* at 15-17. His treatment notes following Dr. Rende's reports detail the studies and documentation relied on to render his opinions and treatment recommendations. (See PX8, 12/1/14, 1/13/15) He also explained why in this instance an MRI with contrast would simply not be beneficial. *Id*; (PX11, p.36-39) He explained that given the fact that her MRI showed a superior labral tear, there is no reason to then go get an MRI arthrogram because it's already showing the tear. If you have a negative MRI that doesn't show a tear and you feel like they have one clinically, that's when you would get an MRI arthrogram to go back and see if you can increase that sensitivity by having the arthrogram performed. (PX11, p.36-37).

Dr. Mall testified that the need for surgery on Petitioner's right and left shoulders and left elbow was related to her work injury on September 25, 2013. (PX11, p. 18, 19) He testified Her mechanism of injury was classic for superior labral injury, and therefore given the MRI which demonstrates a clear superior labral tear and the fact that her mechanism of injury is consistent with superior labral tear, and the fact that her examination is also consistent with a superior labral tear, that her superior labral tears in her shoulders were causally connected with her work injury. He further elaborated On an overhead or chest height pulling and then a shift in that pull is well known to be a cause for a superior labral injury. *Id.* at 19-21. Dr. Mall testified that SLAP tears do present as posterior shoulder pain, and that when a tear is present in the posterior or superior posterior labrum, there is no anatomical variation that could falsely present as a SLAP tear. *Id.* at 40-42. He testified that the location of the shoulder pain cannot serve as a basis to rule out the presence of a SLAP tear. *Id.* at 43.

Dr. Mall explained that lateral epicondylitis, while commonly sustained as a result of repetitive activity, can also be of acute or traumatic origin. *Id.* at 43 He noted that she had previously had lateral epicondylitis on the right side, and has now developed similar symptoms on the left elbow as well. He indicated She has a job that's fairly repetitive in nature, and therefore the epicondylitis symptoms are very classic for this type of job category. He felt that given the fact that she's been a case picker for the last 15 years, this would definitely be something that could be work related. *Id.* at 19-21.

Dr. Mall also believed Petitioner's accident caused her scapholunate ligament tear and believed Petitioner's condition would require surgical intervention by a hand specialist. *Id.* at 21, 22.

On December 18, 2014, Dr. Mall performed surgery on Petitioner's left shoulder and left elbow. (PX10, 12/18/14) The intra-operative findings during Petitioner's surgery confirmed the presence of a superior labral tear, type II, a partial thickness rotator cuff tear, and both medial and lateral epicondylitis. *Id.* Petitioner testified at Arbitration that her left upper extremity symptoms improved markedly following surgery. (T.15).

CONCLUSIONS OF LAW

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

The Arbitrator notes that Petitioner had no symptoms and did not require any treatment or diagnostic

evaluation of her shoulders, left elbow, or left wrist prior to her accident. Petitioner complained of bilateral shoulder pain and left arm/wrist pain immediately following her injury. (PX3) These symptoms persisted despite Petitioner's cervical surgery.

Although Petitioner's upper extremity symptoms were not actively treated for a time because they were thought to be related to her cervical spine, when her cervical surgery did not alleviate the upper extremity complaints, the focus of treatment was turned to them. (PX3; PX5; PX8) It is not uncommon for injuries to be masked or presumed to be related to a different suspect than the actual culprit. In cases like these, what it is important to the issue of causal connection is not whether there is a gap in treatment, but whether the symptoms and findings later in the treatment match up to the symptoms immediately following the accident. *See Sharon Langorgen v. K-Mart*, 09 I.W.C.C. 1160 (2009); and *William Gordon v. IL DOT Joliet Yard*, 07 I.W.C.C. 1599 (2007). The medical records consistently document Petitioner's upper extremity complaints from the time of her injury through her current treatment. Further, the Arbitrator found Petitioner's testimony to be forthright and credible.

Dr. Mall and the radiologist who performed Petitioner's MRI studies clearly identified bilateral shoulder, left elbow and left wrist pathology that would account for Petitioner's complaints. (PX4, PX8) Petitioner's bilateral shoulder injuries responded favorably to injection, which confirmed the source of Petitioner's shoulder complaints were the findings on the objective MRI studies. (PX8) Dr. Mall further noted that Petitioner's left elbow epicondylitis complaints, which were absent prior to the accident, can be of acute or repetitive origin. (PX11) He also noted that, although Petitioner's left epicondylitis was catalyzed by the work incident on September 25, 2013, Petitioner's job is repetitive and that Petitioner developed work-related repetitive epicondylitis in her right upper extremity in the past. (PX11) Hence, he concluded that regardless of whether Petitioner's epicondylitis was traumatic or repetitive in origin, Petitioner's employment was a causative factor. *Id.* at 19-21, 43. Dr. Mall also noted that Petitioner's left wrist complaints began on the date of her work accident and stated that there is no other cause for her complaints. *Id.* at 21-22. Dr. Mall also presented credible medical literature to support his opinions on causation and his treatment recommendations for Petitioner's upper extremities. (PX8, 12/1/14, 1/13/15; PX11)

The Arbitrator found the testimony and opinions of Dr. Mall much more persuasive than those of Dr. Rende, who ignored the objective findings on Petitioner's MRI studies and gave no plausible explanation for the cause of Petitioner's complaints, which surfaced immediately following her injury and were non-existent prior to Petitioner's work accident. (RX1). Even assuming that Petitioner's left elbow condition was brought about by her years of employment with Respondent, the evidence in this record establishes that she was not symptomatic prior to the accident and became symptomatic immediately thereafter, the Arbitrator concludes that the accident either caused or aggravated Petitioner's elbow condition to the point that it became symptomatic and required treatment.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds that the conditions of ill-being in Petitioner's right and left shoulders, left elbow, and left wrist are causally related to her accident of 9/25/2013.

<u>Issue (J)</u>: Were 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 Arbitrator found the opinions of Dr. Mall persuasive. There was no persuasive evidence in the record to contest the reasonableness and necessity of the treatment performed. In fact, the parties stipulated that the treatment related to the cervical spine is compensable. Further, the Arbitrator notes Dr. Mall's opinions regarding Petitioner's left shoulder were confirmed by the left upper extremity intraoperative findings, which confirmed all of his diagnoses. In addition, the improvement in Petitioner's left upper extremity complaints following surgery substantiated his recommendations for treatment. (PX10, 12/18/14)

Based upon the foregoing and the record taken as a whole, the Arbitrator finds that all of the medical care rendered to Petitioner has been reasonable and necessary to relieve her of the effects of her undisputed work injury.

Respondent shall pay reasonable and necessary medical expenses of $201,527, as set forth in Petitioner's Exhibit 1, pursuant to the fee schedule, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit for any medical expenses previously paid as well as any medical expenses paid by the group insurance carrier. 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 (K): Is Petitioner entitled to any prospective medical care?

There is no evidence in the record to support any contention that Petitioner has reached maximum medical improvement, or that no further treatment options are available to Petitioner. Based upon the foregoing and the record taken as a whole, the Arbitrator finds that Petitioner is entitled to prospective medical care under the Act. Respondent shall authorize the treatment recommended by Dr. Mall related to Petitioner's shoulders, left elbow. and left wrist and/or any hand specialist to which Petitioner may be referred for evaluation of her work-related scapholunate ligament injury.

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

The parties did not dispute the period of Petitioner's incapacity up to the time of hearing. Respondent disputed its liability for payment of benefits based upon the issues of causal connection and reasonableness and necessity of medical treatment. Having previously found the conditions causally related to the accident and the treatment reasonable and necessary the Arbitrator finds Petitioner was temporarily and totally disabled for 9 1/7weeks from 1/9/14 through 2/11/14 and 12/18/14 through 1/16/15.

Respondent shall pay Petitioner temporary total disability benefits of $457.36/week for 9 1/7 weeks, commencing 1/9/14 through 2/11/14 and 12/18/14 through 1/16/15, as provided in § 8(b) of the Act. Respondent shall be given a credit of $2,221.46 for temporary total disability benefits that have been paid and shall be given further credit for any non-occupational disability benefits paid.

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

ANTHONY BULVAN,

Petitioner,

vs. NO: 12 WC 28080

PEPSI CO.,

16IWCC0665

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 "Petition to Rescind Settlement Agreement; and attachments" and being advised of the facts and law, denies Respondent's Petition to Rescind Settlement Agreement.

On July 28, 2015, a settlement contract was approved by Arbitrator Thompson-Smith. On August 13, 2015, Respondent filed a Petition to Rescind Settlement alleging that a condition precedent of the settlement was that Petitioner execute a Confidential Settlement Agreement and General Release of Employment, but that Petitioner failed to do so. As such, Respondent argues that the settlement does not accurately reflect the terms and conditions of the negotiated disposition between the parties.

According to Respondent's brief, a hearing was held before Arbitrator Thompson-Smith on September 30, 2015, but the Arbitrator declined to rule on the petition based on jurisdictional grounds. The Commission notes that no document or order reflecting the Arbitrator's decision is in the Commission file. On October 19, 2015, Respondent filed a Petition for Review.

Respondent asks that the settlement agreement be rescinded based on an additional document or agreement that is not in evidence. Respondent does not cite any Commission precedent or case law that would allow it to rescind a contract under these circumstances. It is not alleging that there was a clerical or typographical error. Nor is Respondent arguing that there was a mutual mistake. Rather, Respondent argues that the contract, which it prepared, is incomplete and missing some terms. However, this is due to Respondent's choice to write the

contract without referencing this other side agreement and remaining silent about that issue. The Commission has discretion over the approval of settlement agreements and this presumes that all of the terms of the settlement are included in the contract. Whether it is appropriate for a respondent to include such ancillary agreements in a workers' compensation settlement does not need to be decided here. However, we find that it is inappropriate for Respondent to now claim that it really didn't agree to what it agreed to, as evidenced by the contract, because of terms and conditions that it chose not to include in the contract.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent's Petition to Rescind Settlement Agreement is hereby denied.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $44,800.00. 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: OCT 2 0 2016

Charles J. DeVriendt

Ruth W. White

Joshua D. Luskin

SE/
O: 9/13/16
49

STATE OF ILLINOIS)
) SS.
COUNTY OF ADAMS)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

KANDIS CONNOUR,

Petitioner,

vs. NO: 06 WC 54982

KETTERMAN COMMUNICATIONS,

16IWCC0666

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issue of "Improper Dismissal and Denial of Reinstatement" and being advised of the facts and law, reverses the Decision of the Arbitrator as stated below.

According to Petitioner's Amended Motion to Reinstate, her attorney sent an e-mail to Arbitrator Dearing on April 24, 2014, requesting that the Quincy Docket status date on May 7, 2014, be continued because Petitioner was continuing psychiatric care with her most recent visit having been on January 28, 2014. However, Petitioner had become stable and depositions could be scheduled. (Amended Motion to Reinstate at #7 and Ex. 4).

On May 7, 2014, this case was apparently dismissed by Arbitrator Flores as evidenced by the Commission mainframe computer and a Notice of Dismissal that was dated September 12, 2014. We note that it is strange that it would take over four months for this notice to be sent. It is also unclear why Arbitrator Flores would have dismissed a case that had been assigned to Arbitrator Dearing. Furthermore, although this notice was attached to Petitioner's motion, there is no copy in the Commission file.

Petitioner represents that her attorney appeared before Arbitrator Dearing on August 6, 2014, in Quincy, Illinois and the case was continued to November 5, 2014.

According to Petitioner's motion, her attorney received the previously mentioned Notice of Dismissal by Arbitrator Flores on September 20, 2014.

On November 5, 2014, Petitioner filed a Motion to Reinstate. The Notice of Motion and

Order form indicates that it was to be heard by Arbitrator Flores in Geneva, Illinois on November 12, 2014.

Petitioner's Amended Motion to Reinstate claims that the parties appeared on November 24, 2014, before Arbitrator Flores who stated that she had not dismissed the case. However, she did not make a decision regarding Petitioner's motion to reinstate but, instead, indicated that she would "ask the Chairman's office what to do." (Amended Motion at #6). The Commission notes that no record was made at this hearing and there is no resolution indicated on that Notice of Motion and Order form.

On July 28, 2015, Petitioner filed her Amended Motion to Reinstate and noticed it up before Arbitrator Dearing in Quincy, Illinois. The corresponding Notice of Motion and Order form reflects that Petitioner's motion was denied on August 5, 2015, but a record does not appear to have been made of that hearing. Petitioner filed her Petition for Review on August 25, 2015.

The Commission finds that, based on the problems mentioned above with the Notice of Dismissal, it seems more likely than not that this case was dismissed due to a clerical error and inaccurately attributed to Arbitrator Flores, who was not even assigned to the Quincy Docket. Furthermore, the fact that no records were made of either of the reinstatement hearings renders further clarification impossible. The Commission finds that under the totality of the circumstances of this case, reinstatement is warranted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's case is reinstated and remanded to the Arbitrator for further proceedings.

DATED: OCT 20 2016

Charles J. DeVriendt

Mario Basurto

Joshua D. Luskin

SE/
O: 10/5/16
49

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

DOUGLAS JACKSON,

Petitioner,

vs. NO: 11 WC 47132

KEYSTONE STEEL & WIRE,

16IWCC0667

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

The Commission affirms the Arbitrator's decision, but finds that Petitioner's benefits between September 18, 2014 and December 14, 2014, should be classified as maintenance instead of temporary total disability.

The Petitioner was found to have essentially reached maximum medical improvement by Dr. Howard as of August 13, 2014, and was released back to work by Dr. Howard on September 17, 2014, subject to the restrictions noted in Petitioner's FCE. (Px6) Since Petitioner's condition had stabilized, he is not entitled to temporary total disability after September 17, 2014. Petitioner

had not returned to work as of this date and was still undergoing vocational rehabilitation services, and is therefore entitled to maintenance under Section 8(a) beginning September 18, 2014.

However, on December 11, 2014, Respondent extended Petitioner a job offer commencing December 15, 2014. (Rx20) Petitioner rejected the job offer via correspondence sent on December 12, 2014. (Px18) As Petitioner was capable of returning to his former position, but rejected the job offer, maintenance benefits are terminated as of December 14, 2014.

The Commission also corrects a clerical error in the decision. The second page of the decision states, under "Order" that "Respondent shall pay temporary total disability benefits for 160-2/7 weeks." The Arbitrator miscalculated the total period of time for which Petitioner was entitled to temporary disability and maintenance benefits, so the decision is modified accordingly.

The Commission hereby modifies the decision to award temporary total disability benefits from November 18, 2011 through September 17, 2014 for a total of 147-6/7 weeks. Petitioner is also entitled to 12-4/7 weeks of maintenance benefits for the period from September 18, 2014, through December 14, 2014.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on September 30, 2015, is modified as stated above, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $608.03 per week for a period of 147-6/7 weeks, from November 18, 2011 through September 17, 2014, 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 $608.03 per week for a period of 12-4/7 weeks, from September 18, 2014 through December 14, 2014, for maintenance benefits under §8(a) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $6,926.55 for medical expenses under §8(a) of the Act subject to the medical fee schedule in §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of

expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

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

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

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

DATED: OCT 2 0 2016

Charles J. DeVriendt

Ruth W. White

Joshua D. Luskin

CJD/dm
o100516
49

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

JACKSON, DOUGLAS
Employee/Petitioner

Case# **11WC047132**

KEYSTONE STEEL & WIRE
Employer/Respondent

16IWCC0667

On 9/30/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.10% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0225 GOLDFINE & BOWLES PC
ATTN: WORK COMP DEPT
4242 N KNOXVILLE AVE
PEORIA, IL 61614

0507 RUSIN & MACIOROWSKI LTD
JOHN MACIOROWSKI
10 S RIVERSIDE PLZ SUITE 1530
CHICAGO, IL 60606-3833

STATE OF ILLINOIS)
)SS.
COUNTY OF PEORIA)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Douglas Jackson
Employee/Petitioner

Case # 11 WC 47132

v.
Keystone Steel & Wire
Employer/Respondent

Consolidated cases:

16IWCC0667

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Gregory Dollison, Arbitrator of the Commission, in the city of Peoria, on 6/18/15. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

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

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

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

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

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

G. [ ] What were Petitioner's earnings?

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

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

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

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

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

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

N. [ ] Is Respondent due any credit?

O. [ ] Other ______________________________

FINDINGS

On the date of accident, 11-17-11, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $47,426.08; the average weekly wage was $912.04.

On the date of accident, Petitioner was 45 years of age, married, with 1 child under 18.

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

Respondent shall be given a credit of $97,458.51 for TTD, $0 for TPD, $0 for maintenance, and $7,800.00 for 8(j), for a total credit of $105,258.51.

Respondent is entitled to a credit of $7,800.00 under Section 8(j) of the Act.

ORDER

Respondent shall pay temporary total disability benefits of $608.03 per week for 160-2/7 weeks commencing November 18, 2011 through December 14, 2014 as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services of $6,926.55 as provided in Section 8(a) of the Act. Respondent shall pay any unpaid, related medical expenses according to the fee schedule and provide documentation with regard to said fee schedule payment calculation to Petitioner.

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

RULES REGARDING APPEALS Unless a *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.

Signature of Arbitrator

Date 9/29/15

ICArbDec19(b) p. 2

SEP 3 0 2015

In support of the Arbitrator's finding relating to (F) Causation and (L) Temporary Total Disability or Maintenance Benefits, the Arbitrator makes the following findings of fact and conclusions of law:

Petitioner has a high school education and one year of college. His work experience prior to commencing employment with Keystone Steel & Wire consisted of operating a forklift in shipping and receiving, being a lead man supervisor, building of brick patios and sidewalks, landscaping, and as a stocker. (RX 1)

On November 17, 2011 while working as a machine operator in the fence department Petitioner pushed the wrong button, resulting in the carrier coming towards him instead of away from him, pinning his right foot between two carriers which weighed 2500 pounds apiece. Petitioner was taken by scooter to Respondent's medical department where an accident report was completed (PX 1) and Petitioner was sent to the OSF Emergency Room. The initial diagnosis was right foot contusion (PX 2)

The following day, Petitioner presented to OSF Occupational Health where he was seen by Dr. Homer Pena. The doctor assessed crush type injury of the right foot with objective findings lacking for any significant trauma. Dr. Pena added that "...the degree of pain appears to be out of proportion to the appearance of the foot. It was compared to the left foot and looked very similar... I feel that the employee needs to be at work in some capacity, but sedentary work is not available at Keystone..." Dr. Pena took Petitioner off work and ordered a MRI. The MRI when taken on December 1, 2011 showed possible posttraumatic versus degenerative change first cuneiform metatarsal joint. No other acute abnormality was noted. Petitioner also underwent a CT scan of the right foot which was taken on December 6, 2011 and was negative for fractures. (PX 2)

At the referral of Dr. Pena, Petitioner saw Dr. Frank Russo at IPMR for an EMG-NCV study. Dr. Russo recorded a history of accident indicating Petitioner was suffering from a "... significant soft tissue crush...[and] since time he has had some ongoing pain,...numbness diffusely in the foot..., difficulty with movement of the leg, increased pain with weight bearing in the right foot." The EMG revealed mild irritability in the right foot, most likely due to local trauma. Dr. Russo noted the other aspects of the exam were within normal limits with the exception of recruitment and interference patterns based on decreased voluntary effort and/or pain inhibition. The doctor indicated that there were normal electrical findings of the nerves tested with some low range normal to borderline evoked motor and sensory responses. It was noted that there was no clear cut evidence of focal peripheral nerve injury. Dr. Russo opined that the clinical signs and symptoms suggested the possibility of some sympathetic dysfunction in the right lower extremity and some sympathetic mediated pain. (PX 2)

Due to another referral by Dr. Pena, Petitioner saw Dr. Nirain D'Souza at Midwest Orthopedic on January 10, 2012. The physical exam showed no temperature change, no color change, and no swelling. He had tenderness in the entire right foot and his range of motion was extremely limited both passively and actively. Dr. D'Souza reviewed the EMG and interpreted it as showing no axonal injury. The doctor also reviewed the MRI and CAT scans which collectively showed no fracture. Dr. D'Souza provided that he had no orthopedic options for Petitioner. Instead, the doctor recommended pain management, physical therapy, and desensitization modalities. (PX 4)

At Respondent's request, Petitioner attended a Section 12 independent medical examination with Dr. John Krause, an orthopedic surgeon on January 30, 2012. Petitioner advised Dr. Krause that he could not bear weight. During examination, the doctor noted mild surrounding erythema, swelling with warmth in the foot,

normal hair distribution, normal sensibility, no areas of point tenderness and diffuse tenderness at the malleoli and across the midfoot and forefoot. Radiographs were normal with no significant soft tissue swelling. Dr. Krause recorded that he observed Petitioner while he was walking in the parking lot. He provided that Petitioner was able to put full weight on the right foot as he pivoted into the vehicle. Dr. Krause opined that other than an ulcer on the anterior aspect of the ankle and redness over the anterior ankle and dorsum of the foot, Petitioner had no other objective findings either clinically or radiographically. Dr. Krause stated, "It sounds like the patient suffered a very minimal injury on 11/17/11 documented by multiple outside physicians. It appears that the patient can bear weight although he chooses not to do so." He felt Petitioner had obtained the appropriate tests which confirmed his negative examination findings. He did not believe Petitioner needed pain management but needed to be weightbearing. Dr. Krause stated that "[Petitioner] clearly demonstrated that he could put full weight on his foot as he was getting into his vehicle." He anticipated maximum medical improvement in two to four weeks and did not anticipate any permanent restrictions. (RX 5)

Petitioner returned to Dr. Pena on February 7, 2012. At that time, Petitioner continued to state he could not bear weight and continued on crutches. Dr. Pena's examination revealed normal appearance of the right foot, no edema, no deformity, no skin mottling, normal color, no wasting or atrophy. He had normal temperature but excessive pain behaviors. Dr. Pena indicated Petitioner had a minor soft tissue injury marred by functional behaviors driven by unknown incentives. He released Petitioner to return to work February 8, 2012 without restriction. (RX 6)

Petitioner testified that he drove himself to work on February 8, 2012. Petitioner stated that he had not driven a vehicle since his injury; he pulled his car over several times on the way due to fear; and he limped into the employee locker room with the aid of co-workers and got to his work station. Petitioner provided that his union steward, Tim Kelly, and foreman argued over his return. It was agreed that Petitioner would be sent home.

Petitioner testified that he saw his family physician, Dr. Gregory Moskop on that day. Dr. Moskop's records show Petitioner presented of pain and moderate tenderness along the medial aspect of the foot and ankle. Dr. Moskop assessed contusion to the right foot and ankle with continued pain over several months. Petitioner was taken off work and referred for pain management with Dr. Demaceo Howard. (PX 5)

Petitioner first saw Dr. Howard on March 6, 2012. Upon examination, Dr. Howard noted discoloration from about midway through Petitioner's leg to the toes. No significant nail bed changes were noted. There was a decreased right calf circumference, 15 cm on the right as opposed to 16cm on the left, and diminished sensation at the plantar aspect of the right foot. Dr. Howard diagnosed chronic foot pain and sympathetically mediated pain. Dr. Howard recommended additional physical therapy and lumbar sympathetic blocks. (PX 6)

Petitioner underwent two lumbar sympathetic blocks, March 20, 2012 and April 6, 2012 respectively. On April 10, 2012, Dr. Howard noted that the blocks did not provide significant relief. On examination, the doctor observed temperature discrepancy between the left and right side. The right foot was mottled and grey and there was hypersensitivity to touch. Also noted were mild nail bed changes with thickening of the nails on the right foot. Dr. Howard assessed complex regional pain syndrome in his right foot. The doctor recommended a spinal cord stimulator noting Petitioner had failed minimally invasive interventional care. (PX 6)

On June 8, 2012 Dr. Howard performed a trial surgical implantation of a spinal cord stimulator. (PX 6) On June 12, 2012, Dr. Howard noted Petitioner reported a 60% reduction in his right lower extremity pain. As such a permanent implantation was discussed. (PX 6)

At Respondent's request, Petitioner attended a Section 12 independent medical examination with Dr. Howard Konowitz, a board certified internist, pain management doctor, and anesthesiologist, on July 5, 2012.

Dr. Konowitz obtained a history, reviewed Petitioner's medical records, including but not limited to his diagnostic studies, and performed an examination. On examination, the doctor indicated positive findings of the right foot to include decreased temperature, color changes, swelling of the dorsal of the foot and decreased range of motion of the toes and motor strength of the toes. Also noted was preservation of internal/external rotation of the ankle with limitations. Dr. Konowitz stated that there were no inconsistent findings on examination and opined that Petitioner met the clinical diagnostic criteria for complex regional pain syndrome. He opined that Petitioner was not at maximum medical improvement and same would not occur until the permanent implantation of a spinal cord stimulator is accomplished. He felt Petitioner could reach maximum medical improvement 90 days after the permanent implantation of a spinal cord stimulator is accomplished. Lastly, he provided that he did not agree with regular duty work status. (PX 7) Petitioner testified that Respondent resumed the payment of TTD benefits shortly thereafter.

Dr. Howard inserted the permanent spinal cord stimulator on July 24, 2012. Later, on August 12, 2013 Dr. Howard had to operate again to replace a mal-functioning battery in the stimulator. (PX 6)

On August 15, 2012, Dr. Howard recorded that Petitioner indicated the spinal cord stimulator therapy was not as effective as it had been. Petitioner offered that the higher voltages were uncomfortable. The doctor also provided that Petitioner was quite emotional regarding home stressors. Arrangements were made to reprogram the stimulator. Dr. Howard also referred Petitioner to Dr. Lisa Rogers to specifically address his psychological issues. (PX 6)

Petitioner continued with Dr. Howard. On October 29, 2012, Dr. Howard noted Petitioner's right foot was cold as compared to the left foot. His right foot was diffusely hyperemic compared to the left. Slight muscle loss and skin mottling was also noted. Dr. Howard noted that he was referring Petitioner for a functional capacity examination, "specifically for what was directed to us from _____ Group in regards to patient's long term functional status." (PX 6)

Petitioner attended the functional capacity assessment on November 20 and November 21, 2012. According to documentation submitted, Petitioner was evaluated based on the demands of "Fence JOB TITLE Monarch." It was noted Petitioner demonstrated the ability to do the job functions of a machine operator and was able to frequently stand/walk, being 34 to 66% of the day; low level activity 34 to 66% of the day; climb stairs 34 to 60% of the day; lift-carry 40 pounds occasionally, 20 pounds frequently, 10 constantly; push/pull 88 to 146 pounds occasionally. The evaluator provided that Petitioner gave consistent full effort on 12 out of 13 tests. The evaluator stated that Petitioner demonstrated the ability to meet the job function needed for return to work. Modifications were recommended to include being able to transition between sitting and standing. Also noted was that if Petitioner was not deemed ready to return to work, he would benefit from a work conditioning program. (RX 8)

Petitioner participated in a work conditioning program December 4, 2012 through February 13, 2013. On February 13, 2013, the therapist wrote, "Mr. Jackson continues to complain of increased right foot pain, numbness, and swelling along with back pain. He continues to state "my foot feels like it's asleep." He continues to ambulate into the clinic with a quadruped cane and then uses a rolling table during work conditioning program because of subjective pain. He has demonstrated the ability to function at the above levels with safe and stable body mechanics with increased subjective pain...He continues to limited weight bearing on [the] right foot during activities because of increased subjective pain. Mr. Jackson continues to demonstrate symptom focused behaviors throughout the sessions, mostly during stair climbing activities..." The therapist recommended discharge from the work conditioning program indicating Petitioner had met all goals regarding return to work lifting goals and had plateaued with improvement in stair climbing ability. The therapist also provided that they were unable to make a recommendation for returning to work due to Petitioner only

attending work conditioning three days a week. (RX 9, RX 10, RX 11) Petitioner did not attempt to return to work at that time.

On February 14, 2013, Dr. Howard noted Petitioner was released from work conditioning. The doctor stated that Petitioner noted gradual improvement of his physical activities albeit with pain particularly on the undersurface of his feet. Dr. Howard noted Petitioner reported efficacy with the use of the stimulator, however the pain relief was not to the point Petitioner could return to his former occupation. The doctor kept Petitioner off work and noted he was not released to drive both because of the foot pain as well as the narcotic therapy. (PX 6)

On February 26, 2013, Dr. Howard authored a narrative report at that request of Petitioner's attorney. Dr. Howard provided that Petitioner's symptoms are a direct result of the trauma he sustained on November 17, 2012. He provided that Petitioner's pain pattern would require monthly visits for medication management. The doctor provided that Petitioner continues to report pain complaints which he numerically rates at 7 out of 10; he had noted extension of his pain into the undersurface of the foot; there was some slight discoloration consistent with the diagnosis; his peripheral pulses were intact; there was no muscle wasting; and his weight bearing was better with therapy and the implant. Dr. Howard provided that he would defer to the work conditioning report regarding Petitioner's ability to return to work. The doctor noted same indicated Petitioner had met all return to work goals relative to lifting and had plateaued with improvement in stair climbing. With respect to driving, the doctor provided that his uniform practice is to restrict patients from driving while on narcotic therapy. He provided that until Petitioner is weaned off the narcotic therapy, going to and from employment would have to be provided for him. The doctor also recommended an assessment through IPM&R driving rehabilitation program to assess whether a modified pedal to the left foot is appropriate for him to operate heavy machinery in the work place. Lastly, Dr. Howard provided that a driving assessment would be necessary before he could render an opinion on maximum medical improvement. (PX 6)

On March 7, 2013, Dr. Howard authored an addendum to his February 2013 narrative report, specifically addressing any restrictions being imposed. The doctor indicated that Petitioner would be limited to sedentary duty at best in the immediate near future. He felt that Petitioner would not be weaned from his narcotics within the next several months, based largely on Petitioner's report of escalating pain. The doctor also provided that Petitioner would be restricted from driving. (PX 6)

At Respondent's request, Petitioner attended a third Section12, this time with Dr. Samuel Vinci, a podiatrist at M & M Orthopedics, on April 2, 2013. Dr. Vinci reviewed medical documentation and performed an examination. Dr. Vinci noted in his exam that there was a "…marked coloration difference in the right lower extremity to be more reddish with brawny edema versus the uninvolved left…Integument abnormalities to be noted are again the skin is very shiny and very dry on the right as compared to the left. There is a loss of hair growth on the right compared to the left…he has a color change to where there is more darkness or rubor-purplish appearance when comparing the right to the uninvolved left. He does have a temperature gradient to where the right is warmer during my examination on the left…" Measurements of the midcalf, ankle and midfoot were taken. The midfoot mearsure 10-1/2 inches on the right and 10 inches on the left; the Malleoli was 11 inches on the right with 10-1/2 inches on the left; and the mid-calf was 12-1/2 inches on the right and 12 inches on the left. Dr. Vinci indicated that the swelling "…correlates with an obviously gross increase in size clinically noted…" X-rays were taken at Dr. Vinci's office which the doctor indicated showed obvious demineralization of bone to be noted on specifically the distal tibia on the right versus the left. Also on the lateral view, there was disuse osteoporosis noted, more so on the right calcaneus than on the left. (PX 8)

Dr. Vinci's impression was status post crush injury to the right lower extremity and CRPS Type I. Dr. Vinci opined felt that Petitioner was at maximum medical improvement on April 8, 2013. He felt Petitioner had some permanent residual impairment from the injury sustained and diagnosis of CRPS Type I. He opined

Petitioner could return to the workforce with permanent restrictions in the form of a sit-down job with minimum walking activities. The doctor opined that Petitioner will require maintenance, "...most likely the specialty of pain management." (PX 8)

On May 2, 2013, Dr. Howard noted that Petitioner reported higher levels of pain as well as swelling and discoloration of his right foot. The doctor noted Petitioner could not weight bear to any significant degree and he continued to need assistance/cane for ambulation. Dr. Howard reiterated his concern with Petitioner being on narcotics and attempting to participate in some sort of work related activity. (PX 6)

On May 16, 2013, Respondent retained a vocational expert, Jim Ragains, who first met with Petitioner on May 28, 2013. Records submitted show Mr. Ragains met with Petitioner regularly between May 2013 and January 2014. Mr. Ragains administered several vocational tests placing Petitioner in the average range for spelling, reading. Mr. Ragains provided that math was Petitioner's least favorable skill which he rated at the 7th grade level. Mr. Ragains indicated that based on Petitioner's work history, his sedentary work restrictions per Drs. Howard and Vinci, and his vocational testing results, there were no viable semi-skilled occupations of a sedentary nature to which Petitioner could transfer his skills that would aid job placement. Mr. Ragains stated, "It is my opinion to a reasonable degree of vocational rehabilitation certainty based upon my work experience in the Peoria, Il and surrounding job markets... there is no available market for unskilled, or essentially unskilled sedentary work involving no driving to perform in which Mr. Jackson might be placed for employment as he is. There is no need for a labor market survey in this regard. Thus, and unfortunately due to his still relatively young work age, Mr. Jackson is not employable." Mr. Ragains suggested re-training and authorization of the counseling and continuing physical therapy recommended by Dr. Howard. (PX 14)

Throughout his records, Mr. Ragains recorded that Petitioner had been fully cooperative and well motivated. Mr. Ragains subsequently enrolled Petitioner in a computer skills class offered by Goodwill. Mr. Ragains noted Petitioner made steady, albeit slow, progress with his with computer skills class. According to Mr. Ragains, on January 7, 2014 Respondent issued a directive to close his file and cease vocational efforts. (PX 14) Petitioner testified that eventually he completed the computer class training in July of 2014 and was proficient in Excel, Microsoft Word, and Power Point.

Petitioner continued with Dr. Howard while participating in vocational training. On May 28, 2013, Dr. Howard opined that Petitioner had reached maximum medical improvement. He however noted that there may be continued improvement with psychological and physical therapy. On June 26, 2013, Dr. Howard noted Petitioner continued to report significant levels of pain. On July 24, 2013, Dr. Howard indicated that Petitioner's increase in pain was most likely due to lack of stim coverage with the neurostimulation device which he attributed to equipment malfunction. Because of the failed device, Dr. Howard removed said failed device and implanted a new IPG with programming on August 12, 2013. By September 17, 2013, Petitioner reported 55% pain relief. (PX 6)

Petitioner testified and the records show Petitioner consulted with Dr. Lisa Rogers for his anxiety and depression in 2013. Petitioner's counseling sessions began on September 11, 2013 with Frandy S. Raso, at Advanced Behavioral Health. Records show Petitioner's symptoms/impairments were anxiety and worry (severe); brooding over the past (moderate); complaints of pain in the back, right buttocks, hip and leg (extreme); concern over physical health (moderate); depressed mood (moderate); difficulty falling and staying asleep (severe); and feeling of hopelessness (moderate). Petitioner's diagnoses were (Axis I) anxiety due to chronic back, buttocks, and leg pain with generalized anxiety and depression; (Axis III) chronic back pain; (Axis IV) problems with primary support group, disruption of family by divorce and family conflict; and occupational problems, unemployment. (PX 10)

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At Respondent's request, Petitioner underwent a fourth Section 12 examination. The examination was conducted by Dr. Shanna Kurth of Neuropsychology Clinic, P.C. on January 10, 2014. Dr. Kurth's report indicates she performed a neuropsychological evaluation for persistent pain syndrome and evaluation of possible psychological factors effecting recovery. Dr. Kurth observed and recorded that Petitioner's mental status examination was significant only for hypervigilance regarding his pain and, in particular, the impact of his pain on his everyday life. The doctor indicated Petitioner was pleasant and cooperative, appearing to apply adequate and unflagging effort throughout 7 hours of testing. She reported that the intellectual examination suggested Petitioner was functioning in the low average range of intellectual function. His comprehensive emotional/psychiatric questionnaire results were judged to be valid. Dr. Kurth indicated "[f[rom a psychiatric standpoint, by history and current clinical findings this patient appears most appropriate for the diagnosis of Generalized Anxiety Disorder as well as an unspecified depression disorder. Issues regarding the possibility of Somatic Symptom Disorder, either comorbid with or in lieu of CRPS." She indicated that "[f]rom a cognitive standpoint, this patient exhibits variable attention/concentration difficulties in the context of otherwise unremarkable psychometric results in the average to low average range. His difficulty with attention/concentration is readily attributable to a combination of factors, to include anxiety, presence of pain, pain medication effects, and inadequate sleep." Dr. Kurth indicated that Petitioner certainly meets the diagnostic criteria for Somatic Symptom Disorder. She indicated same represented a significant complication to Petitioner's expected course of recovery and may have a substantial impact on his prognosis. Dr. Kurth recommended continued counseling services. (PX 9)

On March 12, 2014, Dr. Howard authored a note indicating Petitioner was at maximum medical improvement and could return to restricted sedentary work consisting of no stairs or ladders; no driving; and no lifting over 10lbs. The doctor also recommended physical therapy noting however that he was not expecting dramatic improvement that would allow Petitioner to gain pre-injury functional status. (PX 6)

On August 13, 2014, Petitioner returned to Dr. Howard. Petitioner was accompanied by Nurse Case Manager Cathy Hilton Jeffries during that appointment. In his report dated same, Dr. Howard wrote that with the combination of neurostimulation therapy and narcotic therapy, his pain had been under better control. The doctor noted that Petitioner's attempt at physical therapy escalated his pain symptoms and that his report of escalation of pain was in spite of relatively normal appearing right lower extremity. There however was some slight discoloration but no swelling or muscle wasting. Dr. Howard noted that inasmuch as the progress with physical therapy was slow at best, he didn't believe that continuing same would be beneficial in the long term. Dr. Howard stated that essentially Petitioner was at maximum medical improvement and discontinued the physical therapy. He felt Petitioner's baseline pain levels would better controlled with medication and neurostimulation therapy. Dr. Howard requested a FCE and indicated Petitioner could return to full time sedentary work with a 10lb. weight limit, no stair and ladder climbing. The doctor provided that Petitioner may drive. (PX 6)

Nurse Case Manager Cathy Hilton Jeffries memorialized her attendance with Petitioner's appointment with Dr. Howard of August 13, 2014. (RX 15) She also testified at arbitration. Ms. Hilton testified that at the August 13th visit, Dr. Howard advised her that Petitioner was at maximum medical improvement and had no objective findings of active/acute CRPS present on exam.

The second FCE was performed on September 3 and 4, 2014 at the referral of Dr. Howard. It was reported that Petitioner demonstrated very little active motion in the right ankle and with little muscle activation. No muscle wasting or swelling was noted. Petitioner demonstrated that he could walk without crutches, but with multiple rest breaks and at a very slow pace. He could material handle at the light physical demand level. He self-restricted activities due to pain. He demonstrated occasional physical demand level performance with stair climbing, low level work and walk-standing. It was noted that low level work required the use of external support to get in and out of a low level position and he utilized his upper extremities for

intermittent support. Stair climbing required the use of bilateral hand rails and a "step-to" pattern. The evaluator indicated that all the assessment items were completed at a slower pace with several rest breaks during and between test items. He indicated Petitioner self-restricted material handling and walking due to reported pain which Petitioner rated at 8/10. Walking was completed with a shortened right step with decreased toe-off and a narrow stance. No to slight color changes were noted in his injured right foot. He had decreased protective sensation in his right foot. The evaluator stated that Petitioner participated in all portions of the assessment with a fair effort on most testing items and a good effort with his hands. He was consistent in 25 of 27 items. It was recommended that Petitioner not lift and/or carry greater than 25lbs.; not ambulated without an assistive device greater than 136 feet; not complete more than one (1) flight of stairs at one time with the use of bilateral hand rails; no low level work without the use of external support; and change positions as needed for standing to sitting. (It appears the report was completed taking into consideration Petitioner's prior fence machine operator position.) An addendum was then completed on September 9, 2014 with the same restrictions previously noted. Added to the report was "[f]oot control operation with the right foot would be questionable due to decreased sensation and decreased active rang previously noted. A driving evaluation would be appropriate if foot controls are on the right." (PX 15, RX 16, RX 17)

On September 15, 2004, Respondent commissioned measurements of a fork truck at Keystone Steel & Wire. The measurements were taken by Mr. Sean McGinn from OSF Center for Industrial. In a report dated September 15, 2014, Mr. McGinn indicated the "step into fork truck" had a 15 inch and 13 inch step. The pedal pressure for the right foot was "6.5#" to depress and the brake pedal pressure was "25#" to depress. (RX 18)

On September 17, 2014, Dr. Howard noted Petitioner had undergone the FCE. The doctor indicated that Petitioner was free to return to work with a forklift. Dr. Howard stated, "[h[e has been told modification of the forklift would allow him to engage in that type of work activity. He met criteria for operation of foot pedals, both left and affected right lower extremity." Dr. Howard referred Petitioner to IPMR for a driving assessment. Also, the doctor indicated that Petitioner return to work pending said driving assessment and that he was restricted from driving motor vehicles for two months. (PX 6)

In 2014 Respondent retained vocational expert Stephanie Powers, a certified vocational expert. Ms. Powers testified that she first met Petitioner in February 2014 and worked him through December 2014. Ms. Powers stated that she reviewed Petitioner's application and reviewed the reports from Respondent's previous vocational expert, Mr. Jim Ragains. She noted that while Mr. Ragains advised Petitioner undergo computer training, he did not offer any vocational placement. Ms. Powers testified that she assisted Petitioner with crafting resumes, job skills readiness, and job forms. Ms Powers stated she provided Petitioner with 40 to 50 job leads per month which were in his skills condition. With the exception of one lead, HGS, Ms Powers indicated that she received no confirmations from any of the leads that they received a resume/application from Petitioner. Ms. Powers stated that Petitioner did attend an interview with HGS. The position was telemarketing selling toothpaste for an account with Colgate which paid $10.00 per hour. Ms. Powers provided that Petitioner informed her that he asked the prospective employer if he was going to get paid at $23.00 per hour and that he might be a liability. Ms. Power indicated said statement was a barrier to employment.

Ms. Powers also testified that she advised Petitioner to go to three job fairs and two workshops, none of which Petitioner attended. She indicated Petitioner's effort and cooperation during the rehab was zero on a scale of 0 to 10. She also indicated that if a FCE determined Petitioner was at a sedentary level, he could obtain gainful employment.

On cross-examination, Ms. Powers testified that Caterpillar Tractor was hiring at one of the job fairs and that Petitioner might have been hired by them. Ms. Powers provided that she had no knowledge of any specific jobs that Caterpillar was offering. However, she opined that based on Petitioner's transferrable skills, Petitioner could perform sedentary work for Caterpillar if a position was open. Ms Powers stated that she was aware that

Mr. Ragains opined that Petitioner was not employable and she didn't know why he was taken off the case. She also opined that Petitioner could use City Lift for regular transportation to any job. Petitioner testified that he had used City Lift on several occasions and that they were not reliable. He testified that on at least one occasion, he was abandoned at Goodwill by them.

Petitioner underwent a fifth Section 12 examination at the request of Respondent on September 23, 2014. The examination was conducted by Dr. Ken Candido who testified via deposition. Dr. Candido testified that in addition to obtaining a history, reviewing Petitioner past medical and social history, he also performed an examination. Upon examination, the doctor noted Petitioner's quadriceps function was 56 pounds on the left and limited to 4 pounds on the right due to stated pain in the right foot; hip flexion (the iliopsoas muscle function) was 48 pounds on the left and 12 pounds on the right with pain being the limiting factor; there was some swelling and tactile allodynia at the right ankle; temperature measurements showed 85.6 degrees on the right ankle and 85.7 degrees on the left; the right knee measured 78.4 degrees and the left measured 79.4 degrees. Dr. Candido testified that the lack of strength with knee extension could not be anatomically explained as that dealt with the femoral nerve for which there was no documentation of injury. The doctor indicated that said finding was a nonorganic finding implying that there's overt inability to comply with the request to extend the knee. He indicated same could be due to lower extremity pain. He also indicated however, that it could be a reflection of symptom magnification or malingering. (RX 19, pgs. 15-21). With respect to the hip flexion, Dr. Candido explained that for hip flexion to occur, an individual has to tense or contract the iliopsoas muscle group which has no relationship to the foot or ankle and has its origin in the spinal segment. The doctor provided that he would expect symmetry between the left and right sides and as such he felt this was more likely a manifestation of symptom magnification or malingering. (RX 19, p.21)

Dr. Candido testified with respect to the motor examination of the right as compared to the left. The doctor indicated he noted there was a reduction in Petitioner's ability to perform inversion, dorsiflextion and plantar flexion primarily with modest reduction in eversion on the right side. Dr. Candido stated that for an individual to have inversion, eversion, dorsiflexion, and plantar flexion there has to be an intact motor branch of the tibial nerve and the common peroneal nerve. He indicated dorsiflexion requires intact deep peroneal nerve, and plantar flexion requires an intact tibial nerve. Inversion was a mixed function of both. The doctor testified the EMG ruled out any damage to the peroneal nerve and as such, there was no objective explanation for Petitioner's demonstrated lack of inversion and eversion. (RX 19, pgs. 22-24) Regarding the sensory examination, Dr. Candido noted the presence of tactile allodynia, an abnormal sensation to light touch. The doctor noted swelling was present at the lateral malleolus of the right ankle which he indicated could be indicative of an ankle sprain, nerve damage, or lymphatic obstruction. Dr. Candido stated there was no noticeable difference between the temperature measurements between the right and left. He stated the there was mild temperature disparity at the knee, but the criteria established for CRPS demands a minimum of 1 degree centigrade disparity between the effected and non affected side. (RX 19, pgs. 25-28)

Dr. Candido testified regarding diagrams and photos he prepared as part of his report. Dr. Candidio explained that the marking on the diagram depicts the various locations where the sensory nerve functions would be. (RX 19, pgs.29-30,- also see dep #3, pgs. 15, 18-26) The doctor provided that the diagram in conjunction with Petitioner's subjective complaints showed sensory function in all seven nerves, indicating there were no areas where he had numbness or an inability to appreciate stimulation. He stated that for there to have been a defect in inversion there would have to have been an injury with an affecting sensory lesion in nerves 2 through 7. He added that the medical records and clinical exam show no evidence of it. (RX 19, pgs. 31, 32) With respect to the photos taken, the doctor reported same showed no abnormalities in color, no sign of sweating or moisture apparent on either lower extremity, nails and hair distribution symmetrical and no obvious edema. (RX 19, pgs. 32-35)

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Dr. Candido testified that he reviewed the FCE. He noted same was effort dependent. The doctor opined that there was no objective basis to restrict Petitioner's ability to lift, push, or walk 136 feet without an assistive device. The doctor also testified that he reviewed the job description for the fence machine operator as well as reviewing the forklift measurements taken by Mr. McGinn from OSF. Dr. Candido provided that based on his examination and review of the records, Petitioner was capable of driving. (RX 19, pgs. 42, 44)

Dr. Candido testified that he diagnosed Petitioner with neuropathic pain of the right foot and ankle. He provided that he would agree with Dr. Howard if the doctor's examinations in 2014, on an objective basis, revealed no evidence of reflex sympathetic dystrophy. Dr. Candido stated that his examination of Petitioner in September 2014 provided no physiological or organic evidence for the lack of eversion and inversion. He believed this was volitional. (RX 19, pgs. 44-45)

Dr. Candido testified the Budapest clinical diagnostic criteria is used commonly when diagnosing CRPS. The doctor stated the symptoms and signs each have essentially four categories which are similar, i.e., a sensory category, a pseudomotor category, a vasomotor catergory and a motor/trophic category. He stated that an individual has to have a minimum of three out of four symptoms and a minimum of two out of four signs. He stated that subjectively, Petitioner had three out of the four symptoms. He described Petitioner reported 1.) symptoms of ongoing pain and allodynia; 2.) symptoms of swelling or edema; and 3.) symptoms of loss of range of motion or weakness. The doctor provided that Petitioner's description of his symptoms did not match his objective findings and that as of his examination in 2014 there was no objective evidence that Petitioner was suffering from CRPS. He opined that as of his examination, Petitioner was at maximum medical improvement and that Petitioner was capable of returning to his prior position as a fence machine operator. (RX 19, pgs. 46-49) The doctor also noted that Petitioner had informed him that he ambulates with the use of crutches and a cane. He opined that if an individual was using crutches for such a long time he would anticipate seeing severe atrophy from non-weight bearing just after a few months. He indicated his examination revealed no evidence of atrophy, nor was there any lack of muscle tone. Based upon his examination, the doctor opined Petitioner was capable of working in the forklift driver position offered. He added there was no objective basis to restrict Petitioner's walking without assistive device to 136 feet; restrict his lifting or stair climbing; or limit the number of times he could get on and off the forklift. (RX 19, pgs. 50-52)

On cross-examination, Dr. Candido testified that it was impossible for him to determine whether or not Petitioner had ever had CRPS. He indicated that he could only state Petitioner did not have it at the time of his examination of Petitioner. (RX 19, pgs. 55-56) Dr. Candido stated that contemporary research can improve over time with or without treatment. He stated it can be transient and in some instances it can be reversible. He also provided that the symptoms can come and go. Dr. Candido added that the mechanism of injury as described by Petitioner could be a competent cause for CRPS. Dr. Candido also opined that Petitioner treatment at the time it was rendered was appropriate and had no direct criticism of said treatment.

On December 11, 2014, Dr. Pena penned a work status report providing that Petitioner could return to restricted work on December 15, 2014. The restrictions provided limited lifting to 10 lbs. and fork lift work only. The doctor wrote that he concurred with the treatment plan of Drs. Howard and Candido, as well as the FCE. (RX 20)

On December 11, 2014 Respondent faxed a job offer to Petitioner and his counsel. The offer reads in pertinent part, "based upon the medical opinions of your treating doctors and our independent medical evaluation with Dr. Candido that we are in a position to offer to you the Trucker/Laborer position in the Fence Department as a forklift operator. This position is within your capabilities and medical restrictions..." It was noted that the job would pay $17.56 per hour plus the appropriate shift differential for the shift worked. (PX 18, RX 20)

In response to same, Petitioner, through his attorney, advised Respondent that he was not reporting to work. In a letter dated December 12, 2014, Respondent was advised "Dr. Howard has only released Mr. Jackson for a driving assessment, not to operate a motor vehicle or forklift. As we believe the job demands to be beyond Doug's proven physical capacity, Doug will not be reporting to work on Monday…" (PX 18)

As noted above, Petitioner received counseling sessions for his anxiety and depression beginning on September 11, 2013 with Frandy S. Raso, at Advanced Behavioral Health. In addition to other stressors, the records submitted are replete with references regarding his workers' compensation matter. On September 23, 2013, Ms. Raso documented, "The patient got tearful as he described his unhappiness regarding the "hoops" he must jump through to get appropriate services. He is determined to work again, drive, and have the autonomy he once enjoyed." On November 11, 2013, she wrote, "The patient displays an optimistic outlook regarding how things will turn out with his workman's comp. lawsuit but misses the independence he felt before his accident." On January 22, 2014, she recorded, "he spent 11 hours with the psychologist representing Keystone, Dr. Shana Kurth. He did not eat during this time and states he was quite upset about the fact that he was not told the appointment would take this long. The patient's vocational rehab specialist has been taken off his case and Patient will meet his new vocational rehab person on Feb. 6th…" On March 4, 2014, Ms Raso recorded, "patient was upset during our session. He was told by his new vocational rehab representative, Stephanie Powers, that he needs to apply for jobs. Patient states he doesn't drive and is confined to a wheel chair and knows no one will hire him. He feels like this is another way he will be humiliated and put down as he attempts to look for jobs and does not find one. He is certain no employer will hire him…Patient went on to say he would love to have a place to go and a job to enjoy but he is not ready to face rejection due to his current physical limitations." On March 19, 2014, it was noted, "Dr. Howard made a wide list of restrictions for the patient to adhere to which was sent to Keystone. The patient remains very upset about the fact Keystone wants him to apply for jobs when he knows he won't get one…He understands that he will most likely not get employment but that this was good for his case. He is getting depressed at the prospects and the realization that he is being used as a "pawn" in the workman's comp game…The patient sent out about 6 resumes so far…The patient is ready to be rejected enough times so that Keystone knows he can't work. The patient states he is embarrassed and humiliated with all of this but continues to "play the game," with hopes that the case can be settled soon. On April 2, 2014, it was noted, "Patient met with vocational rehab person, Stephanie Powers, today. Patient wanted to know how he is supposed to apply for jobs he knows he will not get. He wants reimbursement for stamps and envelopes which are needed to send out resumes. Patient states Ms. Power was of no help. She reportedly told Patient that being in a wheelchair, no typing skills, and having no college degree will not stand in the way of getting a job. Patient is increasingly depressed and hopeless. He is angry for his current predicament and doesn't trust Ms. Powers but must continue to be kind and do what she says in order to continue to "play the game." The patient has sent out 17 resumes. He has not received any calls for interview." On April 16, 2014, it was documented, "The patient got a call from a telemarketing firm. The job was to cold call people to inquire what Colgate products they used. The patient told the caller his situation and the caller said they may or may not call him for an interview. The patient was embarrassed that the only company out of almost 30 resumes that called was HGH telemarketing, inquiring if the patient wants to call people and ask about toothpaste. The patient remains frustrated about the job search process." By May 22, 2014, Ms. Raso documented "The patient continued to be very frustrated that there have been no strides forward in his case. He has been told by Ms. Powers, his vocational rehab consultant, to continue to apply for jobs but the patient remains depressed knowing that there is not a job out there for him. He is also hoping that she or his attorney will purchase stamps and envelopes for him…" On June 19, 2014, it was conveyed that "…he is quite frustrated regarding the many "hoops" he must jump through for his workman's comp case. The patient states he is humiliated that he must attend computer classes in hopes of finding a job, however he stated that he has been told by many people, including the teacher of his class that he will probably not be offered employment given that he has no transportation and utilizes a wheelchair most of the time. The patient states he has been doing everything that has been asked of him and feels like a "pawn" in a game…We talked about the fact that currently doing what is asked is [a] job and to see it as a means to an end. [He] considered this a good idea…" On August 14, 2014, it's noted that, "The patient

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states he got a new case manager by Keystone...The case manager went to the patient's appointment with Dr. Howard yesterday. They mutually decided to change the patient's prognosis and plan...and is to return to work full time doing sedentary work with no stairs, 10lb. weight restriction, and limited mobility. The patient was told he reached maximum care medically, may drive a car, and should be able to work. The patient has a functional capacity evaluation in September to see what the patient is capable of. The patient states that Dr. Howard said PT hasn't helped over the past 2 years and it is basically time for the patient to seek employment. The patient is very distressed about this. The patient shows signs of increased depression and hopelessness about this new scenario because he can not imagine the pain he will have after working a full day..." On September 15, 2014, Ms Raso wrote, "...The patient had a functional capacity test a few weeks ago...The person who did the test said the patient should not drive, which contradicts what Dr. Howard said about driving. The patient is pleased that he may be put on driving restrictions. He may need a car with hand controls..." On October 6, 2014, it notes, "...Dr. Howard wrote on an evaluation that the patient could drive a forklift but not a car, which is not good for the patient's case." On November 19, 2014, it states, "...The patient continues to seek jobs, as mandated by Keystone. The patient states he continues to be discouraged by this..." The last recorded visit with Ms. Raso occurred on December 14, 2014. At that visit, Ms. Raso recorded, "The patient brought in the IMR (independent medical report) which indicates that the patient can drive a forklift and a car. This was extremely upsetting to the patient as he does not see how he can use his right foot to drive. The patient remains very frustrated about the findings, indicating that the physician who performed the evaluation was employed by Keystone and discredited the patient's complaints. The patient talked about significant depression which had manifested and his disappointment in the fact that once again he feels he has been discredited and has to continue to "jump through hoops..." (PX 10) Petitioner testified that the counseling helped, but that he could not afford it after Respondent terminated his benefits in December 2014.

Petitioner underwent a driving assessment at IPMR on March 11, 2015. The assessment was performed by Ms. Ginny Roehm, an occupational therapist. Ms. Roehm was deposed by the parties on May 20, 2015. Ms. Roehm testified that she obtained her master's degree in occupational therapy in 2010. She has practiced as an occupational therapist for 5 years at IPMR. Ms. Roehm provided that she began administering driving evaluations 1-1/2 years ago and that IPMR purchased a driving simulator machine approximately two years ago. (PX 13, pgs. 4-5) Ms. Roehm testified that their driving evaluation consists of an interview; looking at range of motion and strength of arms and legs; vision testing; visual processing skills in the form of written questions, short-term memory testing, road sign identification, simulator use to test reaction times, and an optional behind the wheel driving test. Ms. Roehm indicated she has performed approximately one hundred driving evaluations at IPMR. She provided that Petitioner was assessed at the request of Dr. Howard and that said evaluation was paid by Petitioner's counsel. (PX 13, pgs. 7-11, 14-15)

Ms. Roehm testified that she examined Petitioner's bare feet and found a loss of protective sensation in the entire bottom of his right foot and toes. She indicated that her examination also revealed limited range of motion, decreased sensation, and decreased strength in Petitioner's right foot. She found decreased strength in his right hip, knee, and ankle. (PX 13, pgs. 17-22) Ms. Roehm also testified that she tested Petitioner's reaction time in the simulator. She provided that Petitioner's right foot average acceleration time was 5.32 seconds and his left foot time was 1.1 seconds. She indicated that one second reaction time was normal. His right foot braking reaction time was 2.94 seconds and his left foot breaking was .68 seconds. Normal reaction time is one second. . (PX 13, pgs. 25-26)

Ms. Roehm testified that with part of testing she utilized a left foot accelerator adaptive device for some of the simulator testing. She indicated this is a device that has an accelerator pedal on the left by the brake pedal, with a bar that extends to the normal accelerator and depresses it. It allows a person to brake and accelerate with their left foot. Ms. Roehm stated the left foot accelerator enabled Petitioner to brake and accelerate in normal time frames. . (PX 13, pgs. 27-28)

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Ms. Roehm testified that she attempted to administer the field driving test in a Ford Explorer SUV with the left foot accelerator device. She indicated Petitioner was unable to fit into the vehicle comfortably with his right leg extended. She provided that he could reach the pedals with his left foot but he was uncomfortable. Ms. Roehm stated Petitioner could reach the pedals but he could not bend his knee and hip to get them away from the right accelerator. Ms. Roehm stated the maneuver was attempted for approximately 15 minutes. Ms. Roehm indicated she consulted with the other therapist who performs evaluations, and they jointly concluded that it wasn't safe for Petitioner to drive in that fashion. (PX 13, pgs. 29-31)

Ms. Roehm's testified that in order to make sure that the examinee gives a full effort, evaluations include repeating tasks multiple times. She indicated Petitioner's simulator results were consistent over multiple tests. Ms. Roehm opined that Petitioner gave her a full effort. (PX 13, pgs. 32-33) Ms. Roehm concluded that it was not safe for Petitioner to operate a motor vehicle with his right foot. She indicated that a left foot accelerator device would allow him to drive safely. (PX 13, pgs. 32-34)

On cross-examination, Ms. Roehm testified that she did not look at any medical records of preexistent care, and Petitioner appeared for the test on crutches. She indicated that Petitioner before doing the test told her there was no way for him to be able to drive the forklift due to pain in his foot. She indicated that the test was effort dependent as was the range of motion, strength, and sensation. She stated that her facility does not have the ability to test the force Petitioner used when pressing the pedal. She did not know what amount of force was required to operate the forklift or brake. She did not do any measurements of either leg or see if there was any atrophy. (PX 13, pgs. 41-43)

Dr. Howard was deposed on two (2) occasions in this matter, the first being July 12, 2012 (PX 11) and the second on January 27, 2015 (PX 12). Dr. Howard provided that he has three board certifications, being in anesthesiology, pain medicine, and in interventional pain management. He has been practicing in pain management since 1988, with 1% to 2% of his patients having CRPS (PX 11, pgs. 5-6) Dr. Howard testified that CRPS is a syndrome or diagnosis established by the presence of certain physical findings or patient complaints. The source of the syndrome is thought to be an inflammation in the nerve beds of the affected extremity. Dr. Howard provided that there are two (2) different classifications of CRPS, that being Type I and Type II. He provided that Type I CRPS is not associated with any direct or demonstrable nerve trauma and Type II is associated with direct nerve trauma, either as the original cause of symptoms or discovered after the presenting symptoms manifest. Dr. Howard provided that when verifying the diagnosis of CRPS, there is considerations for the following objective findings such as temperature changes, color, swelling, nail or hair changes in the affected extremity. Subjectively, he referenced the observation of hyperesthesia. (PX 11, pgs. 6-7)

Dr. Howard testified that he first saw Petitioner, at the referral of Dr. Moskop, on March 6, 2012. Dr. Howard explained that during his examination, there didn't seem to be a lot of hyperesthesia or hypersensitivity to touch and instead of a CRPS diagnosis, he diagnosed Petitioner with sympathetically mediated foot pain. (PX 11, p.15) Dr. Howard indicated that the CRPS diagnosis was not rendered until April 23, 2012. By that time Petitioner had undergone conservative care. On April 23th, Petitioner was still having pain and was experiencing more swelling in the right extremity. Also noted was hypersensitivity to touch which had been absent at the initial intake. (PX 11, pgs. 18-19) As of that date, the doctor provided that Petitioner could perform sedentary work, which remained his restriction through July 2012. Dr. Howard stated that during that period, the doctor recommended and implanted a trail nerve stimulator. The stimulator once implanted was reported to provide a 60 percent reduction of Petitioner's pain which the doctor felt was successful trial. As a result, the doctor recommended proceeding with permanent implantation of the nerve stimulator. (PX 11, pgs. 20-23)

Dr. Howard testified that Petitioner had CRPS, Type I. The doctor noted the EMG previously taken was essentially not suggestive of any major nerve trauma related to the accident. He explained that, "...even without direct nerve trauma you can have soft tissue injury that releases inflammatory mediators that do not have an effect on nerve performance, i.e., auto regulation of blood flow, temperature, even the modulation of incoming sensory information..." Dr. Howard stated that The World Pain Institute in Budapest is the authoritative body that set out the criteria for diagnosis of this condition. (PX 11, pgs. 24-27)

As to the specific issue of causal connection, Dr. Howard testified that Petitioner's diagnosis of CRPS was certainly temporally related to his injury. He mentioned the absence of any prior right foot condition, and the fact that his injury and evolution of symptoms are consistent as well. As of the July 2012 deposition, Dr. Howard provided that his prognosis for Petitioner was guarded. (PX 11, pgs. 29-31)

On cross-examination, Dr. Howard testified that CRPS diagnosis relies heavily on the subjective complaint of pain, at least 50 percent. He indicated differential diagnosis could include disuse, atrophy, unrecognized general medical problems, somatoform disorders, fictitious disorder and malingering. (PX 11, p.36)

Dr. Howard's second deposition occurred on January 27, 2015. (PX 12) Dr. Howard testified that he has continued to treat Petitioner. Subsequent to the previous deposition, a permanent neurostim was inserted in July 2012. The doctor provided that in addition to the neurostim therapy, Petitioner continues to require narcotic supplement. He indicated that since the Fall of 2014, Petitioner had been taking Nucynta, 300 mg per day, a moderate to high dose of morphine. (PX 12, pgs 11-13) Dr. Howard provided that on August 13, 2014, Petitioner reported that while at rest, his medication and nerve stimulation therapy was fairly effective at reducing his baseline pain levels, however, his physical therapy sessions aggravated his symptoms. As a result, the doctor discontinued physical therapy and returned Petitioner to full time sedentary work, no stairs or ladder climbing and no lifting greater than 10 pounds. Dr. Howard also removed the restriction forbidding driving a car at that time. (PX 12, pgs. 22-26)

Dr. Howard testified that he saw Petitioner on the date of the deposition. The doctor was asked what restrictions he would impose as of the date of this visit. The doctor replied that he would defer to the FCE performed in September 2014. However he also indicated that he had some issues with same. The doctor stated, "There are some issues I have with the functional capacity exam, but in terms of on-site limitations, the FCE said that Mr. Jackson could operate a modified forklift. In that FCE, there was a restriction in terms of his ability to walk distances, which might actually call into question how he ambulates in and around the facility independent of being on a forklift..." The doctor stated that if Petitioner cannot work in Keystone on narcotics, then the FCE is void "because he took it while he was taking 300 milligrams of morphine a day...If he can't take narcotics at work, then there's no point in doing a FCE or validating an FCE while he was under narcotics." (PX 12, pgs 28-29) Dr. Howard stated that Petitioner should not be walking up and down stairs; cannot safely walk 300 feet without an assistive device; needs a cane to ambulate; and refrain from climbing in and out of a fork truck on a regular basis. (PX 12, pgs. 31-33) Dr. Howard testified that as of the date of his deposition in January 2015, Petitioner was not cleared to operate a motor vehicle until he successfully completed a driving assessment. (PX 12, pgs. 34-35)

Dr. Howard testified that Petitioner's current diagnosis remains chronic pain, foot pain, and CRPS. He provided that he continues to recommend narcotic therapy in the form of Nucynta. (PX 12, pgs. 38-39) The doctor also stated that he has never noted any malingering or intentional conduct by Petitioner to exacerbate his condition. (PX 12, p. 44) Dr. Howard again testified that Petitioner's soft tissue injury led to the condition of CRPS of his foot and his subsequent treatment. He felt Petitioner's prognosis was guarded stating, "There's not a lot to offer that hasn't already been offered..." The doctor provided that Petitioner will require medical

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treatment in the future. He also provided that the presence and utilization of the stimulator does not prevent Petitioner from engaging in any activity. (PX 12, pgs. 47-49)

On cross-examination, Dr. Howard testified that the purpose of the spinal cord stimulator was to promote recovery and provide relief. He testified the MRI and CT did not show any acute injury and that the EMG did not show any nerve injury or damage to the peroneal nerve. (PX 12, p. 50) He provided that mental health issues could be a factor in an individual having various subjective complaints and that he was aware Petitioner had issues with depression. (PX 12, p. 52) The doctor also acknowledged that Petitioner despite being on Klonopin was previously allowed to drive and attend work. Relative to the medication, Nucynta, Dr. Howard testified that studies have shown that once you're on a consistent dose level, it doesn't affect your ability to drive. (PX 12, p. 55) Dr. Howard testified that Petitioner's function and pain level (six or seven out of ten) had stayed at the same baseline since November of 2012. (PX 12, p. 57)

Dr. Howard testified that he did advise the nurse case manager on August 13, 2014 that Petitioner had no objective findings of active acute CRPS on exam, with muscle tone normal, no signs of atrophy, minimal color difference, and no swelling. The doctor agreed that as of that visit, Petitioner really had no positive clinical findings of CRPS and that Petitioner's pain complaints were solely subjective. He provided that the basis for Petitioner's distance walking and climbing restrictions was based on the validity of Petitioner's complaints which were not clinically corroborated. (PX 12, pgs. 71-72) Dr. Howard stated that after receiving information from Respondent regarding the force required to operate the forklift pedal, he cleared Petitioner to go back to work as a forklift driver. (PX 12, pgs. 75-76)

On March 18, 2015, at Respondent's request, Dr. Candido issued a supplemental report based upon his interpretation of the IPMR driving assessment. Dr. Candido was also deposed regarding said report. Dr. Candido found it significant that despite claiming inability to dorsiflex or plantar flex the foot during his September 2014 examination, Petitioner did so for the physical therapist. He indicated that this was effort dependent. (RX 25, pgs.7-8) The doctor testified that Petitioner did not complain of numbness during his examination. He noted the EMG provided no explanation for lack of movement of the foot. Given the fact that Petitioner demonstrated the ability to maintain plantar flexion of 20 degrees, to do so requires an intact tibial nerve. This is inconsistent with how he portrayed himself during the September 2014 examination. He stated there was no objective basis to limit Petitioner's ability to press the accelerator or brake. (RX 12, pgs. 11-13) The doctor stated that there is no reason why Petitioner could not operate a car if he could operate a forklift. He indicated there was no objective basis that would preclude Petitioner from getting in and out of a vehicle. (RX 25, p. 14) Dr. Candido opined that Petitioner was capable of working in the forklift position offered to Petitioner in 2014. The doctor relied on his prior examination, his review of the medical records and the driver assessment. (RX 25, p.17)

On cross-examination, Dr. Candido testified that as of his September 2014 examination, Petitioner did not meet the criterion for CRPS. He felt Petitioner was capable of working full duty in regards to his right foot and ankle. (RX 25, p.18)

Mr. Mark Bootz testified on behalf of Petitioner. Mr. Bootz testified that he retired from Respondent in 2004. He worked as a fork truck operator for Respondent for the last fifteen years of work. Mr. Bootz stated the fork truck pictured in Petitioner's Exhibit 21 is substantially similar to what he operated. He provided that the clutch and brake are both operated with the left foot. He stated that with the old forklifts for heavier loads the gas pedal and clutch would be used at the same time to "rev it up." He indicated that a regular fork lift operator gets in and out of his truck twenty to twenty five times per day. He provided examples included but not limited to activities such as fueling, picking up scrap, weighing scrap, straighten wire carriers that was being transported, clean up a spilled loads or dropped carriers, use the restroom, taking a break, removing the horn when transitioning from carriers to scrap, going to the store room, going to the machine shop, and picking up

labels. Mr. Bootz testified that a quick pace is necessary because a trucker must keep wire carriers supplied to the several machine operators.

Mr. Bootz testified that Respondent supplied a locker room for its employees. The locker room is located in the upper level of the facility and to enter same, you are required to use a stairwell with approximately 20 steps. Mr. Bootz indicated however that the use of the employee locker room is not mandatory. Mr. Bootz also testified that if an individual was picking up scrap they would not have to lift greater than 10 pounds at any time. He stated, "[you] can pick up two (2) five (5) pounds." Mr. Bootz provided that the forklifts have hoists available to do lifting. He indicated 80% of the job would require moving carriers.

On cross-examination, Mr. Bootz testified that he was not familiar with any upgrades of the equipment or work requirements.

Mr. Jeff Klockkenga, the general supervisor of Respondent's Fencing Department testified on behalf of Respondent. Mr. Klockkenga described the fork truck job offer made in December 2014. He testified that Petitioner would be permitted to regularly park in a handicapped spot in the office parking lot. There, a cart would await Petitioner everyday to transport him to within 136 feet of his fork truck. He indicated Petitioner would not be required to perform the job duties of picking up scrap. He would only transport wire carriers. He stated that a laborer would be available to him at all times to assist Petitioner, indicating Petitioner would not have to get out of the forklift for anything other than breaks or to use the restroom.

On cross-examination, Mr. Klokkenga testified that the forklifts had been upgraded since Mr. Bootz retired. He indicated they do not require as much force to operate. He provided that Respondent doesn't have any employees on their roster who work while utilizing a cane or crutches. He also indicated employees are permitted to work while on pain medications provided they have clearance from Respondent's medical department. Mr. Klokkenga testified that other than the December 2014 job offer, he was not aware of any other restricted duty job offers to Petitioner since his accident in November 2011. He also indicated that the job offer in December 2014 made no mention of provisions for handicap parking or supplying a driver by cart. He further stated that if his right foot was always numb, he would be uncomfortable operating one of Respondent's forklifts.

Petitioner testified that he owns a three-wheeled scooter that he uses for short trips in nice weather. He otherwise relies on his father and older brother for transportation. He hasn't driven a vehicle since February 2012. He uses City Lift sometimes, but doesn't think that they are very reliable. He has no experience or background in sales work. He has never been convicted of any crime. His wife left him one year after his injury. He stated that walking, standing, climbing and lifting were a regular, daily part of that job.

Petitioner's current complaints consist of daily numbness and tingling throughout his right foot. He notices coloration changes in his foot, with the foot occasionally becoming reddish-purple. He has stiffness and pain throughout his right leg extending into his back. He utilizes a cane indoors and crutches when he is outdoors. He currently takes Nucynta and depression medicine. He spends most of his time sitting with his right leg up, and laying down. He doesn't participate anymore in activities with his grandchildren or other sports activities like coaching soccer or baseball, as he did in the past.

Petitioner testified that since December 15, 2014 he has continued to perform his own job search on a weekly basis. His job logs are contained in Petitioner's Exhibit 16. He tries to make fifteen on-line contacts per week, through his home computer. He receives maintenance treatment from Dr. Howard.

Numerous photographs were offered and received as evidence. Petitioner's Exhibit #17 depicts a photograph of Petitioner's right foot. Petitioner's Exhibit #19 is an aerial view of Respondent's property, as

identified by several witnesses. The photo demonstrates an employee parking lot several yards from the entrance and an additional walk through an expansive work area to reach Petitioner's fence department in the back of the plant. The photo also shows a small parking lot near the office. Petitioner's Exhibit #21 is a four page compilation of color photographs of a fork truck as identified by several witnesses. Three of the photos show the foot pedals of the fork truck which shows the pedals to be similar to those of a regular automobile, although larger and raised more than ordinary automobile foot pedals. These gas pedals were measured in conjunction with the FCE in September 2014.

The Arbitrator finds as a result of the November 17, 2011 injury Petitioner sustained a crush injury with a diagnosis of CRPS. On said date, Petitioner's right foot was pinned between two carriers which reportedly weighed 2500 pounds apiece. Petitioner initially treated at Respondent's medical department. Ultimately, Petitioner was referred to Dr. Frank Russo for an EMG-NCV study. Dr. Russo opined that the clinical signs and symptoms suggested the possibility of some sympathetic dysfunction in the right lower extremity and some sympathetic mediated pain. Petitioner was subsequently referred for pain management with Dr. Demaceo Howard. Petitioner first saw Dr. Howard on March 6, 2012. Upon examination, Dr. Howard noted discoloration from about midway through Petitioner's leg to the toes. No significant nail bed changes were noted. There was a decreased right calf circumference, 15 cm on the right as opposed to 16cm on the left, and diminished sensation at the plantar aspect of the right foot. Dr. Howard diagnosed chronic foot pain and sympathetically mediated pain. By April 6, 2012, Petitioner had undergone two unsuccessful lumbar sympathetic blocks. On April 10, 2012, Dr. Howard observed temperature discrepancy between the left and right side. The right foot was mottled and grey and there was hypersensitivity to touch. Also noted were mild nail bed changes with thickening of the nails on the right foot. Dr. Howard assessed complex regional pain syndrome in his right foot. On February 26, 2013, Dr. Howard authored a narrative report providing that Petitioner's symptoms were a direct result of the trauma he sustained on November 17, 2011.

Petitioner underwent a total of five Section 12 examinations at the request of Respondent. Two of the Section 12 examiners, Dr. Howard Konowitz and Dr. Samuel Vinci, diagnosed CRPS. On July 5, 2012, Dr. Howard Konowitz, who is a board certified internist, pain management doctor, and anesthesiologist, documented positive findings of the right foot to include decreased temperature, color changes, swelling of the dorsal of the foot and decreased range of motion of the toes and motor strength of the toes. Also noted was preservation of internal/external rotation of the ankle with limitations. Dr. Konowitz stated that there were no inconsistent findings on examination and opined that Petitioner met the clinical diagnostic criteria for complex regional pain syndrome. On April 2, 2013, Dr. Vinci, a podiatrist at M & M Orthopedics, documented in his examination that Petitioner had marked coloration difference in the right lower extremity more reddish with brawny edema versus the uninvolved left. Integument abnormalities were noted that being the skin was very shiny and very dry on the right as compared to the left. There was a loss of hair growth on the right compared to the left. There was a color change to where there was more darkness or rubor- purplish appearance when comparing the right to the uninvolved left. He noted a temperature gradient wherein the right was warmer. The doctor also noted measurements of the midcalf, ankle and midfoot. The midfoot mearsure 10-1/2 inches on the right and 10 inches on the left; the Malleoli was 11 inches on the right with 10-1/2 inches on the left; and the mid-calf was 12-1/2 inches on the right and 12 inches on the left. Dr. Vinci indicated that the swelling "…correlates with an obviously gross increase in size clinically noted…" Dr. Vinci's impression was status post crush injury to the right lower extremity and CRPS Type I.

Respondent's first and fifth independent examiner, Dr. Ken Candido, and Dr. John Krause, an orthopedist who examined Petitioner very early in his treatment, opined differently. On January 30, 2012, Dr. Krause opined that other than an ulcer on the anterior aspect of the ankle and redness over the anterior ankle and dorsum of the foot, Petitioner had no other objective findings either clinically or radiographically. Dr. Krause stated, "It sounds like the patient suffered a very minimal injury documented by multiple outside physicians…" Dr. Candido who examined Petitioner on September 23, 2014, diagnosed Petitioner with neuropathic pain of the

right foot and ankle. The doctor provided that Petitioner's description of his symptoms did not match his objective findings and that as of his examination in 2014 there was no objective evidence that Petitioner was suffering from CRPS. Dr. Candido testified that it was impossible for him to determine whether or not Petitioner had ever had CRPS. He indicated that he could only state Petitioner did not have it at the time of his examination of Petitioner. Dr. Candido added that the mechanism of injury as described by Petitioner could be a competent cause for CRPS and that Petitioner treatment at the time it was rendered was appropriate and had no direct criticism of said treatment.

The preponderance of the evidence demonstrates that Petitioner's diagnosed CRPS condition of ill-being of the right foot is causally related to the accident sustained on November 17, 2011.

The first documented evidence of temporary total disability appears on November 18, 2011when Dr. Homer Pena from OSF Occupational Health took Petitioner off work. While still in treatment Petitioner saw Respondent's Section 12 examiner, Dr. Krause, on January 30, 2012. As noted above, Dr. Krause opined that other than an ulcer on the anterior aspect of the ankle and redness over the anterior ankle and dorsum of the foot, Petitioner had no other objective findings either clinically or radiographically. Dr. Krause felt Petitioner suffered a very minimal injury and anticipated maximum medical improvement in two to four weeks and did not anticipate any permanent restrictions. On February 7, 2012, Dr. Pena recorded Petitioner had a minor soft tissue injury marred by functional behaviors driven by unknown incentives. He released Petitioner to return to work February 8, 2012 without restriction.

Petitioner testified that he drove himself to work on February 8, 2012. Petitioner stated that he pulled his car over several times on the way due to fear; and he limped into the employee locker room with the aid of co-workers and got to his work station. Petitioner provided that his union steward, Tim Kelly, and foreman argued over his return. It was agreed that Petitioner would be sent home. That same day he saw his family physician, Dr. Moskop who prescribed off work and referred Petitioner to Dr. Howard for pain management.

Petitioner first saw Dr. Howard on March 6, 2012. Dr. Howard diagnosed chronic foot pain and sympathetically mediated pain. Dr. Howard recommended additional physical therapy and lumbar sympathetic blocks. After said recommendations failed to provide relief, the doctor assessed CRPS in the right foot and recommended a spinal cord stimulator. Dr. Howard performed a trial surgical implantation of a spinal cord stimulator on June 8, 2012 which Petitioner reported a 60% reduction in his right lower extremity pain.

Prior to undergoing a permanent implantation, Dr. Konowitz performed a Section 12 examination on July 5, 2012. Dr. Konowitz opined Petitioner met the clinical diagnostic criteria for complex regional pain syndrome. He opined that Petitioner was not at maximum medical improvement and same would not occur until the permanent implantation of a spinal cord stimulator was accomplished. He felt Petitioner could reach maximum medical improvement 90 days after the permanent implantation of a spinal cord stimulator was accomplished. Lastly, he did not agree with regular duty work status. Thereafter, Respondent resumed the payment of TTD benefits and Dr. Howard inserted the permanent spinal cord stimulator on July 24, 2012.

On October 29, 2012, Dr. Howard referred Petitioner for a functional capacity examination, "specifically for what was directed to us from _____ Group in regards to patient's long term functional status." Petitioner attended the functional capacity assessment on November 20 and November 21, 2012. According to documentation submitted, Petitioner was evaluated based on the demands of "Fence JOB TITLE Monarch." The evaluator provided that Petitioner gave consistent full effort on 12 out of 13 tests. The evaluator stated that Petitioner demonstrated the ability to meet the job function needed for return to work. Modifications were recommended to include being able to transition between sitting and standing. Also noted was that if Petitioner was not deemed ready to return to work, he would benefit from a work conditioning program.

Petitioner participated in a work conditioning program December 4, 2012 through February 13, 2013. On February 13, 2013, the therapist wrote that "Mr. Jackson continues to complain of increased right foot pain, numbness, and swelling along with back pain. He continues to state "my foot feels like it's asleep." He continues to ambulate into the clinic with a quadruped cane and then uses a rolling table during work conditioning program because of subjective pain. He has demonstrated the ability to function at the above levels with safe and stable body mechanics with increased subjective pain…He continues to limited weight bearing on [the] right foot during activities because of increased subjective pain. Mr. Jackson continues to demonstrate symptom focused behaviors throughout the sessions, mostly during stair climbing activities..." The therapist recommended discharge from the work conditioning program indicating Petitioner had met all goals regarding return to work lifting goals and had plateaued with improvement in stair climbing ability. The therapist also provided that they were unable to make a recommendation for returning to work due to Petitioner only attending work conditioning three days a week. Petitioner did not attempt to return to work at that time.

On February 14, 2013, Dr. Howard noted Petitioner provided gradual improvement of his physical activities albeit with pain particularly on the undersurface of his feet. Dr. Howard noted Petitioner reported efficacy with the use of the stimulator, however the pain relief was not to the point Petitioner could return to his former occupation. The doctor kept Petitioner off work and noted he was not released to drive both because of the foot pain as well as the narcotic therapy.

On February 26, 2013, Dr. Howard provided that Petitioner continued to report pain complaints which he numerically rates at 7 out of 10; there was some slight discoloration consistent with the diagnosis; his peripheral pulses were intact; there was no muscle wasting; and his weight bearing was better with therapy and the implant. Dr. Howard provided that he would defer to the work conditioning report regarding Petitioner's ability to return to work. With respect to driving, the doctor provided that his uniform practice is to restrict patients from driving while on narcotic therapy. He provided that until Petitioner is weaned off the narcotic therapy, going to and from employment would have to be provided for him. The doctor also recommended an assessment through IPM&R driving rehabilitation program to assess whether a modified pedal to the left foot is appropriate for him to operate heavy machinery in the work place. Lastly, Dr. Howard provided that a driving assessment would be necessary before he could render an opinion on maximum medical improvement.

On March 7, 2013, Dr. Howard reported that Petitioner would be limited to sedentary duty at best in the immediate near future. He felt Petitioner would not be weaned from his narcotics within the next several months, based largely on Petitioner's report of escalating pain. The doctor also provided that Petitioner would be restricted from driving.

Dr. Vinci, Respondent's third Section12 examiner, opined on April 2, 2013 that Petitioner would be at maximum medical improvement on April 8, 2013. He felt Petitioner had some permanent residual impairment from the injury sustained and diagnosis of CRPS Type I. He opined Petitioner could return to the workforce with permanent restrictions in the form of a sit-down job with minimum walking activities. The doctor opined that Petitioner will require maintenance, "…most likely the specialty of pain management."

On May 2, 2013, Dr. Howard reiterated his concern with Petitioner being on narcotics and attempting to participate in some sort of work related activity.

On May 16, 2013, Respondent retained a vocational expert, a Jim Ragains. Mr. Ragains met with Petitioner regularly between May 2013 and January 2014. Mr. Ragains stated, "It is my opinion to a reasonable degree of vocational rehabilitation certainty based upon my work experience in the Peoria, Il and surrounding job markets… there is no available market for unskilled, or essentially unskilled sedentary work involving no driving to perform in which Mr. Jackson might be placed for employment as he is. There is no need for a labor market survey in this regard. Thus, and unfortunately due to his still relatively young work age, Mr. Jackson is

not employable." Mr. Ragains suggested re-training and authorization of the counseling and continuing physical therapy recommended by Dr. Howard. Throughout the records submitted, Mr. Ragains recorded that Petitioner had been fully cooperative and well motivated. Mr. Ragains subsequently enrolled Petitioner in a computer skills class offered by Goodwill. Mr. Ragains noted Petitioner made steady, albeit slow, progress with his with computer skills class. According to Mr. Ragains, on January 7, 2014 Respondent issued a directive to close his file and cease vocational efforts. Petitioner eventually completed the computer class training in July of 2014 and was proficient in Excel, Microsoft Word, and Power Point.

On May 28, 2013, Dr. Howard opined that Petitioner had reached maximum medical improvement. He however noted that there may be continued improvement with psychological and physical therapy. On July 24, 2013, Dr. Howard recorded that Petitioner's increase in pain was most likely due to lack of stim coverage with the neurostimulation device. Because of the failed device, Dr. Howard removed the failed device and implanted a new IPG with programming on August 12, 2013. By September 17, 2013, Petitioner reported 55% pain relief. (PX 6)

Petitioner consulted with Dr. Lisa Rogers for anxiety and depression in 2013. Petitioner's diagnoses were (Axis I) anxiety due to chronic back, buttocks, and leg pain with generalized anxiety and depression; (Axis III) chronic back pain; (Axis IV) problems with primary support group, disruption of family by divorce and family conflict; and occupational problems, unemployment. (PX 10)

Petitioner underwent a fourth Section 12 examination, conducted by Dr. Shanna Kurth of Neuropsychology Clinic, P.C. on January 10, 2014. Dr. Kurth indicated that from a psychiatric standpoint, by history and current clinical findings suggest a diagnosis of Generalized Anxiety Disorder as well as an unspecified depression disorder. There were issues regarding the possibility of Somatic Symptom Disorder, either comorbid with or in lieu of CRPS. She indicated that from a cognitive standpoint, Petitioner exhibited variable attention/concentration difficulties in the context of otherwise unremarkable psychometric results in the average to low average range. She stated that his difficulty with attention/concentration was readily attributable to a combination of factors, to include anxiety, presence of pain, pain medication effects, and inadequate sleep. Dr. Kurth felt Petitioner certainly met the diagnostic criteria for Somatic Symptom Disorder. She indicated same represented a significant complication to Petitioner's expected course of recovery and may have a substantial impact on his prognosis. Dr. Kurth recommended continued counseling services.

By March 12, 2014, Dr. Howard felt Petitioner was at maximum medical improvement and could return to restricted sedentary work consisting of no stairs or ladders; no driving; and no lifting over 10lbs. The doctor also noted that he was not expecting dramatic improvement that would allow Petitioner to gain pre-injury functional status.

On August 13, 2014, Dr. Howard felt that with the combination of neurostimulation therapy and narcotic therapy, his pain had been under better control. There was some slight discoloration but no swelling or muscle wasting. Dr. Howard stated that essentially Petitioner was at maximum medical improvement. He felt Petitioner's baseline pain levels would be better controlled with medication and neurostimulation therapy. Dr. Howard requested a FCE and indicated Petitioner could return to full time sedentary work with a 10lb. weight limit, no stair and ladder climbing. The doctor provided that Petitioner may drive.

The second FCE was performed on September 3 and 4, 2014. The evaluator indicated that all the assessment items were completed at a slower pace with several rest breaks during and between test items. He indicated Petitioner self-restricted material handling and walking due to reported pain which Petitioner rated at 8/10. Walking was completed with a shortened right step with decreased toe-off and a narrow stance. No to slight color changes were noted in his injured right foot. He had decreased protective sensation in his right foot. The evaluator stated that Petitioner participated in all portions of the assessment with a fair effort on most

testing items and a good effort with his hands. He was consistent in 25 of 27 items. It was recommended that Petitioner not lift and/or carry greater than 25Ibs.; not ambulated without an assistive device greater than 136 feet; not complete more than one (1) flight of stairs at one time with the use of bilateral hand rails; no low level work without the use of external support; and change positions as needed for standing to sitting. An addendum report was completed on September 9, 2014. Added to the report was "[f]oot control operation with the right foot would be questionable due to decreased sensation and decreased active rang previously noted. A driving evaluation would be appropriate if foot controls are on the right."

On September 15, 2004, Respondent commissioned measurements of a fork truck at Keystone Steel & Wire. The measurements were taken by Mr. Sean McGinn from OSF Center for Industrial. In a report dated September 15, 2014, Mr. McGinn indicated the "step into fork truck" had a 15 inch and 13 inch step. The pedal pressure for the right foot was "6.5#" to depress and the brake pedal pressure was "25#" to depress.

On September 17, 2014, Dr. Howard indicated that Petitioner was free to return to work with a forklift. Dr. Howard also referred Petitioner to IPMR for a driving assessment. The doctor indicated that Petitioner return to work was pending said driving assessment and that he was restricted from driving motor vehicles for two months.

Respondent retained a second vocational expert, Stephanie Powers. Ms. Powers worked with Petitioner in February 2014 through December 2014. Ms Powers stated she provided Petitioner with 40 to 50 job leads per month which were in his skills condition. With the exception of one lead, HGS, Ms Powers indicated that she received no confirmations from any of the leads that they received a resume/application from Petitioner. Ms. Powers stated that Petitioner did attend an interview with HGS which was telemarketing position selling toothpaste for an account with Colgate. The position paid $10.00 per hour. Ms. Powers provided that Petitioner informed her that he asked the prospective employer if he was going to get paid at $23.00 per hour and that he might be a liability. Ms. Powers also testified that she advised Petitioner to go to three job fairs and two workshops, none of which Petitioner attended. She indicated Petitioner's effort and cooperation during the rehab was zero on a scale of 0 to 10. She also indicated that if a FCE determined Petitioner was at a sedentary level, he could obtain gainful employment.

Dr. Candido, Respondent's Section 12 examiner diagnosed Petitioner with neuropathic pain of the right foot and ankle. He provided that he would agree with Dr. Howard if the doctor's examinations in 2014, on an objective basis, revealed no evidence of reflex sympathetic dystrophy. Dr. Candido stated that his examination of Petitioner in September 2014 provided no physiological or organic evidence for the lack of eversion and inversion. He believed this was volitional. Dr. Candido, referring to the Budapest clinical diagnostic criteria, stated that subjectively Petitioner had three out of the four symptoms. He described Petitioner reported 1.) symptoms of ongoing pain and allodynia; 2.) symptoms of swelling or edema; and 3.) symptoms of loss of range of motion or weakness. The doctor provided that Petitioner's description of his symptoms did not match his objective findings and that as of his examination in 2014 there was no objective evidence that Petitioner was suffering from CRPS. He opined that as of his examination, Petitioner was at maximum medical improvement and that Petitioner was capable of returning to his prior position as a fence machine operator. The doctor also noted that Petitioner had informed him that he ambulates with the use of crutches and a cane. He opined that if an individual was using crutches for such a long time he would anticipate seeing severe atrophy from non-weight bearing just after a few months. He indicated his examination revealed no evidence of atrophy, nor was there any lack of muscle tone. Based upon his examination, the doctor opined Petitioner was capable of working in the forklift driver position offered. He added there was no objective basis to restrict Petitioner's walking without assistive device to 136 feet; restrict his lifting or stair climbing; or limit the number of times he could get on and off the forklift. The doctor also testified that he reviewed the job description for the fence machine operator as well as reviewing the forklift measurements taken by Mr. McGinn from OSF. Dr. Candido provided that based on his examination and review of the records, Petitioner was capable of driving.

Dr. Howard testified that as of his deposition in January 2015, Petitioner was not cleared to operate a motor vehicle until he successfully completed a driving assessment. He felt Petitioner's prognosis was guarded stating, "There's not a lot to offer that hasn't already been offered..." The doctor provided that Petitioner will require medical treatment in the future. He provided that the presence and utilization of the stimulator does not prevent Petitioner from engaging in any activity. The doctor also acknowledged that Petitioner despite being on Klonopin was previously allowed to drive and attend work (Respondent submitted evidence showing Petitioner has been on Klonopin since the 1990s). Relative to the medication, Nucynta, Dr. Howard testified that studies have shown that once you're on a consistent dose level, it doesn't affect your ability to drive. Dr. Howard testified that Petitioner's function and pain level (six or seven out of ten) had stayed at the same baseline since November of 2012.

Petitioner underwent a driving assessment at IPMR on March 11, 2015. The assessment was performed by Ms. Ginny Roehm, an occupational therapist. Ms. Roehm testified that she tested Petitioner's reaction time in a simulator. She indicated Petitioner's simulator results were consistent over multiple tests and concluded that it was not safe for Petitioner to operate a motor vehicle with his right foot. She indicated that a left foot accelerator device would allow him to drive safely. She stated that her facility does not have the ability to test the force Petitioner used when pressing the pedal and she did not know what amount of force was required to operate the forklift or brake.

On March 18, 2015, Dr. Candido issued a supplemental report based upon his interpretation of the IPMR driving assessment. He stated there was no objective basis to limit Petitioner's ability to press the accelerator or brake. The doctor stated that there is no reason why Petitioner could not operate a car if he could operate a forklift. He indicated there was no objective basis that would preclude Petitioner from getting in and out of a vehicle. Dr. Candido opined that Petitioner was capable of working in the forklift position offered to Petitioner in 2014.

On December 11, 2014 Respondent tendered to Petitioner and his attorney a job offer of a forklift driver stated to be within his capabilities and medical restrictions. It would pay $17.56 per hour plus the appropriate shift differential for the shift worked. Petitioner's wage stipulated to at arbitration included overtime. The job offer included Dr. Pena's report of December 11 restricting Petitioner's work to 10 pounds, forklift only, concurring with Dr. Howard's, Dr. Candido's, and the functional capacity evaluation.

Petitioner did not report for the job. Instead, Petitioner's counsel responded to the job offer on December 12, 2014 stating Petitioner was not to operate a motor vehicle or forklift and that the job demands were beyond Petitioner's capability, and he would not report for same. Petitioner held this position despite Dr. Howard having released Petitioner to return to work as a forklift driver on September 1, 2014. He also had previously released Petitioner to drive on August 13, 2014. Dr. Howard during his deposition indicated there was no objective finding that would preclude Petitioner from driving. Dr. Vinci and Dr. Candido had opined Petitioner could drive.

Petitioner made no effort to work the job, which was defined by the note as being forklift driver only with no lifting greater than 10 pounds. It indicated it would abide by the FCE which would not allow walking without an assistive device greater than 136 feet. The job offer was merely transporting the carriers. Mr. Klokkenga indicated that the only time Petitioner would need to get off the forklift would be at break time, to use the restroom, or fuel the forklift, and this would require a walking distance without an assistive device of less than 20 feet. This was a regular job that needed to be performed as they now have laborers picking up any scrap. The job duty appeared to be within the restrictions of the FCE. Again, Dr. Howard released Petitioner to the forklift position.

Mr. Klokkenga indicated that arrangements were made for Petitioner to be picked up from the guard shack. Petitioner would not have to ambulate any distance greater than 20 feet.

Petitioner did not make any attempt to report for the work nor make any additional inquiry about the nature of the job or what it would entail. Petitioner simply responded that he would not show up as he was not released for a forklift driver position, which he clearly had been by the testimony of Dr. Howard, and his reports.

Respondent paid benefits through December 14, 2014, the day prior to tendering a job offer of December 15, 2015 as a forklift operator driving only within the parameters of the FCE. It is clear from the records that Dr. Howard contemplated maximum medical improvement at least by May 28, 2013. Dr. Howard opined that Petitioner had reached maximum medical improvement. However, at that time he felt Petitioner might continue to improve with psychological and physical therapy. By March 12, 2014, Dr. Howard felt Petitioner was at maximum medical improvement and could return to restricted sedentary work noting that he was not expecting dramatic improvement that would allow Petitioner to gain pre-injury functional status. On August 13, 2014, Dr. Howard stated that essentially Petitioner was at maximum medical improvement. Although he later opined differently, the doctor provided that Petitioner may drive. After Respondent commissioned measurements of a fork truck, Dr. Howard, on September 17, 2014, indicated that Petitioner was free to return to work with a forklift.

Dr. Howard also admitted there was no objective basis to preclude Petitioner from driving. Dr. Vinci previously felt Petitioner could drive as of the spring of 2013 and Dr. Candido indicated Petitioner could drive.

Disconcerting are statements in the records of Petitioner to Ms. Raso indicating that he could not work, that he would play the game to get rejected enough times so that he could prove his case. He told Therapist Raso that being released to forklift was not good for his case and was then happy when he was told he could not drive. He also told the therapist that he got a call from a telemarketing firm and he told the caller his situation and the caller said they may or may not call him for an interview.

The Arbitrator finds that the employer made Petitioner a valid job offer, certainly within his capabilities, effective December 15, 2014 at a comparable rate of pay for which Petitioner failed to even attempt to perform or learn additional parameters of it. Petitioner made no effort to contact the company since the job offer but simply refused same.

The Arbitrator is left with no alternative but to deny Petitioner's request for TTD or maintenance benefits after refusal of the job offer. Wherefore, the Arbitrator finds that Petitioner was entitled to TTD benefits from November 18, 2011 through December 14, 2014, a period of 160-2/7 weeks at the rate of $608.03 and not thereafter.

In support of the Arbitrator's finding as to (J) Medical, the Arbitrator makes the following findings of fact and conclusions of law:

Petitioner's Exhibit 20 is a compilation of four medical bills which total $6,926.55. They are for prescriptions from IWP (Injured Worker's Pharmacy) for scripts from Dr. Pena and Dr. Howard covering December 2011 through June 2015 in the amount of $6,437.08. These are awarded, pursuant to fee schedule reduction. The second bill is from Peoria Tazewell Pathology for $11.87 for urine and blood testing prior to the neuro-stim trial. This bill is awarded. The third bill is from Dr. Howard for dates of service between March 2012 and April 2015 in the total unpaid amount of $120.00, subject to fee schedule reduction. The last unpaid medical bill is from Dr. Lisa Rogers and Frandy Raso at Advanced Behavioral Health for counseling. This

treatment was found to be reasonable by Respondent's IME, Dr. Shanna Kurth. This bill is awarded in the amount of $357.60, subject to fee schedule reduction.

Dr. Howard felt Petitioner's prognosis was guarded stating, "There's not a lot to offer that hasn't already been offered..." The doctor provided that Petitioner will require medical treatment in the future. Dr. Candido also opined that Petitioner treatment at the time it was rendered was appropriate and had no direct criticism of said treatment.

Based on the above, the Arbitrator awards medical expenses in the amount of $6,926.55, subject to fee schedule reduction where applicable.

16IWCC0667

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

Michael J. Gans,

Petitioner,

vs. NO: 10 WC 21387

CCMSI, Inc.,

16IWCC0668

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition under §19(h)/8(a) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issue of, causal connection and prospective medical care and being advised of the facts and law, grants Petitioner's motion as stated below. Respondent's motion to dismiss Petitioner's motion is considered herein as well.

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

- Petitioner appeals the Decision of the Arbitrator under §19(h)/8(a). This matter had been heard before Arbitrator Lammie, that decision being filed on February 7, 2011, who found that Petitioner sustained accidental injuries arising out of and in the course of his employment with Respondent on September 15, 2009; that Petitioner established a causal connection, in part, between those accidental work related injuries and his condition of ill-being (MMI found to be February 1, 2010-[causal connection to a soft tissue cervical injury and buttocks injury]); that all temporary total disability benefits were paid; that all reasonable and necessary medical expenses under §8(a) of the Act had been paid; and that Petitioner was entitled to an award of 3% loss of use of Petitioner's person as a whole under §8(d)(2) of the Act (15 weeks at $550.69 per week = $8,260.35 less $2,097.84 credit total PPD). Respondent paid $9,964.74 in TTD benefits.

- Thereafter, Petitioner filed their Petition for Review, oral arguments were heard and the Commission affirmed and adopted the decision of the Arbitrator September 14, 2011. Petitioner filed their Appeal to the Circuit Court which affirmed the Commission decision June 12, 2012. Petitioner thereafter filed a §19(h)/8(a) motion September 11, 2013 which motion was subsequently dismissed by the Commission July 8, 2014 (granted Respondent's motion to dismiss) finding the issue presented was res judicata with the decision final. The Commission further found that Petitioner had failed to present any medical evidence to support their position and that Petitioner's motion failed on its face. Petitioner filed this current §19(h)/8(a) petition December 4, 2014. Respondent filed their motion to dismiss Petitioner's motion June 9, 2015. These motions came before Commissioner Gore April 5, 2016 and May 3, 2016 with proofs then closed and the matter taken under consideration for briefs and oral arguments.

- Petitioner here requested, in brief, that the Commission grant Petitioner's §19(h)/8(a) petition and find the new medical evidence after the December 14, 2010 Arbitration hearing is sufficient to find that Petitioner is entitled to reasonable and necessary medical services after January 7, 2011, the first date of treatment not covered by the first arbitration hearing; Petitioner was entitled to temporary total disability (TTD) from October 13, 2011 through February 5, 2016; and that Petitioner was entitled to permanent partial disability (PPD) of 30% loss of a person as a whole. Petitioner argued that his condition has materially worsened so as to warrant an award under §19(h) of the Act. Petitioner argued the dismissal of the 1st §19(h) did not bar Petitioner from filing another motion and the Commission should deny Respondent's motion to dismiss and rule on the merits based on all the evidence. Petitioner stated the party seeking modification of award must show a material change in the disability; a question of fact for the Commission. Petitioner noted cervical changes by February 10, 2011, different from Dr. Bernstein's opinion Petitioner was at maximum medical improvement (MMI) prior to that date. Petitioner stated that he continued to treat after arbitration and the treating doctor opined Petitioner to be unable to work. Petitioner argued medical records from February 2011 through October 13, 2011 showed a material change in disability and an increase in restrictions. Petitioner further argued that the treating doctors noted deterioration on MRI in the 2013 exam and the doctor concluded that was the cause of Petitioner's cervical and low back pain; another change from Dr. Bernstein's opinion of no herniated discs. Petitioner argued the worsening of the condition warrants an award of TTD and medical expense benefits, and an increase of PPD to 30% loss of a person as a whole, given his the increased restrictions. The Petitioner requested the Commission to grant his §19(h)/8(a) petition.

- At the hearing of this motion, Petitioner agreed he last testified at the Commission December 2010. Petitioner stated that since he last testified he had additional medical care. Petitioner stated that Dr. Payne had been one of his doctors at the time he last testified and that he had continued to see Dr. Payne at Well Group, then Franciscan Specialty Practice. Petitioner testified that since he testified December 2010 his condition had worsened. Petitioner testified a big thing is that he needed to utilize his cane more often. He stated in October 2011 Dr. Payne had prescribed him the cane and a bath chair

that he uses when showering. Petitioner stated that he found his legs are weaker and he has more numbness and tingling in his extremities. Petitioner stated that for the prior year he has had a burning sensation on the side of his right thigh. Petitioner testified that he had trouble with his neck and back. Petitioner testified that when he walks without the cane he has a pretty distinguished limp, so any distance he goes he uses the cane because after a while his legs become weaker. Petitioner had an EMG, he believed in 2011 and recently another in December 2015 where they found ulnar nerve damage. Petitioner wears a 'cuff' on his left arm. He indicated they recommended he wear it all the time and at night to flip it so it does not pinch on the nerve. He went through physical therapy for that in January and also therapy for his lumbar back. Petitioner testified over the prior two years, 2011, 2013, 2015, he had therapy and he also tried Reiki, an alternative type of therapy, which is a form of trying to get the nerves and body to work right, with a naprapath. Petitioner stated when he did the Reiki he could just feel all his extremities becoming numb and tingling; it just really emphasized, he thought, how bad it was. Petitioner testified that he tried the naprapath because a friend recommended that. Petitioner stated that later the naprapath e-mailed Petitioner that he could help no further. Petitioner indicated that the naprapath then recommended Petitioner see an orthopedic specialist so Petitioner returned to see Dr. Payne. Petitioner also saw a pain management doctor, Dr. Adlaka, and continued to see him on and off over the course of years. Petitioner testified that since he last testified he believed he had 2 epidurals in 2011 and a discogram, and in 2014 Dr. Payne referred Petitioner back to the pain doctor, but Dr. Adlaka did not administer epidurals since they did not work the first time. Petitioner stated that he just received pain medication management. Petitioner testified that he currently was on Tramadol and Ibuprofen 800mg. Petitioner stated that he also has received psychological care and continues to see psychologists at Specialty, and some at Aunt Martha's (as it was cheaper there). Petitioner testified that each year he had received notes from Dr. Payne to be off work and now his off work restriction is written until further notice. Petitioner stated that He gets the note on a yearly basis as he was receiving disability insurance from Thrivent Insurance and is now getting SSDI. Petitioner testified to receiving $850 per month from the insurance. Petitioner stated that he had to periodically prove he was still disabled and the forms Dr. Payne completed were sufficient to continue the disability. As to seeing a psychologist and psychiatrist Petitioner stated that he noticed that he was becoming very anxious and had depression he believed about 2011. Petitioner stated that, because of this case, the SSDI case and the case against CCMSI, he stated he was over stressed and felt very suicidal. He stated he would wake in the morning and would already be contemplating suicide. He testified he worked through those issues but he still had other issues he was working with. As to other problems, Petitioner stated that when he walks without shoes he has pain in the bottom of his feet so he saw a foot doctor who said they were fine and referred him back to Dr. Payne for his back injury. Petitioner stated that he had not worked in the past 4-5 years; he filed for SSDI in March 2011 because Petitioner felt he could not do any other job. Petitioner indicated that activities like sitting by the computer causes numbness and tingling (typically right leg) and he has to stand and walk to take care of the symptoms. Petitioner indicated that he gets a burning sensation in the thigh and the numbness and tingling in both legs (like at this hearing). He indicated that he gets neck pain looking at the screen so he can only do that for 10-15 minutes at a time. Petitioner indicated that he

does have trouble driving as he has trouble in blind spots on the sides. His wife drives when they are together but if he drives he makes sure he can pull out of a parking spot so he does not twist and bend to see if someone is coming.

- On cross examination, Petitioner agreed his original workers' compensation accident was September 15, 2009. He agreed after the accident he treated with Dr. McGarry, a chiropractor, and Dr. Payne. Petitioner was examined by Respondent's §12 examiner, Dr. Bernstein in Park Ridge. Petitioner stated that he kind of recalled his December 2010 testimony. Petitioner agreed that he had a chance to try his case and he had seen the Arbitrator's decision. Petitioner stated that he vaguely recalled the Arbitrator finding Petitioner sustained a buttocks contusion and cervical strain. Petitioner agreed he thought his injury was worse than that and appealed it to the Commission which agreed with the Arbitrator. Petitioner indicated he still felt his condition was worse from his work accident than the Commission found. Petitioner also stated that he found medical records were missing. Petitioner agreed his attorney then appealed to the Circuit Court which had agreed with the Commission and Arbitrator as to his condition. Petitioner indicated at this hearing that he still did not agree with what the Arbitrator, Commission, and Circuit Court found as his condition. Petitioner believed he was paid about $6,000 from the case award. Petitioner applied for SSDI due to his neck and back injury and what was found at arbitration as well as for his psychological condition, suicidal thoughts. Petitioner agreed the Social Security Administration found him disabled as result of his neck, back and psychological conditions; they did not find they were just contusions and a strain. Petitioner stated with the back he believed it was a herniated disc or bulging disc. He stated the most recent MRI showed a tear and Dr. Payne thought the tear could have been there before because it is hard to find on MRI. Petitioner agreed he never claimed a left arm injury with his workers' compensation case and he did not claim any psychological conditions as result of the work injury. Petitioner viewed RX 4, identified it as being from Dr. Payne and agreed his handwriting was on the lower half of it. Petitioner indicated it was probably a form for Thrivent disability. Petitioner stated that he received that disability for 5 years and it ended. He agreed that it was non-occupational disability payments, not workers' compensation; it was a policy he had gotten on his own.

- Respondent argued that the Commission lacks jurisdiction to consider Petitioner's Petition to reopen benefits under §19(h). Respondent argued that the limitations period begins to run from the date of the Commission decision and Judicial review does not toll the statute of limitations; in the present case the time limit under §19(h) is 30 months from the Commission award, affirmed September 14, 2011. Respondent stated Petitioner's appeal to the Circuit Court was unsuccessful and did not result in any change, so Petitioner had until March 14, 2014 to file to reopen benefits so this Petition, dated December 4, 2014, must be denied. Additionally, Respondent argued that Petitioner's claim for medical treatment for his current condition of ill-being is barred by the doctrine of res judicata. Respondent stated Petitioner here tries to re-litigate his theory of liability and asks the Commission to award treatment due a disc condition. Respondent stated that Petitioner did not then meet the burden of proving causation and his current Petition is ***barred*** by res judicata. Respondent stated that the Commission already found Petitioner sustained a buttocks contusion and soft tissue cervical strain from the accident 6 years

ago and had been at MMI long before the initial arbitration hearing. Respondent stated Petitioner asks the Commission recognize lumbar and cervical disc conditions here which the Petitioner had the opportunity to allege and offer evidence of at the prior arbitration hearing. Respondent stated Petitioner failed to prove the conditions of ill-being were related to the September 2009 accident at the initial arbitration hearing. Respondent argued Petitioner's request for medical treatment under §8(a) is not for the purpose of curing the effects of his work injury September 2009. Respondent stated the Commission already found Petitioner only sustained a buttocks contusion and soft tissue cervical strain as result of the accident and that the Commission had found Petitioner at MMI. So as to medical treatment for the number of conditions found previously by the Commission not related to the accident, Respondent stated Petitioner's petition should be denied.

The Commission finds Petitioner testified of his current condition of ill-being. The Commission notes the medical evidence indicates Petitioner's multiple physical conditions and other conditions of ill being as unrelated to this 2009 accident. Petitioner had been found at MMI at the initial hearing and had essentially a buttocks contusion and cervical strain type injury from the accident and had been awarded 3% loss of use of a person as a whole. The MRI's then were indicated as normal. It was not until later MRI's Petitioner was noted with degenerative discs and osteophytes and maybe some protrusion or herniation. There was no real indication of radicular symptoms at that hearing and the later EMG/NCV only indicated possible peripheral neuropathy. While medical records note the initial fall accident and symptoms since then, there is clearly no causal chain to his current condition of ill-being, rather there was the prior finding he was at MMI at time of that hearing, and further, there are no medical causation opinions to even suggest his multiple conditions of ill-being now, including a buttocks contusion and cervical strain as previously determined (or any worsening thereof), is related to that 2009 fall from a chair. Petitioner's testimony is rebutted and not supported in the evidence that his current condition of ill-being is causally related to his 2009 accident to show a material worsening of his condition. Petitioner failed to meet the burden of proving his current worsened condition is causally related to warrant such consideration requested by Petitioner's petition.

The Commission finds, further, that Petitioner's current petition was filed December 4, 2014. The Commission affirmed the Arbitrator's decision September 14, 2011 and the Circuit Court affirmed the Commission so the statutory time limit to file under §19(h) began to run at the time of the Commission decision. When this petition was filed it was clearly after the 30 month time limit under §19(h) of the Act regardless of the fact Petitioner failed above to prove his worsened condition was causally related to the 2009 accident; rather the evidence shows it is his multiple unrelated conditions causing the material changes. Regardless, the Commission, again noting that Petitioner had been found at MMI previously with a buttocks contusion and cervical strain injury from the 2009 accident, finds that the issue of Petitioner's conditions of ill-being to be res judicata.

The Commission, therefore, finds that Petitioner failed to meet the burden that his current material 'worsening' condition of ill-being is causally related to the 2009 accident given the prior finding of MMI is res judicata and with not even a medical causal opinion to even slightly suggest any causal relationship. Regardless, Petitioner failed to prove any such worsening as the

petition was not filed until after the time period ran out. With finding of no medical causal connection, and the issue being res judicata, as Petitioner having previously determined to be at maximum medical improvement (MMI), Petitioner's petition under §19(h)/8(a) is hereby denied, and Respondent's motion to dismiss Petitioner's petition is hereby granted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's §19(h)/8(a) petition is hereby denied and dismissed. Respondent's Motion to dismiss Petitioner's petition is hereby granted.

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 probable cost of the record to be filed as return to Summons is the sum of $35.00, payable to the Illinois Workers' Compensation Commission in the form of cash, check or money order therefor and deposited with the Office of the Secretary of the Commission.

DATED: OCT 2 0 2016
o-8/25/16
DLG/jsf

David L. Gore

Stephen Mathis

Mario Basurto

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GANS, MICHAEL
Employee/Petitioner

Case# **10WC021387**

CCMSI
Employer/Respondent

16IWCC0668

On 2/7/2011, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.17% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0293 KATZ FRIEDMAN EAGLE ET AL
DAVID M BARRISH
77 W WASHINGTON 20TH FL
CHICAGO, IL 60602

2837 GUSTAFSON, THADDEUS J
ROBERT SABETTO
2 N LASALLE ST SUITE 2510
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

Michael Gans
Employee/Petitioner

v.

CCMSI
Employer/Respondent

Case # **10** WC **21387**

Consolidated cases: _____

16IWCC0668

An *Application for Adjustment 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 Lammie**, Arbitrator of the Commission, in the city of **Chicago**, on **December 14, 2010**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **September 15, 2009**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$47,726.12**; the average weekly wage was **$917.81**.

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

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

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

Respondent shall be given a credit of **$9,964.74** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$9,964.74**.

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

ORDER

See attached.

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

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

February 7, 2011
Date

FEB - 7 2011

Findings of Fact, and Conclusions of Law

In regard to issue F: "Is the petitioner's present condition of ill-being causally related to the injury?" the Arbitrator makes the following findings:

The petitioner's present condition of ill-being is causally related to the injury, in part. In support of that finding, the Arbitrator notes the following testimony and evidence.

The petitioner testified that he was injured what he stood up to obtain a calculator to use. Apparently, his swivel chair moved backwards, and when he went to sit down again, he missed it and fell to the floor landing on his buttocks. At that time, he did not feel injured, but rather, embarrassed. But shortly thereafter, he started to develop headaches, and he reported the accident to his supervisor.

He testified that he worked the following day, and then went to see his chiropractor. The respondent argued that those records were not introduced. But they were, and they are in the record as petitioner's exhibit one. The petitioner's personal injury questionnaire was filled out on September 16, 2009. But the office records indicate that he arrived as the office was closing, and so they did not see him until the following day. He gave a consistent history, but in the questionnaire, he only complained of headaches, and a stabbing pain in his left upper thigh. However, he must have had some back complaints because the chiropractor requested cervical and lumbar x-rays, and examined the cervical and lumbar spine, noting findings. He then proceeded to render some treatment.

In his report, the chiropractor stated that the petitioner sustained trauma to the lumbar, cervical, and cranial regions. He opined that the injuries were a result of the accident in question.

The respondent's Section 12 examiner, Dr. Avi Bernstein conceded that perhaps the petitioner sustained a cervical strain, but nothing more.

In regard to issue J: "Were the medical services that were provided to the petitioner reasonable and necessary? Has the respondent paid all the appropriate charges for all reasonable and necessary medical services?" the Arbitrator makes the following findings:

The Medical Services that were provided to the petitioner were reasonable and necessary, in part. The respondent has paid all the appropriate charges for all reasonable and necessary Medical Services. In support of that finding, the Arbitrator notes the following testimony and evidence.

The petitioner did not submit any bills from Chiro One. The Arbitrator finds that the petitioner's buttocks contusion resolved by the time he saw Dr. McGarry on

September 25, 2009 and therefore finds this to be the date of MMI for that condition.

Further, the Arbitrator adopts Dr. Bernstein's opinion that the petitioner reached MMI for his neck by the time of his Section 12 examination on February 1, 2010. This is consistent with Dr. McGarry's opinion in October 2009 that the petitioner's soft tissue cervical condition would resolve in time.

After a close examination of the respondent's medical expense payment record. the Arbitrator finds that notwithstanding Dr. Bernstein's report of February 1, 2010, the respondent still paid, pursuant to fee schedule, medical expenses for services as recent as October 28, 2010. Those payments are not in dispute. Most of these charges were for prescriptions even though some were for doctor visits and physical therapy. The petitioner did not offer evidence of any charges before MMI. The Arbitrator therefore finds that the respondent has provided all reasonable and necessary medical treatment, and is not liable for any further medical expenses.

The petitioner admitted that the respondent continued to pay COBRA benefits after his termination. The respondent therefore would be entitled to a credit under Section 8(j). However, the Arbitrator finds that none of the charges listed were causally related to the petitioner's work accident. Every single charge listed in the group carrier Ingenex's Medical Payment Summary was for treatment *after* February 2010. Many of these charges were for conditions not alleged under this claim (e.g., finger contusion, unspecified acquired hypothyroidism, contact dermatitis, eczema, muscle weakness, brachial neuritis). Further, many of these charges were for treatment with doctors whose records were not offered.

In regard to issue K: "What temporary benefits are in dispute?" the Arbitrator makes the following findings:

The petitioner was temporarily totally disabled for 12 & 6/7 weeks, representing the period of November 4, 2009 through February 1, 2010 (the date of Dr. Bernstein's examination) inclusive. In support of that finding, the Arbitrator notes the following testimony and evidence.

Nowhere in the records of Chiro One is there any documentation that the petitioner was authorized off from work.

At this point, the record becomes very unclear and confusing.

Apparently, the petitioner began treating with Dr. McGarry on September 25, 2009. Both parties refer to that date in their proposed findings. But there is no

office entry for September 2009 in the record. But that is probably irrelevant. The petitioner admitted on cross-examination that Dr. McGarry did not authorize him to miss any time from work. The petitioner in fact returned to work for the respondent on September 28, 2009.

He was not authorized to miss any time from work by anyone until he saw Dr. Payne on November 4, 2009 according to his testimony. This was after he had been terminated by the respondent on October 13, 2009. It appears he had additional complaints at that time. But there is no record of that office visit.

Dr. Payne apparently ordered MRIs of the petitioner's cervical and lumbar spine. Both parties, in their proposed findings, refer to those MRIs and Dr. Payne's reading of them. But neither of the MRI reports, nor any record of Dr. Payne's review of them, is in the record.

They were done, however, because the respondent's Section 12 examiner, Dr. Bernstein, reviewed them and commented on them in his report. According to Dr. Bernstein, the cervical MRI was essentially normal. It demonstrated a "minimal" disc bulge and extremely mild degenerative changes. As to the lumbar MRI, Dr. Bernstein reports that there is no evidence of disk herniation or nerve root compression.

Dr. Bernstein further opined that the petitioner was at maximum medical improvement, and that there was no medical reason why he could not perform full time work without restriction.

Additionally, the petitioner's own actions belie his claim for temporary total disability. He admitted that he found a job with a tax preparation firm while allegedly disabled and collecting disability benefits in January 2010. Further, the petitioner filed for and collected unemployment compensation, and pursued alternate employment opportunities after the respondent terminated his employment. While it is true that the collection of unemployment compensation benefits is not a bar to a recovery of workers compensation benefits, it is persuasive on the issue. The petitioner certified that he was ready, willing, and able to work, and he admitted that he did so in order to collect those benefits.

In regard to issue L: "What is the nature and extent of the injury?" the Arbitrator makes the following findings:

The petitioner has sustained a permanent loss of use of the Man As A Whole, pursuant to Section 8(d)2, to the extent of 3% thereof. In support of that finding, the Arbitrator notes the following testimony and evidence.

As noted above, the only evidence as to what the MRI scans show is Dr. Bernstein's report. Therefore, it appears that the petitioner sustained nothing more than a cervical strain.

In regard to issue N: "Is the respondent due any credit?" the Arbitrator makes the following findings:

Inasmuch as the respondent has overpaid TTD benefits in the amount of $2097.84, they are therefore entitled to a credit against permanency in that amount. In support of that finding, the Arbitrator notes the following testimony and evidence.

The amount paid is stipulated. The amount owed is pursuant to finding "L" above.

By Order of the Arbitrator:

The respondent shall pay to the petitioner the sum of $6,162.51, pursuant to finding "L" above. (15 weeks @ $550.69 = $8,260.35 less the $2,097.84 credit.)

STATE OF ILLINOIS	)		
	) SS.		
COUNTY OF JEFFERSON	)		

☐ 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

Creed Bevolo,

Petitioner,

vs. NO: 15 WC 2506

Continental General Tire, **16IWCC0669**

Respondent.

DECISION AND OPINION ON REVIEW

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

The Commission modifies the Arbitrator's Decision by vacating the award of mileage/travel expenses. The Arbitrator allowed Petitioner's request for travel expenses and ordered Respondent to reimburse Petitioner for mileage of $609.50 for 5 round trips to Dr. Paletta, a total of 1,060 miles at 57.5 cents per mile. Petitioner testified that he injured his left shoulder at work on October 20, 2014 when he was adjusting squeeze on a curing press (Tr 14). Petitioner testified he saw Dr. Cohen, the company doctor at Respondent's plant (Tr 15). He testified that Dr. Cohen referred him to Dr. Paletta shortly after Petitioner visited him (Tr 15). Dr. Paletta is an orthopedic surgeon who performed left shoulder surgery on January 20, 2015 (Tr 16). The surgery consisted of an arthroscopy with extensive debridement of the subacromial bursa and space and debridement of a partial rotator cuff tear that was diagnosed. Petitioner followed-up with Dr. Paletta, who released him from his care on April 23, 2015 (Tr 16-17).

Petitioner testified he traveled back and forth from his home to see Dr. Paletta (Tr 24). The distance traveled was 106 miles each way (Tr 24). Petitioner made 6 visits to Dr. Paletta. Petitioner was issued a mileage check for his first visit to Dr. Paletta (Tr 24). On cross-examination, Petitioner testified that he lives 35.6 miles from Respondent's plant (Tr 30). He was paid for his mileage the first time he saw Dr. Paletta (Tr 30). After that first visit, Petitioner continued to treat with Dr. Paletta (Tr 30). Petitioner saw Dr. Paletta several times and chose to have surgery by him (Tr 30). Petitioner is not familiar with the doctors in Mt. Vernon or the surrounding areas (Tr 31). He does know that there are hospitals in the immediate area (Tr 31). Petitioner is aware that those hospitals in the immediate area do shoulder surgeries (Tr 31-32). Petitioner does use the internet and researches things on Google (Tr 32). Petitioner acknowledged he could have found a physician in the Mt. Vernon area should he have chosen not to travel (Tr 32). Before the day of arbitration, Petitioner had not requested mileage from Respondent for his travel (Tr 32).

According to the medical records from The Orthopedic Center of St. Louis, Px1, Petitioner saw Dr. Paletta on December 3, 2014. In the office notes of that date, Respondent is noted as Petitioner's employer and the Claim Adjuster is noted as Galen Black of Sedgwick. Dr. Paletta noted that Petitioner presented for evaluation of a chief complaint of left shoulder pain dating back to an incident occurring on October 20, 2014. Dr. Paletta noted, "Unfortunately he had continued complaints of pain and was thus referred for further orthopedic evaluation."

"The Illinois Workers' Compensation Act does not specifically provide for reimbursement to injured workers for travel expenses related to medical treatment. Illinois courts have held that an injured worker may receive reimbursement for medically related travel expenses if the Petitioner can show that the trip was necessary because the type of medical treatment sought was not available in their local area." See Schmidt v. Salem Bowl, 10 IWCC 1059, 07 WC 29651, 2010. Based on the above, the Commission finds that Petitioner chose to treat with Dr. Paletta and was not referred for treatment by Respondent. Petitioner initially saw Dr. Paletta for an evaluation and Respondent paid him mileage for this trip. Thereafter, Petitioner chose to treat with Dr. Paletta. The Commission further finds that Petitioner failed to prove that the subsequent trips were necessary because the type of medical treatment sought was not available in his local area. Petitioner was aware that hospitals in his immediate area do shoulder surgeries and acknowledged he could have found a physician in the Mt. Vernon area. The Commission affirms all else.

IT IS THEREFORE ORDERED BY THE COMMISSION that the award of mileage/ travel expenses is hereby vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $606.91 per week for a period of 50.6 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the permanent disability of the person as a whole to the extent of 10.12%.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury. The Commission notes that Respondent paid $96.34 in TTD benefits and $9,103.65 for PPD benefits for a total credit of $9,199.99.

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $21,600.00. 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: OCT 2 1 2016
MB/maw
o09/08/16
43

Mario Basurto

Stephen J. Mathis

DISSENTING OPINION

I respectfully dissent from the majority decision and would affirm the Arbitrator's well reasoned decision in its entirety.

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BEVOLO, CREED
Employee/Petitioner

Case# **15WC002506**

16IWCC0669

CONTINENTAL GENERAL TIRE
Employer/Respondent

On 10/2/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.10% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

3067 KIRKPATRICK LAW OFFICES PC
ERIC KIRKPATRICK
#3 EXECUTIVE WOOD CT SUITE 100
BELLEVILLE, IL 62226

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

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

Creed Bevolo
Employee/Petitioner

v.

Continental General Tire
Employer/Respondent

Case # **15** WC **02506**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Mt. Vernon**, on **August 7, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **October 20, 2014**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did*** sustain an accident that arose out 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 $**52,599.04**; the average weekly wage was $**1,011.52**.

On the date of accident, Petitioner was **29** 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 $**96.34** for TTD, $**-** for TPD, $**-** for maintenance, and $**9,103.65 for PPD payments**, for a total credit of $**9,199.99**.

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

ORDER

- Respondent shall pay Petitioner Permanent Partial Disability benefits in the amount of **$606.91 a week** for **50.6 weeks** as Petitioner suffered **10.12% loss of use of the man as a whole** under §8(d)2.

- Petitioner's request for travel expenses is allowed and Petitioner shall be reimbursed for mileage expenses at the current IRS mileage reimbursement rate of 57.5 cents per mile for a total of 1060 miles (5 round trips to Dr. Paletta) for a total of $609.50.

- Respondent shall pay Petitioner compensation that has accrued between October 20, 2014 and August 7, 2015 and shall pay the remainder of the award, if any, in weekly installments.

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

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

Signature of Arbitrator

September 21, 2015
Date

OCT 2 2015

CREED BEVOLO VS. CONTINENTAL GENERAL TIRE, 15 WC 0250

Findings of Fact and Conclusion of Law

Petitioner alleges an injury to the left shoulder as a result of a traumatic injury while in the employment of Respondent. The disputed issues are nature and extent and travel expense. The only witness was Petitioner. Respondent tendered no exhibits.

The Arbitrator Finds:

On October 20, 2014, Petitioner was employed as a passenger tire cure set-up technician for the Respondent. At that time he was using a torque wrench to adjust a press when he felt a pop and a burning sensation in his left shoulder. He initially sought treatment with the company physician. Those records were not submitted into evidence. Petitioner came under the care of Dr. George Paletta beginning on December 3, 2014. Petitioner testified that this was on referral from the plant physician and he admitted that following the first visit he continued to treat voluntarily with Dr. Paletta.

On January 20, 2015, Petitioner underwent a diagnostic arthroscopy of the left shoulder with debridement of the subacromial bursa, subacromial space, and debridement of a partial thickness bursal-sided rotator cuff tear. This was performed by Dr. Paletta. The post-operative diagnosis was left shoulder pain, left shoulder subacromial bursitis, and a partial thickness rotator cuff tear. Surgery consisted of an arthroscopy with extensive debridement of the subacromial bursa and subacromial space along with debridement of the partial thickness rotator cuff tear.

Petitioner followed-up post-operatively with Dr. Paletta on January 28, 2015, March 4, 2015, and April 22, 2015. Dr. Paletta noted on April 22, 2015, that Petitioner was doing much better although he had minimal discomfort at the extreme forward flexion and extreme external rotation with the arm at the side. Petitioner had completed physical therapy and requested a release to return to full duty. There was no tenderness in the AC joint and no pain on cross body abduction testing. Petitioner had normal rotator cuff strength. The consensus was that Petitioner was doing well and had only minimal residual subjective symptoms with minimal rotational motion loss. Dr. Paletta felt that Petitioner had excellent strength and recommended a return to full duty work as tolerated without restrictions or limitations. It was recommended that Petitioner undergo a short course of prescription anti-inflammatories, and then once that was concluded, over-the-counter anti-inflammatories could be used as needed. Petitioner was placed at maximum medical improvement and told to return as needed.

At trial Petitioner testified that he has returned to his regular job for Respondent making the same rate of pay as before and he has not missed any time from work as a result of the shoulder injury. He did complain of a popping and grinding sensation occasionally when he is operating a fork truck and turning the steering wheel. He also experiences some symptoms when working on certain machines at shoulder height or above and away from his body. Petitioner admitted that his job rotated and he was

not working on those machines every day. Petitioner also testified that he has some reduced range of motion with his arms extended straight above his head and indicated that he would have some difficulty if he were to attempt to pitch a baseball with his left arm. Petitioner testified that he has pain when working with anything heavy with his arm out away from his body or across his body particularly at or above shoulder/chest level. He demonstrated this to the Arbitrator. He described that this causes him to have some difficulty in doing his job as a "curing set up technician" because changing out parts on machines requires him to lift parts with his arms extended and in confined spaces. Sometimes his job requires him to operate a truck lift. Petitioner stated he was ambidextrous, but wrote right-handed. Petitioner stated he occasionally had some problems sleeping, but had no complaints that this injury had impeded or affected any outside activities. He also stated he occasionally uses over-the-counter pain relievers.

Petitioner testified that on six occasions he traveled 212 miles to Dr. Paletta's office from his home in Iuka, Illinois. Petitioner did testify that his home was 35.6 miles away from the Respondent's location in Mt. Vernon, Illinois.

Petitioner admitted that he agreed to treat with Dr. Paletta and that it was his choice to continue to treat with Dr. Paletta after the initial evaluation. Petitioner stated that while treating with Dr. Paletta he had retained legal counsel and had made no demands for travel expense prior to the date of trial. Petitioner further testified that he was familiar with the fact that there were hospitals in the Mt. Vernon area where shoulder surgeries were performed and that he was comfortable using the internet to research items such as medical treatment and where it would be available.

The Arbitrator Concludes:

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

Pursuant to §8.1b (b) the arbitrator bases the determination of permanent partial disability on the following factors:

i) No AMA rating was submitted by Petitioner or Respondent. The Arbitrator gives no weight to this factor.

ii) The occupation of the injured employee. Petitioner is a passenger tire cure set-up technician. He described his job as replacing parts on passenger tire building machines within the plant and also occasionally cleaning conveyor belts of tires. This was the same job he was doing prior to the injury. Petitioner credibly explained that he works on different machines, some of which create more symptoms for him than others. While Petitioner's injury was to his non-dominant arm, his job does require the use of both arms. The Arbitrator gives some weight to this factor.

iii) The age of employee at the time of the injury was 29. Given Petitioner's young age, the Arbitrator reasonably infers that Petitioner will have to live and work with the effects of his injury longer than a much older worker. The Arbitrator gives weight to this factor.

iv) The employee's future earnings capacity is the same as it was prior to the injury. Petitioner stated that he had returned to work making the same rate of pay as prior to the injury and has physical restrictions or limitations. The Arbitrator gives weight to this factor.

v) Evidence of Disability as corroborated by the treating medical records. Petitioner was diagnosed with a partial rotator cuff tear and underwent surgery that consisted of significant debridement of the tear and of the bursa. The last note of Dr. Paletta indicates a loss of internal and external range of motion on the left compared to the right. Petitioner's demonstration of work activities and motions that affect his level of pain were consistent with the range of motion issues noted by Dr. Paletta. Dr. Paletta expected him to need anti-inflammatory medication for a couple of weeks after his release. Petitioner's complaints at trial with reduced range of motion aret consistent with the last reports of Dr. Paletta indicating a reduced range of motion at the ends of some planes. Petitioner made no complaints of any loss of strength and that is also consistent with the reports of Dr. Paletta. The Arbitrator gives weight to this factor.

Based upon the foregoing factors, the Arbitrator awards Petitioner 10.12% loss of use of the body as a whole under §8(d)2.

<u>Issue O</u>: Travel expense - Mileage.

Petitioner is awarded reimbursement for his mileage to and from his home to the office of Dr. Paletta. Petitioner testified that on six occasions he traveled 212 miles to Dr. Paletta's office from his home in Iuka, Illinois.

While the records of the Respondent's on-site physician were not put into evidence it is credible that Petitioner was referred to Dr. Paletta by that physician. The Petitioner was paid for his first visit to Dr. Paletta, but was not paid thereafter.

Petitioner admitted that he agreed to treat with Dr. Paletta and that it was his choice to continue to treat with Dr. Paletta after the initial evaluation. Petitioner stated that while treating with Dr. Paletta he had retained legal counsel and had made no demands for travel expense prior to the date of trial. Petitioner further testified that he was familiar with the fact that there were hospitals in the Mt. Vernon area where shoulder surgeries were performed and that he was comfortable using the internet to research items such as medical treatment and where it would be available.

Respondent deemed it reasonable to send Petitioner to Dr. Paletta in the first place, rather than sending Petitioner to someone closer. Respondent has also agreed to pay all of Petitioner's medical bills

and by doing so has inherently agreed that the services rendered by Dr. Paletta were reasonable and necessary. In awarding mileage, the issue is one of reasonableness. In this instance the Arbitrator finds it appropriate to award the mileage for the additional visits with Dr. Paletta. In reaching this decision the Arbitrator relies heavily on Dr. Paletta's office note of December 3, 2014 in which he set forth a treatment plan for Petitioner, including a follow-up visit with the doctor in four weeks. This was not an isolated examination. There is no evidence in the record indicating Petitioner was advised by Respondent or Dr. Paletta regarding an election to treat and/or that mileage would be an issue. From Petitioner's perspective he was being guided by Respondent in the medical management of his case and his employer was telling him where to go for treatment.

While Respondent has cited the recent decision of Lozano vs. Coolersmart, 15 IWCC 0007, 12 WC 31176 (2015) in support of its contention that mileage should not be awarded, the Arbitrator notes that just the opposite result was reached in the Wayne Bruce v. Black Beauty Coal Co., 2007 IWCC 1123 and Petitioner was awarded his mileage.

****

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Aidar Gazafer,

Petitioner,

vs. NO: 14 WC 16471

Naperville School District 203,

16IWCC0670

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of medical, causal connection, temporary total disability, vocational rehabilitation and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. 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 January 26, 2016 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.

16IWCC0670

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: OCT 2 1 2016

MB/mam
o:9/29/16
43

Mario Basurto

David L. Gore

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

GAZAFER, AIDAR
Employee/Petitioner

Case# **14WC016741**

16IWCC0670

NAPERVILLE SCHOOL DISTRICT 203
Employer/Respondent

On 1/26/2016, 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 0.41% 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:

1505 SLAVIN & SLAVIN LLC
DAVID OVERLOOP
20 S CLARK ST SUITE 510
CHICAGO, IL 60603

0481 MACIOROWSKI SACKMANN & ULRICH
ROBERT ULRICH
105 W ADAMS ST SUITE 2200
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF DuPage)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
CORRECTED
ARBITRATION DECISION

Ajdar Gazafer
Employee/Petitioner

v.

Naperville School District 203
Employer/Respondent

Case # 14 WC 16741

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 **Jessica Hegarty**, Arbitrator of the Commission, in the city of **Wheaton**, on **8/20/15**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance [x] TTD
L. [ ] What is the nature and extent of the injury?
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [x] Other **Vocational Rehabilitation and Maintenance under Section 8(a)**

FINDINGS

On **8/22/13**, 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.

In the year preceding the injury, Petitioner earned **$45,342.44**; the average weekly wage was **$871.97**.

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

Respondent shall be given a credit of **$19,930.59** for TTD benefits paid and **$3,500.00** for an advance made to Petitioner for a total credit of **$23,430.59**.

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

ORDER

- Respondent shall pay outstanding medical bills in the amount of $3,315.00 subject to the applicable provisions of Section 8.2 of the Act.
- Respondent shall pay Petitioner temporary total disability benefits of $581.31/week for 102 weeks, commencing 8/26/13 through 11/16/13 and 11/27/13 through 8/20/15, as provided in Section 8(b) of the Act.
- Respondent shall pay Petitioner ongoing maintenance benefits of $581.31/week throughout the duration of Petitioner's vocational rehabilitation, commencing 8/21/15, as provided in Section 8(a) of the Act.
- Respondent shall provide a vocational assessment and vocational rehabilitation as provided in Section 8(a) of the Act.
- Respondent shall be given a credit of $23,430.59 for benefits that have been paid.

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

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

Signature of Arbitrator

1/21/15
Date

JAN 2 6 2016

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

AJDAR GAZAFER,
Petitioner,

v.

NAPERVILLE SCHOOL DIST. 203,
Respondent,

Case No: 14 WC 16741
Wheaton

CORRECTED
ADDENDUM TO THE DECISION OF THE ARBITRATOR

This case was tried before Arbitrator Jessica A. Hegarty in Wheaton, Illinois pursuant to Sections 19(b) and 8(a) of the Illinois Workers' Compensation Act on August 20, 2015. (Arbitrator's Ex. 1)

The issues in dispute are:

- Causal connection;
- Unpaid medical bills,
- TTD from 8/26/13 through 11/16/13 and 11/27/13 through 8/20/15;
- Petitioner's entitlement to vocational rehabilitation and maintenance benefits.

STATEMENT OF FACTS

Petitioner, Ajdar Gazafer, who has been employed by Respondent since 1999, was involved in an undisputed work accident on August 22, 2013 while performing his regular work duties for Respondent.

Petitioner testified that on August 22, 2013, he suffered an injury to his low back while stacking boxes of paper. Petitioner was in the process of moving one of the boxes of paper and, while holding the box, twisted to his left to avoid being run into by a forklift and struck his right lower back on boxes of paper that were stacked on a pallet.

Petitioner testified he felt immediate pain that traveled from his lower back to his right thigh, but kept working to finish his shift. Although the pain had not subsided, Petitioner returned to work on August 23, 2013 and again on August 24, 2013. However, due to the persistent pain in his lower back, Petitioner was unable to complete his shift on August 24, 2013 and left work early. Petitioner testified he had never had pain like this in his back before, and when the pain did not resolve over the weekend, he presented to Edward Hospital on August 26, 2013 for treatment.

On August 26, 2013 Petitioner was examined by Dr. Jeffrey Williamson-Link at Edward Hospital who noted a history of injury while attempting to move out of the way of a forklift, backing into the corner of a box and striking his right lower back and right posterior buttock and hip. (Px1) Petitioner reported he thought his pain would dissipate but experienced persistent right lower back and now feels occasional numbness in his right thigh. (Id.) Petitioner was diagnosed with lumbar back pain, a lumbar contusion and a posterior hip contusion. The Petitioner was authorized off of work and the Respondent commenced paying temporary total disability ("TTD") benefits.

The Petitioner returned to Edward Hospital on September 3, 2013 reporting improvement in his low back and denying any tingling or pain in the thighs. On September 16, 2013, Petitioner returned to Edward Hospital reporting improvement, "He does not have much discomfort today, and he rates it as 1/10. He states he is feeling overall much better." When examined, the Petitioner had "minimal tenderness on palpation." The treatment plan was to release the Petitioner to full duty the following Monday, unless his condition worsened.

The Petitioner returned to Edward Hospital on September 23, 2013 reporting that his back felt better with only mild discomfort and a pain level of 1-2 on a scale of 10, mostly in the right lumbar area.

On October 1, 2013 the Petitioner came under the care of Dr. Martin Fetzer complaining of pain in the "low back, left buttock and lateral thigh to the knee". Petitioner described the pain as a "mild aching, grabbing that is constant". Walking, standing and lifting were noted to increase the pain. Dr. Fetzer noted Petitioner's history of two renal transplants, first on the right which failed and on the left which is still functioning. Petitioner provided a consistent history of moving to avoid a forklift while loading Xerox paper and striking his back on stacked boxes on another palate. Petitioner complained of low back pain radiating to his right lower limb. Dr. Fetzer noted that despite being released to light duty work, Petitioner's employer was unable to accommodate such. After performing a physical examination, Dr. Fetzer diagnosed Petitioner with low back and right lower limb pain since a work place injury in August. He recommended Petitioner begin a course of physical therapy and remain on restrictions. (Px 2) The doctor indicated the paresthesias in Petitioner's right arm and lower limbs did not appear to be related to the accident, but were more likely related to peripheral neuropathy attributable to Petitioner's renal disease. The doctor ordered physical therapy which the Petitioner participated in from October 11, 2013 through November 8, 2013. (Px 2, Rx 8)

The Petitioner was discharged from physical therapy on November 8, 2013 after 12 physical therapy visits. (Rx. 8, page 1, 2) According to the November 8, 2013 discharge summary, "Patient reports that he feels his low back pain has been about the same the past few weeks. He feels he can walk around and overall the discomfort is much better than when he first started therapy." (Id.)

On November 12, 2013 Petitioner returned to Dr. Fetzer with complaints of low back and tailbone pain. Dr. Fetzer recommended a lumbar corset brace and continuation of non-narcotic pain medication. He released the Petitioner to return to work without restrictions. (Px 2)

Petitioner testified that he returned to work on November 17, 2013 and attempted full-duty for a little over a week. Petitioner further testified that his attempt at full-duty work did not go well.

On November 26, 2013 Petitioner returned to Dr. Fetzer with continued complaints of low back pain. Dr. Fetzer noted that despite improvements in Petitioner's condition with physical therapy and bracing, he was unable to tolerate the return to work and his pain was exacerbated. The doctor noted lumbar x-rays "reviewed from August" showed decreased disc space and deterioration at L5-S1 "which is the likely cause of his symptoms". Dr. Fetzer recommended an MRI of Petitioner's lumbar spine and continued bracing. (Px 2)

On December 3, 2013 Petitioner underwent a lumbar MRI at Future Diagnostics Group. The radiologist's impression was:

1. Lumbar spondylosis, especially L3-4 and L4-5
2. At L3-4, there is a left posterolateral disc extrusion along with facet arthropathy which results in moderate central spinal canal stenosis and moderate to severe left foaminal narrowing
3. At L4-5, posterior bulging disc along with facet arthropathy results in moderate central spinal canal stenosis, moderate to severe right foraminal narrowing, and mild to moderate left foraminal narrowing
4. At L2-3, there is a subtle far left posterolateral disc protrusion which results in mild left foraminal narrowing
   (Px 5)

Petitioner returned to Dr. Fetzer on December 19, 2013. After reviewing the MRI, Dr. Fetzer diagnosed Petitioner with degeneration of lumbar or lumbosacral intervertebral disc, lumbar spondylosis without myelopathy, and spinal stenosis, lumbar region, without neurogenic claudication. He recommended facet injections and provided a referral for Petitioner to seek a surgical opinion with Dr. Pelinkovic. (Px 2)

On December 23, 2013, Dr. Fetzer administered a lumbar facet joint injection followed by a transforaminal epidural steroid injection on January 10, 2014. On January 23, 2014, the Petitioner complained to Dr. Fetzer of low back pain as well as bilateral thigh numbness following the second injection. The Petitioner reportedly received no relief from the injection and the decided against any further injections. Dr. Fetzer referred the Petitioner to Dr. Pelinkovic for a surgical opinion (Px 2).

Petitioner presented to Dr. Pelinkovic of DuPage Medical Group on February 10, 2014. Dr. Pelinkovic reviewed Petitioner's treatment history as well as the lumbar MRI, and

found the MRI to show spinal canal stenosis with foraminal stenosis at L3-4 and L4-5. Dr. Pelinkovic diagnosed Petitioner with lumbar spinal stenosis, L3-4, L4-5 and spondylolisthesis, L3-4, L4-5. Dr. Pelinkovic opined that Petitioner had reached MMI from a non-surgical standpoint, or would otherwise benefit from a 2-level decompression and fusion at L3-4 and L4-5. (Px 2)

Petitioner testified that after receiving the surgical recommendation from Dr. Pelinkovic he sought a second opinion with Dr. Douglas Anderson at Loyola Medicine on February 19, 2014. Dr. Anderson opined that the MRI spine showed L3-4 and L4-5 stenosis, and concurred that Petitioner may benefit from a decompression and fusion. (Px 4)

Petitioner returned to Dr. Pelinkovic on July 14, 2014. Dr. Pelinkovic maintained his previous diagnosis and recommendation, and recommended Petitioner remain off work and attempt another course of physical therapy.

Petitioner underwent physical therapy at DuPage Medical Group from August 13, 2015 through September 6, 2014, with continued complaints of back pain until he was discharged due to lack of progress. (Px 2)

Petitioner followed up with Dr. Pelinkovic on August 25, 2014 who noted Petitioner was severely incapacitated by his lower back pain, but was afraid of surgery. He recommended Petitioner remain off work and continue with nonoperative treatment. Petitioner underwent a second course of physical therapy at DuPage Medical Group. (Id.)

Petitioner has continued to see Dr. Pelinkovic periodically without undergoing any further invasive treatment. (Px 2, 3)

On February 2, 2015, Petitioner presented for a Section 12 examination with Dr. Avi Bernstein at Petitioner's request. Dr. Bernstein testified regarding the examination at an evidence deposition on April 8, 2015. According to his testimony, he reviewed Petitioner's medical records, performed a physical examination and personally reviewed the MRI scan films of December 3, 2013. (Px 6)

Dr. Bernstein testified that the MRI demonstrated a left-sided disc herniation at L3-4 and arthritic facet changes at L4-5. He diagnosed Petitioner with a herniated disc and discogenic back pain. He explained discogenic pain is pain emanating from the wall of a disc that produces symptoms of mechanical low back pain such as Petitioner described, but did not necessarily produce radicular symptoms. This type of pain was consistent with the MRI findings of the herniated disc at L3-4. The doctor further testified that Petitioner's act of twisting and striking his back in avoidance of the forklift was a competent cause of the disc injury identified on the MRI, either as a direct cause or an aggravation of any preexisting degenerative condition that may exist. Dr. Bernstein agreed that the fusion surgery would be appropriate treatment for the injury identified but acknowledged that it was also reasonable for the Petitioner to be reluctant to have

the surgery because of his history of a kidney transplant. He further testified that all the treatment Petitioner had undergone had been reasonable and necessary, and opined that if Petitioner was not going to undergo a surgery, he would have permanent sedentary restrictions due to the identified disc injury resulting from the August 22, 2013 work accident. (Px 6)

On April 9, 2014, Petitioner presented to Dr. Wellington Hsu for a Section 12 Examination at Respondent's Request. Dr. Hsu testified regarding the examination at an evidence deposition on May 13, 2015. Dr. Hsu testified that he likewise performed a physical examination and reviewed medical records, including the records of Drs. Pelinkovic and Anderson, as well as the MRI report from December 3, 2013 which he related as reporting pathology at L4-5 and L2-3. Dr. Hsu also took a history from Petitioner confirming that he was in the process of moving boxes when he turned and hit his back. Dr. Hsu also reviewed the December 3, 2013 MRI films. (Rx 7)

Dr. Hsu testified that the December 3, 2013 MRI revealed mild L4-5 stenosis, with no evidence of stenosis elsewhere. He diagnosed Petitioner with a resolved lumbar contusion relative to the work injury, and unrelated lumbar stenosis and spondylosis. He agreed that Petitioner's objective findings and subjective complaints warranted decompression and fusion surgery, however such a procedure would not be related to the August 22, 2013 work injury. Further, he assigned restrictions of no heavy lifting over 20 pounds, and bending/crushing/stooping on an occasional basis; again, relating these to the preexisting condition warranting surgery, and not, in his opinion, the work injury. (Rx 7)

CONCLUSIONS OF LAW

(F) In support of the Arbitrator's decision regarding whether Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator concludes the following:

The Arbitrator finds Petitioner's current condition of ill-being to be causally related to the injury. The Arbitrator relies on Petitioner's credible testimony as corroborated by the treating records. Further, the Arbitrator finds the opinions of Petitioner's treating physicians and Petitioner's Section 12 examiner, Dr. Bernstein, to be more credible than the opinions of Respondent's Section 12 examiner, Dr. Hsu.

Petitioner testified to specific, consistent, ongoing complaints of pain and discomfort in his low back since the undisputed accident of August 22, 2013, unrelieved by physical therapy and injections. Despite experiencing some initial relief, after Petitioner's attempted return to full duty work in November of 2013, the pain was exacerbated, and continued up through the date of hearing. Petitioner further testified that he had no such pain in his back prior to August 22, 2013.

Respondent's Section 12 Examiner Dr. Hsu, while acknowledging Petitioner's ongoing symptoms and need for further treatment, testified that his review of the MRI revealed stenosis at L4-5. Dr. Hsu's report likewise declares mild L4-5 stenosis with no evidence of stenosis elsewhere. Despite reviewing the records of Dr. Pelinkovic and Anderson and relating that those records contained diagnoses of pathology at L3-4 as well as L4-5, Dr. Hsu provides no reasoning as to why he disagreed with the physicians' assessment of Petitioner's L3-4 disc. Further, Dr. Hsu relates in his written narrative that the MRI report identifies L4-5 posterior disc bulging with stenosis and foraminal narrowing as well as a left posterior lateral disc protrusion at L2-3. The Arbitrator notes the actual MRI report also identifies a left posterolateral disc extrusion with moderate central stenosis and moderate to severe left foraminal narrowing at L3-4; however, this finding is absent from Dr. Hsu's recitation of the MRI report.

Drs. Pelinkovic, Anderson and Bernstein all reviewed Petitioner's MRI and reported positive pathology and stenosis at both L3-4 and L4-5. Moreover, Dr. Bernstein specifically noted a herniated disc at L3-4 that was consistent with Petitioner's ongoing symptoms, and found Petitioner's mechanism of injury to be a competent cause of the damage Dr. Bernstein identified in the disc.

In light of three other spine surgeons specifically identifying pathology at L3-4 as well as L4-5, and Dr. Hsu's complete disregard of the L3-4 level, the Arbitrator finds Dr. Hsu's opinion to be unpersuasive. Accordingly, the Arbitrator adopts the findings of Petitioner's treating physicians and Dr. Bernstein that Petitioner suffered from damage to both L3-4 and L4-5. Furthermore, as Dr. Bernstein provided a well-reasoned and detailed analysis regarding how the pathology identified at L3-4 correlated with Petitioner's ongoing symptoms and was causally related to the Petitioner's August 22, 2013 injury, the Arbitrator finds Petitioner's current condition of ill-being to be causally related to the undisputed work accident of August 22, 2013.

(J) In support of the Arbitrator's decision regarding whether the Petitioner has received all reasonable and necessary medical services, and whether Respondent has paid all appropriate charges for said medical services, the Arbitrator concludes the following:

Petitioner submitted unpaid medical bills in the amount of $3,315.00 for treatment rendered at DuPage Medical Group. In light of the Arbitrator's finding above that Petitioner's current condition of ill-being is causally related to the undisputed work accident of August 22, 2013, and the Arbitrator's reliance on, and adoption of, the opinions of Drs. Pelinkovic and Bernstein, the Arbitrator finds the treatment rendered at DuPage Medical Group to be reasonable and necessary. As such, Respondent is to pay to Petitioner the outstanding medical bills submitted, subject to the applicable provisions of Section 8.2 of the Act.

(K) In support of the Arbitrator's decision regarding whether Petitioner is entitled to TTD benefits, the Arbitrator concludes the following:

The Arbitrator finds Petitioner is entitled to TTD benefits of $581.31/week for 102 weeks, commencing 8/26/13 through 11/16/13 and 11/27/13 through 8/20/15, as provided in Section 8(b) of the Act.

Petitioner remained under restrictions from August 26, 2013 through November 16, 2013 which Respondent could not accommodate. From November 17, 2013 through November 26, 2013, Petitioner attempted a full-duty return to work, but experienced an exacerbation of his lingering back pain. Thereafter, Dr. Fetzer reinstituted restrictions which Respondent could not accommodate. Upon Petitioner's transfer of care to Dr. Pelinkovic, Petitioner's restrictions were first maintained until Dr. Pelinkovic took Petitioner off work completely on July 14, 2014. Dr. Pelinkovic has not released Petitioner to return to work since that time. Furthermore, Dr. Bernstein testified in his evidence deposition that Petitioner is capable of sedentary work only. Moreover, although he does not relate the restrictions to the work accident, Dr. Hsu testified that Petitioner's condition warranted restrictions of no heavy lifting over 20 pounds, and occasional bending/crushing/stooping. Petitioner testified there was no work available for him with restrictions, and Respondent presented no evidence to counter Petitioner's testimony.

Regarding which benefits are due to Petitioner and for what periods, the Arbitrator notes that an employee is entitled to TTD compensation 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. Interstate Scaffolding, Inc. v. Com'n, 923 N.E.2d 266 (Ill. 2010). Thus, a Petitioner is entitled to TTD until he reaches MMI.

Dr. Bernstein testified that if the Petitioner does not proceed with surgery, he has reached maximum medical improvement with permanent restrictions. Accordingly, the Arbitrator finds that upon testifying under oath at the August 20, 2015 hearing, Petitioner at that time reached MMI. Therefore, as Petitioner remains unable to perform full duty work and Respondent is unable to accommodate, Petitioner is entitled to TTD benefits from August 26, 2013 through August 20, 2015, less the period of attempted full-duty work from November 17, 2013 through November 26, 2013. Respondent will receive a credit for all TTD benefits paid.

(O) In support of the Arbitrator's decision regarding whether the Petitioner is entitled to vocational rehabilitation and maintenance under Section 8(a) of the Act, the Arbitrator concludes the following:

The Arbitrator finds that Petitioner is entitled to Vocational Rehabilitation under Section 8(a) of the Act. Respondent shall pay Petitioner ongoing maintenance benefits of $581.31/week throughout the duration of Petitioner's vocational rehabilitation, commencing 8/21/15, as provided in Section 8(a) of the Act.

A claimant is entitled to maintenance benefits after he reaches MMI until either Petitioner finds work within his restrictions or the Respondent can show that there are jobs reasonably available within Petitioner's restrictions. Illinois Workers' Compensation Comm'n v. Intermet Decatur Foundry Wagners Castings, 01 IL. W.C.41704, 2009 WL 3269722. Moreover, pursuant to Rule 7110.10 of the Rules Governing Practice Before the Illinois Workers' Compensation Commission, when it can be reasonably determined that the injured worker will, as a result of the injury, be unable to resume the regular duties in which engaged at the time of injury, or when the period of total incapacity for work exceeds 120 continuous days, whichever first occurs... [t]he employer or his representative, in consultation with the injured employee... shall prepare a written assessment of the course of medical care, and, if appropriate, rehabilitation required to return the injured worker to employment. 50 Ill.Adm.Code 7110.10(a) (2009).

As discussed above, Petitioner has permanent restrictions as a result of the undisputed work accident of August 22, 2013. Respondent has provided no evidence that there are jobs reasonably available within Petitioner's restrictions. Further, Rule 7110.10 dictates it is Respondent's obligation to coordinate a consultation with Petitioner and prepare a written assessment of rehabilitation required to return Petitioner to employment. Respondent has not done so.

Petitioner has permanent restrictions resulting from the injury suffered in the undisputed work accident of August 22, 2013 which Respondent cannot accommodate, Respondent is hereby ordered to provide a Vocational Assessment and develop a Vocational Rehabilitation Plan for Petitioner.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Wayne E. Wilson,
Petitioner,

vs. NO: 14 WC 33655

16IWCC0671

Dollar General Corp.,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under Section 19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, casual connection, temporary total disability, medical expenses and prospective medical expenses and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission hereby 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 does correct a typographical error in the Arbitrator's Decision. The Arbitrator's corrected Decision, filed November 3, 2015, awarded 35-1/7 weeks of TTD benefits, as noted in the rider to the Decision and the "Order" section of the 19(b) Decision form. However, the "Findings" section of the 19(b) Decision form references a temporary total disability period of 37 weeks. The correct total is 35-1/7 weeks of benefits, so the "Findings" section is amended to reflect that. All other findings and awards are affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 3, 2015, 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.

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 $12,400.00. 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: OCT 2 1 2016

Joshua D. Luskin

Charles J. DeVriendt

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jdl/wj
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Ruth W. White

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

WILSON, WAYNE E
Employee/Petitioner

Case# **14WC033655**

DOLLAR GENERAL CORP
Employer/Respondent

16IWCC0671

On 11/3/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.28% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2424 SAUTER SULLIVAN LLC
CHRISTOPHER K GELDMACHER
3415 HAMPTON AVE
ST LOUIS, MO 63139

1505 SLAVIN & SLAVIN LLC
MARK F SALVIN
20 S CLARK ST SUITE 510
CHICAGO, IL 60603

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
19(b)

Wayne E. Wilson
Employee/Petitioner

v.

Dollar General Corp.
Employer/Respondent

Case # **14** WC **033655**

Consolidated cases: **N/A**

16IWCC0671

An *Application for Adjustment 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 and Collinsville**, on **June 10, 2015 and July 22, 2015**, respectively. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

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

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

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

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

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

G. [ ] What were Petitioner's earnings?

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

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

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

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

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

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

N. [ ] Is Respondent due any credit?

O. [x] Other **Section 8(j) credit for medical bills**

FINDINGS

On the date of accident, **08/21/14**, 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 **$37,583.97**; the average weekly wage was **$736.94**.

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

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

Petitioner ***has not*** received all reasonable and necessary medical services.

Petitioner was temporarily totally disabled from **09/2/14** through **05/05/15**, a period of **37 weeks.**

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$5,000.00** for other benefits, for a total credit of **$5,000.00**.

Respondent is entitled to a credit of **$0** for medical bills paid under its group medical plan for which credit may be allowed under Section 8(j) of the Act.

ORDER

Respondent shall authorize and pay for the treatment recommended by Dr. Gornet, ie., the transforaminal steroid injection at L3-4.

Respondent shall pay Petitioner temporary total disability benefits at a rate of $491.29/ week, commencing September 2, 2014 through May 5, 2015, a period of 35 1/7 weeks, as provided in Section 8(b) of the Act. Respondent shall receive a credit in the amount of $5,000.00 (an advancement made to Petitioner) as stipulated to between the parties.

Respondent shall pay reasonable and necessary medical services as follows: Sparta Community Hospital -- $1,274.45; Midwest Emergency Sparta - $582.00; Dugan Radiology - $50.00; Belleville Family Medicine – $162.00; Dr. Matthew Gornet -- $726.00; and MRI Partners of Chesterfield -- $2,994.21, subject to the Medical Fee Schedule 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.

16IWCC0671

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

Signature of Arbitrator

November 1, 2015
Date

ICArbDec19(b)

NOV 3 - 2015

Wayne Wilson v. Dollar General, Case # 14 WC 033655 (19(b))

FINDINGS OF FACT and CONCLUSIONS OF LAW

The Arbitrator finds:

According to the medical records, in May of 2000, Petitioner came under the care of Dr. Riew at Washington University Medical Center due to back problems. Petitioner completed a Pain Questionnaire in which he reported that his symptoms had begun on April 24, 2000 when he woke up and could hardly get out of bed or walk due to severe pain which included his low back and legs (75% left leg, 25% right leg). Petitioner reported the worst positions for him were sitting, standing, and walking although bending forward and sitting exacerbated it even more. He could only stand or walk for up to ten minutes without pain. Petitioner had not been working since April 24, 2000 and had been treated with anti-inflammatories, narcotics and two epidural steroid injections. Dr. Riew recommended a repeat injection while waiting for surgery (a micro-lumbar discectomy at L5-S1). Dr. Riew didn't recommend surgery at L4-5 as it appeared asymptomatic. While the surgery would probably help with the leg pain, Petitioner was advised it would likely be of no help with his back pain, especially if the pain wasn't arising from a disc herniation. Dr. Riew believed it unlikely Petitioner would be able to return to the heavy manual labor he was currently performing. At that time Petitioner underwent an MRI of his lumbar spine, which demonstrated a prominent disc herniation at L5-S1, mild central disc protrusion at L4-L5, and disc desiccation at L4-L5 and L5-S1. (PX 16)

Petitioner underwent two lumbosacral spine surgeries later that year. The first was the lumbar discectomy (June of 2000). The second surgery was on August 16, 2000 and consisted of an evacuation of pseudomeningocele and a redo hemilaminotomy at L5-S1 and excision of a recurrent disc. (PX 11, 12) As of September 21, 2000 Petitioner was reporting his left leg pain was much better but he was still experiencing some radiating right leg pain down to his calf. He reported that that had begun before the 2nd procedure and had persisted. Dr. Riew noted that Petitioner's MRI taken prior to the 2nd procedure did not show any abnormalities and, thus, he was unclear as to the etiology of the right leg symptoms. He recommended a Doppler to rule out a DVT. (PX 11, 12) Petitioner followed up with Dr. Riew on January 2, 2001 reporting the recurrence of gradual left leg pain a couple of weeks earlier. Dr. Riew suspected some cervical cord compromise since Petitioner had reported several years of slightly altered sensation in his hands and he further suspected a herniated disc at L5-S1. A repeat MRI was ordered. The MRI showed no scar or recurrent disc hernation, some mild stenosis at L4-5 but nothing "terribly significant", and minimal stenosis at L3-4. The doctor, still unclear as to etiology, and wondering if there might be something else wrong with Petitioner, referred Petitioner to Dr. Metzler for an evaluation and an EMG/NCS. (PX 11)

An EMG/NCS was performed on February 26, 2001 and revealed no evidence of a peripheral neuropathy but did show evidence of a left chronic/old left L5 radiculopathy and clinical evidence of bilateral L5 radicular symptoms. Bilateral L5 injections were recommended. (PX 11)

Petitioner returned to see Dr. Riew on March 8, 2001. Petitioner was still reporting bilateral leg symptoms and pain. In light of Petitioner's prolonged history of symptoms and two surgeries (the second one being a pseudo-meningocele repair and that Petitioner had an osteophyte v. osteochondroma that had been pressing on his nerves for some time) Dr. Riew believed Petitioner might have some permanent nerve damage. A referral to Dr. Dowling was made for a second opinion. (PX 11)

Dr. Dowling examined Petitioner on March 29, 2001. Petitioner gave a ten year history of chronic low back and left lower extremity pain that he related to a work-related injury approximately ten years earlier when he fell from a ladder landing on his back. He had initially been told he had broken his tailbone and had a lumbar strain. He underwent four weeks of physical therapy but didn't return to work and sued for his work-related injury, the latter of which was later resolved. Following that he had a number of jobs all of which involved physical labor, including lifting. In April of 2000 he woke up with severe left lower extremity pain and he began treating with Dr. Schultz and, ultimately, Dr. Riew. Dr. Dowling felt Petitioner was suffering from failed back surgery. He suggested spinal cord stimulation pending a psychological evaluation. (PX 11) The spinal cord stimulation had to be deferred due to insurance issues. (PX 11, 5/14/11 o/n)

In October of 2001 Petitioner was involved in a two vehicle accident in which he was a restrained passenger. Petitioner was seen at Sparta Community Hospital ER with complaints regarding pain in the right side of his neck and facial abrasions. Petitioner's past history included ongoing low back pain and prior surgeries. A pain drawing referenced "chronic" low back pain. Petitioner was treated and released. (PX 16) Petitioner returned to Sparta Community Hospital on April 4, 2002 to undergo a cervical spine MRI due to the October motor vehicle accident. Petitioner had evidence of a mild midline disc protrusion at C5-6 and a mild left posterolateral disc protrusion at C7-T1. (PX 16)

In April of 2007 Petitioner established care with Dr. Wolff at Belleville Family Medical Associates, Ltd. Petitioner presented with a history of insomnia and chronic pain in his low back and neck after a fall at work many years earlier followed by a motor vehicle accident. Petitioner had resultant left lower extremity radiculopathy for which he was on medications. Petitioner was noted to be on disability. Dr. Wolff also noted that he was going to review Petitioner's records to determine if an updated MRI was appropriate to try and see if anything more could be done for Petitioner's left lower extremity radiculopathy. (RX 3)

In June of 2007 Petitioner sought care with Dr. Wolff for a bothersome cystic mass in the right side of his neck. His low back was noted to have some slight left paralumbar tenderness and he was displaying a slightly antalgic gait favoring his left lower extremity. An MRI was ordered. (PX 13, RX 3)

Petitioner underwent an MRI of his lumbar spine in June of 2007 which demonstrated a mild annual disc bulge without disc desiccation at T11-12 and conus medullaris at T12 (PX 13) Petitioner followed up with Dr. Wolff who noted that the MRI showed post-operative changes from his previous surgeries and a prominent disc bulge at L4-5 with bilateral neuroforaminal

narrowing due to facet hypertrophy and disc bulging. Thereafter, Dr. Wolff referred Petitioner to Dr. Heffner. (PX 13, RX 3)

In August of 2007 Petitioner presented to Dr. Heffner. As part of the exam Petitioner completed a Medical History Questionnaire. He listed his occupation as "Disabled." His chief complaint was described as "Severe pain in back down both legs, numbness and tingling in feet and legs, pain in neck and down right arm, etc...." Petitioner reported that his problem began in 1982. Petitioner reported chronic low back pain going back to 1999. Petitioner advised the doctor about his earlier back surgeries reporting that "[o]ver the years he has previously had to see pain management and used multiple medications and overall his situation may be slightly better now than it was a couple of years ago but for the most part is not changing dramatically. Petitioner's primary complaints were low back pain and some left lower extremity complaints." (RX 3) Dr. Heffner further noted that Petitioner's primary complaint was low back pain with some left lower extremity pain along his lateral thigh and calf but no weakness or sensory loss. (RX 3) Petitioner also reported a motor vehicle accident in 2002 with some residual neck pain. Dr. Heffner diagnosed Petitioner with post laminectomy syndrome, back pain, and degenerative disc disease. Dr. Heffner authored a letter to Dr. Wolff on August 14, 2007. He wrote that, given the troubles Petitioner has had with his previous surgeries, he did not advise any further surgeries absent "a very strong reason." He offered him nothing in particular at that time from a neurosurgical perspective other than pain medications and pain management, if necessary. (RX 3; PX 13)

In October of 2007 Dr. Wolff noted that Petitioner was on disability for his chronic neck and back pain. Petitioner was noted to be quite dysfunctional for any type of physical labor and even sedentary work would be uncomfortable for him. As requested by Petitioner, Dr. Wolff signed some forms for an educational loan forgiveness request due to Petitioner's inability to earn money in any capacity. (RX 3)

Dr. Wolff continued to monitor Petitioner from 2007 through February 15, 2010. On the latter date, Petitioner presented for general follow up. Dr. Wolff noted that Petitioner was on disability but had just started a position at a local store which had helped "enhance his sense of self worth." (RX 3)

On April 12, 2010 Petitioner saw Dr. Wolff complaining of neck pain and bilateral arm stiffness and pain. No low back or lower extremity complaints were noted. (RX 3)

In April of 2010, Petitioner underwent an MRI of his cervical which demonstrated osteoarthritis of the cervical spine and an abnormal T2 weighted signal in the central portion of the spinal cord at the C7-T1 level. In June of 2010 Petitioner returned to see Dr. Heffner in regard to chronic intermittent neck pain and right arm tingling and numbness. (PX 13) Petitioner was diagnosed with cervical spondylosis, cervical disc bulging, neck pain and posterior headaches. The medical records indicate Petitioner subsequently underwent a cervical spinal fusion in 2011. (PX 13, 14, 15)

On November 29, 2011, Petitioner presented to Dr. Wolff reporting an exacerbation of low back pain that radiated into the right buttock, posterolateral thigh and down to the ankle. He

reported some parethesia and numbness in the right leg. Straight leg raising was positive on the right. Petitioner displayed intact strength of the dorsiflexors of the right foot but limited his effort due to pain. Petitioner's right buttocks was somewhat tender to palpation and his gait somewhat antalgic, favoring the right lower extremity. If his symptoms or pain worsened, Petitioner was to advise him and he would order an MRI and have him re-evaluated by a spine surgeon. Dr. Wolff noted that most of Petitioner's chronic pain was due to degenerative disc disease and degenerative joint disease of the low back manifested by a left lower extremity radiculopathy, for which Petitioner had undergone 2 lumbar spine surgeries in the past. (RX 3) Dr. Wolff continued to monitor Petitioner's medications but did not have another visit with Petitioner until December 7, 2012 at which time Petitioner presented for a routine follow-up. Petitioner reported he was managing a Dollar General Store and doing well. He complained of some knee pain, mostly on the right, associated with prolonged standing and walking which his job entails. He needed no medication refills. Petitioner followed up again in December of 2012, at which time he complained of knee pain, mostly on the right with prolonged standing and walking. (RX 3)

Petitioner was seen by Dr. Wolff on August 6, 2014 for a routine medical visit. Dr. Wolff recorded that Petitioner was feeling well. His chronic neck and back pain was described as being at "baseline." Petitioner was functioning on his current medications and working as a store manager for Respondent. (RX 3)

On September 1, 2014, Petitioner presented to the emergency room complaining of severe chronic back pain in the area of the left lower lumbar spine, left SI joint, lower lumbar spine, sacrum, right lower lumbar spine, right SI joint and radiating to the right hip and thigh. He reported the onset was 11 days prior when "he was turning (pushing water container at work)." He described the quality as a sharp, aching pain similar to prior episodes. Petitioner had limited range of motion in his back. Petitioner was diagnosed with lumbar radiculopathy and sciatica. Petitioner underwent an x-ray of his lumbar spine, which demonstrated moderately severe degenerative disc disease at the lower three lumbar disc levels, prominent bilateral facet joint arthritis at the L4-5 and L4-S1 levels, and slight lumbar dextroscoliosis. Ication. The reason given for the x-ray was "lifting injury on August 21st, back pain extending down both legs." (PX 1; PX 2) Petitioner was advised to limit his lifting, refrain from strenuous activity, and rest. Medication for pain and muscle spasms was provided. He was instructed to follow up with his doctor.

Two days later, on September 3, 2014, Petitioner presented to Dr. Edward Wolff at Belleville Family Medical Associates in follow up after the visit at Sparta ER and "workmen's comp." Petitioner reported that in late August, he had "wrenched his low back lifting at work." He complained of right low back pain radiating down the right leg and reported that he had not worked since September 2nd due to pain. His other medical conditions included anxiety, chronic lower back pain, degenerative disc disease (low back, neck, fall at work and MVA, left lower extremity radiculopathy), degenerative joint disease, depression, impaired glucose tolerance and insomnia. A significant surgical history was also noted, including cervical arthrodesis C5-T1, two spine surgeries including discectomy/laminectomy in May and September 2000, a spinal blood patch and excision EIC right neck. The assessment was sciatica and lumbar strain. Petitioner was placed off work for one week and advised to use heat/cold and engage in gentle stretching and walking. Medication was dispensed. (PX 2 ; RX 3)

Petitioner returned to see Dr. Wolff on September 8, 2014 reporting he was no better and still having radiating pain down his right lower extremity. According to the office note, "Per pt, his WC personnel tried to tell him he did not need the prednisone for this condition and would not cover it; he purchased it and took it but w/o much benefit." Petitioner noted pain in his right low back and lower extremity with walking. Petitioner was diagnosed with "chronic low back pain" and given a renewal script for his hydrocodone and started on gabapentin. Petitioner was advised to walk as tolerated and remain off work. He was to call back in 3-4 days and, if he was no better, an MRI would be ordered. (PX 2; RX 3)

As instructed, Petitioner called in on September 11, 2014 reporting no improvement and that the gabapentin made him sleepy but didn't help with the pain. An MRI "for debilitating right lower extremity radiculopathy after low back strain" was ordered and Petitioner's medications were adjusted. (PX 2; RX 3)

Petitioner signed his Application for Adjustment of Claim herein on September 25, 2014. The Application alleges that Petitioner injured his neck, back, spine, and body as a whole "moving a container containing bottled water when he....[not completed.]" (AX 2)

Due to insurance issues the MRI was cancelled as workers' compensation had denied it stating it wasn't needed. Petitioner reported that he had hired an attorney and was seeing Dr. Gornet as suggested by his attorney. (PX 2; RX 3)

On September 29, 2014, Petitioner presented to Dr. Matthew Gornet at The Orthopedic Center of St. Louis complaining of low back pain on the right side, right groin, with right leg pain down the leg to the posterior calf. Dr. Gornet recorded the following:

> He presents with a chief complaint of low back pain to the right side, right groin, right leg pain down his right leg into his posterior calf. He states his current problem, at least in its magnitude and severity, began on 8/21/14. He is a manager at Dollar General. He was moving a large rolling cart called a Rolltainer. The wheels on the cart were bad and he had to use excessive force to try and push the cart through. The cart contained at least 70 cases of 24-pack water. He felt pain and it was reported that day. There was some delay in treatment. He went to Sparta Hospital, where he was treated and released. He then returned the next day because of still severe pain. He eventually saw his medical doctor. He readily admits to a history of low back pain and surgery in the past. His first surgery was 15 years ago by Dr. Dan Riew in his low back. This was complicated by a second surgery for recurrent disc herniation. He does not recall any intervening treatment in his low back since that time, although he states he has had a low level of pain for many years and he has been maintaining this on Hydrocodone per Dr. Wolff. Of other note, he has worked at Dollar General doing essentially the same job as a manager for over five

years full duty with no restrictions. (PX 3)

Dr. Gornet noted that Petitioner had been off work since September 2, 2014 and was experiencing constant symptoms worse with Valsalva, such as coughing, sneezing, bending or lifting, and only relieved, to some extent, by a change in position or leaning to the left. Petitioner was denying any left leg pain, only right leg pain, numbness and weakness. Petitioner specifically denied any previous problems after his recovery from surgery with Dr. Riew except for a time in 2007 when he treated with Dr. Heffner for his neck and an MRI of his low back was also ordered. He denied any significant low back treatment with Dr. Heffner. On physical examination Dr. Gornet noted that Petitioner had a "fairly standard pose of a large herniated disc with his knee being bent." Petitioner had decreased sensation to L5 dermatome on the right.

Petitioner brought films with him, and Dr. Gornet reviewed them. He noted early degenerative scoliosis with facet changes at L3-4, L4-5 and L5-S1. He had a loss of disc height at L4-5 and L5-S1. A 2007 MRI showed a disc herniation central at L4-5, with mild protrusion at L3-4. An MRI from 2000 showed a large central left-sided herniation at L5-S1, which correlated with his symptoms. Dr. Gornet commented that while Petitioner certainly had pre-existing problems with his low back he had been working at his current job for over five years. Dr. Gornet stated, "I do believe his current symptoms in their magnitude and severity, particularly the severe right leg pain and weakness, is causally connected to his recent work related injury." Dr. Gornet ordered an "emergent" MRI which could not be done that day due to time constraints. He suspected Petitioner would need some injection. In the interim, he also placed Petitioner off work. (PX 3)

Petitioner underwent an MRI of his lumbar spine on September 30, 2014, which demonstrated the following: a broad-based disc protrusion and facet arthropathy resulting in moderate lateral spinal canal stenosis and bilateral moderate to severe foraminal encroachment at L3-4 and L4-5; bilateral moderate foramina encroachment due to lateral disc bulge and facet arthropathy at L5-S1; and partial laminectomy and micro discectomy with post-surgical changes at L5-S1. (PX 4)

At a follow-up visit with Dr. Gornet on December 15, 2014, Petitioner and Dr. Gornet reviewed the MRI. Dr. Gornet believed it revealed a facet cyst on the right at L3-4, fairly severe foraminal stenosis and a right-sided annular tear at L3-4. Petitioner also had evidence of degeneration and foraminal and lateral recess stenosis on the right at L4-5 as well as foraminal stenosis at L5-S1. Petitioner reported ongoing right-sided pain. Dr. Gornet recommended a transforaminal steroid injection near Petitioner's facet cyst at L3-4 on the right. He reiterated his causation opinion. (PX 3)

At Respondent's request, Petitioner attended an Independent Medical Examination with Dr. Petkovich on February 11, 2015. Dr. Petkovich reviewed some cervical and lumbar diagnostic films pre-dating Petitioner's alleged accident and noted a large amount of medical records he had provided; however, he did not state exactly what those records were comprised of.Dr. Petkovich also took a subjective history from Petitioner and performed a physical examination of Petitioner. (RX 1)

Dr. Petkovich opined that all of Petitioner's complaints were consistent with his long history of chronic lower back pain. Dr. Petkovich opined that Petitioner's degenerative lumbar disc disease, degenerative thoracic disc disease, and degenerative cervical disc disease were all present prior to the incident on August 21, 2014 and were not aggravated or accelerated by the incident on August 21, 2014. Dr. Petkovich's opined that the MRI from September 30, 2014 did not reveal any acute findings. (RX 1)

Petitioner's case proceeded to arbitration on June 10, 2015 in Herrin. The disputed issues were: accident; causal connection; medical bills; temporary total disability benefits; 8(j) credit; and prospective medical care. Mrs. Renee Wilson, Petitioner's wife, was the first witness called to testify.

Mrs. Wilson testified that she has been married to Petitioner since December 30, 1999. Mrs. Wilson testified that Petitioner has had problems with his back and neck during their entire marriage. Mrs. Wilson testified that after Petitioner's surgeries in 2000, he was unable to work due to his pain. She further testified that over time, Petitioner's back did appear to get better. Mrs. Wilson testified that when Petitioner got off of Social Security disability and began working for Respondent that he was "much happier." She testified that both she and Petitioner were very proud when Petitioner was made a manager.

Mrs. Wilson testified that sinice Petitioner's injury at work in 2014, he has been "totally different" and that he's not the same as he was when he had been working. She testified that the day that Petitioner went to Sparta Community Hospital, he wasn't able to get out of bed and that his condition was very painful. Mrs. Wilson testified that she had not seen him like that in years. She testified that Petitioner not working since the injury has put a great hardship on their family and that they are in the process of losing their home. Mrs. Wilson testified that she much preferred the condition her husband ("the old Wayne") was in before his injury than after.

Mrs. Wilson further testified that from 2002 to 2009 Petitioner had been awarded social security disability on account of his chronic and unremitting back pain, which resulted in two lumbar surgeries in 1999 and 2000. Mrs. Wilson also testified that the cause of her husband's injury resulting in the award of Social Security Disability (hereinafter SSD) occurred when Petitioner was walking out of his home when he coughed and stepped off a stair.

Mrs. Wilson also testified that Petitioner felt he wanted to seek part-time employment and sought Medicare's approval so he would not become unqualified for social security disability. With the approval in hand, Petitioner sought part-time employment with Respondent beginning in 2009.

Petitioner's wife admitted that her husband was in pain before the August accident but it wasn't severe pain. She also testified that he was on prescription pain medication (Hydrocodone) for his back and neck.

At the conclusion of Mrs. Wilson's testimony, the case was continued until July 22, 2015 in Collinsville, Illinois. At that time Petitioner was called to testify.

Petitioner testified that he is 49 years of age. He testified that he has had back problems dating back to 1999. According to Petitioner, there was not an incident which precipitated his low back problems, but that he simply woke up one morning in excruciating pain. He went to his primary care physician who ordered x-rays and then an MRI. Petitioner's primary care physician then referred him to Dr. Daniel Riew in the Orthopedic Surgery Department at Washington University Medical Center. Petitioner testified that Dr. Riew performed two surgeries on him in 2000.

Petitioner testified that before the surgeries, he was working as a laborer for a stove foundry. After the two surgeries in 2000, Petitioner was unable to return to his employment. Initially, Petitioner was on short term disability, but later applied for, and was granted, Social Security disability. Petitioner testified that he received Social Security disability benefits from 2002 through 2009.

During the time period that Petitioner was receiving Social Security benefits, he mostly stayed at home and took care of his dogs. He exercised and tried to build up his back. Petitioner testified that he lost about 75 pounds which helped his back. Petitioner testified that he was not happy during this time, because he wasn't working which caused him to feel unfulfilled and useless.

Petitioner testified that around the end of 2009, he wanted to attempt to go back to work. He applied for, and was hired for, a part-time position with Dollar General. Petitioner reported his hiring to Social Security and testified that officials of Social Security were aware of his employment. Petitioner's original job title was part-time sales associate/cashier. He held this title for six months and, when questioned about how he liked working again, testified that he loved it.

Approximately six months after first being hired, (approximately the summer of 2010) Petitioner was promoted to a full-time position at Dollar General. His new title was lead associate. Around this time, Petitioner testified that he was able to get off of his Social Security disability benefits. Petitioner testified that he was thrilled to be working again and off of Social Security disability. According to Petitioner, the physical requirements of his job at Dollar General were lifting up to 50 pounds, staying on his feet for hours at a time, lifting merchandise to be scanned, basic cleaning and stocking. In the Spring of 2012, Petitioner was promoted again to store manager. Petitioner testified that going from being on Social Security disability to being the manager of retail store made him feel useful again, and that he loved his store and loved working.

Petitioner testified that between being released by Dr. Riew in 2002 and his injury on August 21, 2014, he always had some degree of pain and had to continuously receive treatment from his physician. He testified that he believed he was able to return to work in 2009 partially because he had learned to cope with his pain and partially because he was properly managing the pain with medication. However, Petitioner testified that he was never without pain. He stated that during this time, his pain ranged from being minimal to having really bad days. He received treatment from his primary care physician during this entire time. Petitioner testified that despite

the ups and downs associated with his condition, he was always able to perform his job duties at Dollar General.

On August 21, 2014, Petitioner was working at Dollar General. On that day, Petitioner was receiving a truck of merchandise in his stockroom. Petitioner testified that he was moving a "rolltainer" of bottled water to make room for the new shipment when he felt a pop in his back. He testified that a "rolltainer" of bottled water contained about 50 cases of bottled water stacked on a device with wheels on the bottom and that each case of water contained about 24 bottles of water and that each bottle was 12 ounces.

Petitioner testified that he did not tell anyone about the problem immediately, but that he sent an email to his supervisor, Michelle Schubert. According to Petitioner, he wrote in the email that he felt a pop in his back while working but he didn't think it was anything serious and would keep her posted.

Petitioner testified that the following day, he woke up with pain in his back that was radiating into his right leg and pain in his groin which he had not previously experienced. Petitioner testified that prior to his injury on August 21, 2014, he had primarily experienced pain radiating into his left leg. After August 21, 2014, Petitioner testified that he was experiencing increased pain in his low back and pain radiating down his right leg. Petitioner testified that the increased pain and the pain radiating into his right leg have not subsided since his injury on August 21, 2014.

Petitioner testified that he communicated with his supervisor and told her that he was going to need to see a doctor about his condition. Petitioner testified that the supervisor advised him to call a company nurse hotline. Petitioner did so and was advised to go to Sparta Community Hospital to seek medical treatment.

Petitioner testified that he went to Sparta Community Hospital at the recommendation of the nurse on Respondent's hotline.

Petitioner testified that he has never had the opportunity to get the treatment recommended by Dr. Gornet, because Respondent has refused to pay for it. Petitioner testified that his last day of work was August 29, 2014. Petitioner indicated that his goal in this proceeding is to get the treatment Dr. Gornet was requesting paid for so that he can receive said treatment, to get benefits paid for the time he has missed from work, and to recover so that he can get back to work. Petitioner stated that his misses his store and his job terribly.

Stacy Schott testified on behalf of Petitioner. Ms. Schott began working for Respondent in 2006. She was working for Respondent when Petitioner started working for Respondent. Ms. Schott testified that when Petitioner started working for Respondent, she did not observe him exhibiting any physical restraints or problems. She testified that prior to August 21, 2014, Petitioner never complained to her about problems with his back or about struggling to perform the physical requirements of his job. Ms. Schott testified that in the days that followed August 21, 2014, she could tell that Petitioner was in severe pain, that he was bent over when walking,

and that he wasn't working like his normal self. Ms. Schott testified that prior to August 21, 2014, she never had observed Petitioner acting in the fashion he was after that date.

Ms. Schott testified that Petitioner told her that he hurt his back while trying to push an overloaded rolltainer of water. She testified that Petitioner told her that the rolltainer started to fall and that he tried to catch it when the injury occurred. On cross-examination, Respondent entered a written statement of Ms. Schott into evidence which was signed by Ms. Schott and dated September 12, 2014. The statement read that Ms. Schott did not recall Petitioner saying to her that he hurt his back on August 21, 2015, and that Ms. Schott did not witness the injury occur. The statement further read that Petitioner did tell Ms. Schott one morning that he did hurt his back and that he did seem to be in pain, but that she was not certain which day this was.

Ms. Schott admitted that she considers Mr. and Mrs. Wilson her friends and that she freely and voluntarily appeared at both hearing dates to provide supportive testimony to aid and assist Mr. Wilson in any way she could regarding his claim of a work related injury.

Respondent called Michelle Schubert as a witness. Ms. Schubert is a District Manager for Respondent and is in charge of various stores owned by Respondent. Ms. Schubert testified that Petitioner was a store manager for her at Respondent's Marissa store. She testified that she and Petitioner had a good relationship, that Petitioner was a great worker and great manager for her, and that he did a lot of wonderful things for the Marissa store.

Ms. Schubert testified that Petitioner did not report the injury to her until an email was sent on August 29, 2014 in which Petitioner advised her he was going to have to go to the emergency room. She testified that the first time she was given notice of any alleged incident was over a week later on August 29, 2014 when Petitioner sent her an e-mail advising her that he was going to the emergency room. Ms. Schubert further testified that she reviewed store video footage which did not show anything out of the ordinary on the day that Petitioner reported he was injured. Ms. Schubert testified that the video showing the receiving room showed a rolltainer of bottled water, but that she didn't see it move. Ms. Schott testified that she obtained statements from two employees regarding whether they saw anything happen on August 21, 2014, and whether Petitioner said anything to them about.

On cross-examination, Ms. Schubert testified that Petitioner did report the injury to her. She testified that she did not have any knowledge about whether or not Petitioner spoke to the company nurse about his injury that she would think that Respondent would keep records of conversations employees have with the company nurse, but that she never looked into whether or not there was a record of Petitioner speaking to the company nurse. She admitted that if Petitioner did speak with the company nurse about the injury that this would be in compliance with Respondent's policy of reporting injuries. Ms. Schubert admitted that the video, which was not brought with her to the hearing, does not show the entire receiving room. She admitted that in August it was likely that there was more than one rolltainer of bottled water in the receiving room. Ms. Schubert testified that Petitioner's injury could have occurred in an area which she could not see on the video. Ms. Schubert testified that she was not at the Marissa store between August 21. 2014, and Petitioner's last day of work to be able to observe what condition he was in.

The Arbitrator concludes:

ISSUE (C), DID AN ACCIDENT OCCUR ON AUGUST 21, 2014 THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT BY RESPONDENT?

Petitioner sustained an accident on August 21, 2014 that arose out of and in the course of his employment with Respondent.

At the outset, the Arbitrator finds that Petitioner was a very credible witness. This conclusion is based, in part, upon the Arbitrator hearing Petitioner's testimony and finding it to be truthful and genuine and, in part, upon Petitioner's history. Petitioner is an individual who was on Social Security disability for several years. When Petitioner began to notice that his condition was improving and that he was managing it better, he could have easily just kept this information to himself and remained on disability. Instead, Petitioner began working again and got himself off of disability completely. These are not the actions of a dishonest or untrustworthy person.

It is clear from the record that Petitioner had a very significant pre-existing and chronic low back condition that had rendered him disabled under Social Security guidelines. Nevertheless, Petitioner was able to eventually find employment which his primary care doctor noted to be of great psychological and emotional benefit to Petitioner. Consequently Petitioner's job with Respondent enhanced his self worth and the Arbitrator does not believe he would have feigned an accident to stop working at a job he was emotionally deriving such great benefit from. It does not make sense to the Arbitrator that the same person who did what few others would do, remove himself from Social Security disability benefits in favor of returning to work, would now be dishonest in these proceedings to obtain workers' compensation benefits.

The evidence that Respondent produced in favor of its argument that Petitioner did not sustain an injury on August 21, 2014, is circumstantial and does not overcome Petitioner's credible testimony. Respondent's witness, Ms. Schubert, testified that Petitioner reported his injury to her on August 29, 2014. Further, Ms. Schubert admitted that she could not contradict Petitioner's claim that he called the company nurse hotline in compliance with company policy. Respondent did not produce records from Respondent's nurse hotline despite Ms. Schubert testifying that she assumed that such records existed. The evidence that Respondent produced about a delay in reporting the injury to Petitioner's district manager does nothing to overcome or contradict Petitioner's credible testimony.

Ms. Schubert testified that she did not see Petitioner injure himself on the store video system. However, Ms. Schubert admitted that the video she viewed did not show the entire back receiving area, that there were likely more rolltainers containing bottled water than the one that she testified was shown on the video, and that Petitioner's injury could have occurred in an area of the back receiving room not shown on the video. Even more concerning, as it relates to Respondent's contentions, is the fact that Respondent did not produce the video it is relying on to back its position. Ms. Schubert's testimony about what she could see and what she could not see

on a video that was not even produced at the hearing does nothing to overcome or contradict Petitioner's credible testimony.

While Petitioner's co-worker, Ms. Schott, provided a statement in which she noted no information about Petitioner sustaining an accident, Petitioner had no obligation to report any accident to her and she did acknowledge a change in Petitioner's physical condition before and after the date of accident.

The Arbitrator also finds that the inconsistent testimony of Petitioner regarding his referral to Dr. Gornet insufficient to overcome the bulk of Petitioner's credible testimony. Similarly, Petitioner's delay in seeking medical treatment was not so excessive as to suggest there was no accident.

ISSUE (F) IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO HIS AUGUST 21, 2014 ACCIDENT?

ISSUE (K) IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE?

Petitioner's current condition of ill-being in his low back is causally connected to his August 21, 2014 and Petitioner is entitled to the prospective medical care as recommended by Dr. Gornet. In so concluding the Arbitrator relies upon Petitioner's credible testimony and the opinions of Dr. Gornet who is found to be more persuasive than Dr. Petkovich.

Petitioner candidly admitted his earlier prior medical records into evidence and between he, his wife, and Petitioner's co-worker, Ms. Schott, established a difference in Petitioner's low back condition prior to and after the accident of August 21, 2014.

The two contradicting medical opinions in this matter do agree on one thing -- that Petitioner did sustain an injury on August 21, 2014. Where they differ is in the extent of the injury that Petitioner sustained on that date. Dr. Gornet provides the opinion that the current magnitude and severity of Petitioner's condition is causally related to his August 21, 2014, work injury and that said condition requires Petitioner to be off of work and requires treatment which is also causally related to the work injury. Dr. Petkovich states that Petitioner suffered a lumbar strain while working on August 21, 2014, which has now resolved, that said lumbar strain did not cause any aggravation or acceleration of Petitioner's pre-existing condition, and that Petitioner's present complaints are consistent with his chronic degenerative lumbar spine condition that was present prior to August 21, 2014.

In order to adopt Dr. Petkovich's conclusions, one would have to believe that Petitioner is being untruthful and dishonest about the fact that he is in severe pain and that the pain he began experiencing on August 21, 2014, has not resolved in the way that a lumbar strain would. Petitioner testified that since his surgeries, he has sustained, on occasion, lumbar strains. Petitioner testified that these lumbar strains would always resolve and that he would return back to his baseline status. In fact, records from Petitioner's primary care physician, from fifteen days prior to his injury, state that Petitioner felt well, that his chronic neck and back pain were at

baseline, that Petitioner was functional on current medications, and that he was able to work at his job as a store manager. Every medical record after this date records a history that Petitioner injured his back while moving a container of water at work. While the medical histories in some of the records reflect variations as to how the accident occurred (for example the emergency room records refer to a lifting event) Petitioner's history of the incident has, overall, been consistent and Respondent's defense has been largely focused on whether any accident occurred whatsoever, rather than the exact mechanism of injury.

With regard to Dr. Petkovich's opinions the Arbitrator notes that he provided no detailed explanation for his opinions nor is it clear from his report what, if any, medical records pre-dating the accident he actually reviewed. Granted, his report references certain pre-accident diagnostic films and he refers to "voluminous outside medical records;" however, those records are not identified with specificity. In this instance that is important. The doctor took issue with Petitioner's report of minimal right lower extremity complaints prior to his August 21, 2014 accident as he felt that representation was directly contradicted by Petitioner's earlier medical records. However, the doctor cited no specific records in support thereof. While Petitioner did have some right lower extremity complaints as late as November 29, 2011, no further mention of same was made until after August 21, 2014 when Petitioner presented to the emergency room post accident. Thus, Petitioner's representation to Dr. Petkovich does not appear contradictory to the records. The Arbitrator also notes that when Petitioner was last seen by the doctor in November of 2011 he denied any need for pain medication refills. He then sought no further medical treatment for any back complaints until after the August 21, 2014 accident. This lack of treatment or need for pain medication refills certainly suggests Petitioner was doing well overall and was at his baseline. Since the accident at work on August 21st, he has never returned to that baseline. Furthermore, Dr. Petkovich focused his causation opinion on Petitioner's pre-existing degenerative disc condition and never directly addressed Dr. Gornet's assessment of a facet cyst on the right at L3-4 or the annular tear at L3-4.

Given the finding that Petitioner is credible and given the contents of the medical records available from before and after August 21, 2014, the Arbitrator finds Dr. Gornet's opinion to be more persuasive than Dr. Petkovich's opinion. The Arbitrator concludes that Petitioner suffered an injury on August 21, 2014, which has not resolved and which requires further treatment. The Arbitrator concludes that the treatment recommended by Dr. Gornet is reasonable and necessary to attempt to cure Petitioner of his condition of ill-being and orders Respondent to pay all reasonable costs of the same, pursuant to the fee schedule of the Illinois Workers' Compensation Act.

ISSUE (L) WHAT TEMPORARY TOTAL DISABILITY BENEFITS ARE IN DISPUTE?

The Arbitrator further concludes that Petitioner was temporarily and totally disabled from employment since September 2, 2014 through May 5, 2015 (see AX 1) The Arbitrator orders Respondent to pay Petitioner temporary total disability benefits at a rate of $491.29 for the period of September 2, 2014 through May 5, 2015, a period of 35 1/7 weeks. Respondent shall receive a credit in the amount of $5,000.00 (an advancement made to Petitioner) as stipulated to

between the parties. (See AX 1) This conclusion is based upon the Arbitrator's causation determination above and the medical treatment records.

ISSUE (J) HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES?

Petitioner is awarded the following medical bills: Sparta Community Hospital -- $1,274.45; Midwest Emergency Sparta - $582.00; Dugan Radiology - $50.00; Belleville Family Medicine – $162.00; Dr. Matthew Gornet -- $726.00; and MRI Partners of Chesterfield -- $2,994.21. Said bills are awarded pursuant to the Medical Fee Schedule.

ISSUE (O) IS RESPONDENT ENTITLED TO A CREDIT FOR ANY MEDICAL BILLS PAID BY A GROUP MEDICAL PLAN FOR WHICH CREDIT MAY BE ALLOWED UNDER SECTION 8(j) OF THE ACT?

Respondent failed to prove it is entitled to a credit under Section 8(j) of the Act. Mrs. Wilson testified that her husband had no health insurance through Respondent. Her testimony was not rebutted.

****

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Kem Long,
Petitioner,

vs. NO: 08 WC 01120

City of Springfield,
Respondent.

16IWCC0672

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

All findings and awards of the Arbitrator are affirmed, but the Commission does correct a typographical error in the Decision. The Arbitrator, on page 30 of the rider to the Decision, awarded Petitioner 3% permanent partial disability under Section 8(d)2 of the Act. However, in the "Order" section on page 2 of the Decision, it states the claimant failed to prove that he was permanently partially or totally disabled. The Commission corrects this sentence to reflect, consistent with the rest of the Decision, that the claimant was permanently partially disabled to the extent of 3% of the whole person under Section 8(d)2 of the Act, and the Respondent shall accordingly pay the Petitioner $515.97 per week for 15 weeks.

IT IS THEREFORE ORDERED BY THE COMMISSION that, beyond the above-noted correction, the Decision of the Arbitrator filed September 8, 2015 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $515.97 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 the 3% loss of use of man 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.

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: OCT 2 1 2016

Joshua D. Luskin

Charles J. DeVriendt

o-10/05/16
jdl/wj
68

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

LONG, KEM
Employee/Petitioner

Case# **08WC001120**

CITY OF SPRINGFIELD
Employer/Respondent

16IWCC0672

On 9/8/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.27% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1816 NESSLER & ASSOCIATES LTD
JONATHAN NESSLER
536 N BURNS LANE SUITE 1
SPRINGFIELD, IL 62702

0332 LIVINGSTONE MUELLER ET AL
DENNIS O'BRIEN
P O BOX 335
SPRINGFIELD, IL 62705

-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

KEM LONG,
Employee/Petitioner

v.

CITY OF SPRINGFIELD,
Employer/Respondent

Case # 08 WC 1120

Consolidated cases: _____

16IWCC0672

An *Application for Adjustment 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 **7/27/15**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of 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 **1/11/05**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$40,285.96**; the average weekly wage was **$774.73**.

On the date of accident, Petitioner was **49** 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 **$00.00** for TTD, **$00.00** for TPD, **$00.00** for maintenance, and **$00.00** for other benefits, for a total credit of **$00.00**.

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $0/week for 0 weeks, as provided in Section 8(b) of the Act, because petitioner has failed to prove by a preponderance of the credible evidence that he was temporarily totally disabled.

Respondent shall pay reasonable and necessary medical services for petitioner's cervical spine and right shoulder from 1/11/05 through 3/23/05, as provided in Sections 8(a) and 8.2 of the Act.

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

Respondent shall pay Petitioner permanent partial or permanent total disability benefits of $0/week for 0 weeks, as provided in Section 8(b) of the Act, because petitioner has failed to prove by a preponderance of the credible evidence that he was permanently partially or totally disabled.

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

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

[signature]
Signature of Arbitrator

8/31/15
Date

ICArbDec p. 2

SEP 8 - 2015

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 49 year old truck driver/laborer, sustained an accidental injury that arose out of and in the course of his employment by respondent on 1/11/05. There exists a dispute as the causal connection between the petitioner's current condition of ill-being and his injury on 1/11/05, as well as medical expenses, temporary total disability benefits, and the nature extent of petitioner's injury.

Petitioner worked for respondent as a truck driver/laborer for about 17 years. His duties included different tasks. He would do backfill work, pick up concrete and load it in truck, lay asphalt, drill holes for rebar, and tamp sand and rock into area that was cut out in the roadway.

Prior to the injury on 1/11/05 petitioner had a significant history of treatment to his lumbar spine, cervical spine, and shoulder dating back to 1997. In the early 1990's petitioner underwent a lumbar laminectomy at L3-L4. On 4/18/97 Dr. Petkovich drafted a letter to respondent indicating that he performed a Section 12 examination on 2/18/97, and his final analysis was that petitioner had reached maximum medical improvement regarding his lumbosacral spine, and could perform the job of truck driver/laborer.

In 1998 petitioner's complaints included low back pain on 5/15/98. He was diagnosed with spinal stenosis and ESIs were recommended. Petitioner was taken off work. On 5/26/98 petitioner was released to light duty work with no lifting greater than 25 pounds for his diagnosis of spinal stenosis. His prognosis at that time was fair.

In 1999 petitioner continued treating for his lumbar spine and spinal stenosis. On 2/5/99 his restrictions included no lifting more than 15 pounds and no jack hammering. His prognosis remained fair. On 2/24/99 petitioner was taken off work for surgery to address his spinal stenosis and herniated disc. On 3/6/99 he was also diagnosed with lumbar lordosis. In June of 1999 petitioner underwent a lumbar fusion for his spinal stenosis, performed by Dr. Pineda and Dr. Russell.

In 2000, on 2/4/00 and 2/16/00 petitioner told Dr. Pineda and Dr. Russell, respectively, that he was doing well until he took a fall on the ice and experienced more back pain and radiating pain. He also had decreased range of lumbar spine motion His diagnosis remained spinal stenosis. He was continued off work due to ongoing back pain. On 3/14/00 petitioner continued with complaints of back and leg pain and was diagnosed with a kidney tumor and colon problems. He was continued off work. On 3/31/00 petitioner still complained of back and leg pain and was diagnosed with a disc herniation at L3-L4. On 4/3/00 petitioner was released to return to regular duty. On 7/9/00 petitioner presented to Memorial Medical Center following a motor vehicle accident where petitioner was struck from behind by a vehicle going 40 miles an hour. Petitioner complained of

neck and lower back pain, as well as some mild discomfort in the posterior aspect of his right leg. He was assessed with a cervical and lumbar strain.

On 7/24/00 petitioner was examined by Dr. Wagner. Petitioner gave a history of injuring his back in 1991 and undergoing a laminectomy in 1994. In June 1999 petitioner stated that he had a spinal fusion with instrumentation and continued to have low back pain following that. Petitioner also described an injury to his left shoulder. Petitioner complained of pain on a daily basis in his back which was quite severe. He also complained of a burning sensation on the right, especially in the area of the donor site on the right leg. He stated that he had been using a cane for at least the last six months. Dr. Wagner was of the opinion that petitioner had evidence of a lumbar stenosis and an injury in 1991. He opined that lumbar stenosis is a progressive problem that will continue to progress irrespective of petitioner's activities. Dr. Wagner did not believe petitioner's stenosis was related to an injury at work. Petitioner complained of a burning sensation on the left that would radiate to the left ankle.

On 7/26/00 petitioner told Dr. Russell that he had pain centering around both sides of his neck, extending into the upper shoulders, and complaints of a severe headache. He also complained of exacerbating his back pain, and aching legs. Dr. Russell believed petitioner suffered a cervical strain. Petitioner was taken off work due to back pain and depression. On 8/22/00 petitioner reported to Dr. Russell that he still had occasional neck and shoulder discomfort. Dr. Russell believed petitioner had reached maximum medical improvement. Dr. Russell concurred with petitioner's plans to try and obtain disability, since he did not believe that petitioner would ever be going back to a position that required any significant lifting, standing, or bending.

On 2/13/01 petitioner complained of some numbness in his left arm to Dr. Russell. He was felt to have a pinched nerve in his neck. Dr. Russell did not believe petitioner was going to be employable. On 3/27/01 petitioner told Dr. Russell that he had been denied disability on several occasions. He had complaints of some neck pain and had a very mild C6 radiculopathy, that Dr. Russell believed was due to degenerative spondylosis. On 4/2/01 petitioner presented to Dr. Korda. It was noted that petitioner's neck and shoulders ached. It was noted that for the last 4 to 5 years petitioner's had severe low back pain and could not walk with anything except a cane. It was also noted that petitioner's left leg was weak, and he was dragging it. On 5/8/01 petitioner called Dr. Russell reporting that he was having trouble with his back, neck, and shoulders. On 6/5/01 petitioner called Dr. Russell asking for a script stating that he was unable to work. Dr. Russell gave it to him. On 7/20/01 petitioner complained of some neck and radiating pain proximally into the left arm, and some pain into the left hip and proximally into the leg. Dr. Russell again filled out petitioner's disability forms. On 8/10/01 Dr. Russell gave petitioner a script restricting him from lifting greater than 30 pounds, and being able to get out and

stretch after an hour of driving. On 11/5/01 petitioner again presented to the emergency room at Memorial Medical Center following another motor vehicle accident. Petitioner struck his head on the back window of his pickup truck. He complained of some neck pain and back pain, as well as a headache. He was assessed with a paraclavicular/lumbar strain. On 12/29/01 petitioner presented to Dr. Pineda complaining of a lot of focal back pain and neck pain following a car accident on or about 11/2/01. He complained of improved back pain with some leg pain in his right leg and his left heel. He also complained of a lot of neck pain since the accident and some radiating pain towards his shoulder.

On 12/31/01 petitioner underwent an MRI of the lumbar spine that showed posterior lumbar interbody fusion at L3 and at L4 with laminectomy at these levels. No central canal stenosis was noted. There were suggestions of diffuse disc bulge at L4–L5 and at L2–L3. Also noted was mild central canal stenosis, and possibly some foraminal narrowing bilaterally at L4–L5, greater on the right. That same day petitioner underwent an MRI of the cervical spine that revealed degenerative endplate and osteophytic changes at C6–C7 and C7–T,1 possibly resulting in some degree of foraminal stenosis, greater on the left. Also noted was mild bulging discs at C4–C5 and at C6–C7.

On 4/3/02 petitioner underwent an EMG/NCV of his lower limbs that showed evidence of chronic poly radiculopathy in the L3 and L4 distribution on the right side. On 4/15/02 petitioner underwent an L4–L5 foraminal epidural steroid injection. On 5/9/02 petitioner underwent a cervical epidural steroid injection. Dr. Narla performed these injections for petitioner's cervical pain with left-sided radiculopathy secondary to C6–C7 disc and osteophyte producing cervical stenosis, as well as chronic back pain with right-sided radiculopathy, and status post lumbar laminectomy and fusion, L2 through L4. On 12/14/02 petitioner was diagnosed by Dr. Narla with worsening cervical pain with left-sided radiculopathy, and progressive lumbar back pain with bilateral lower limb numbness. On 12/24/02 petitioner underwent an MRI of the cervical spine and lumbar spine that showed spondylitic disease at C6-C7 with mild central and bilateral neural foraminal stenosis and some left sided uncovertebral disease causing left foraminal narrowing at C4-C5. Also noted were post-operative changes with transpediculate screw fixation at L3-L4, diffuse herniation at L2-L3, and residual recurrent diffuse bulging disc asymmetric to the right at L3-L4 and L4-L5. The results also revealed underlying developmental lumbar spinal stenosis. On 12/30/02 petitioner was seen by Dr. Narla who diagnosed him with chronic cervical pain with left-sided radiculopathy, and chronic low back pain with bilateral radiculopathy.

On 1/8/03 petitioner underwent an EMG and nerve conduction studies of the lower limbs. The results revealed evidence of chronic radiculopathy in the L3–L4 distribution and evidence possibly suggesting that there was definite irritation of the L3–L4 nerve roots on the right side. The results were suggestive of an acute

denervation, that was not seen before. That same day, Dr. Fortin indicated that petitioner was taking fetanyl patches and Zanaflex. On 1/27/03 petitioner underwent a cervical epidural steroid injection. On 2/14/03 petitioner underwent an L4–L5 right sided epidural steroid injection. On 9/11/03 Dr. Smucker noted that petitioner had a long-standing history of low back problems. Petitioner complained of low back pain, as well as pain and discomfort in his right buttock and thigh. Dr. Smucker assessed suspect right lumbar radiculopathy, status post lumbar fusion, now with angulation at L3–L4, and peroneal neuropathy on the right side. On 10/2/03 petitioner underwent an L4–L5 lumbar epidural steroid injection on the right side. Dr. Narla performed these injections for petitioner's cervical pain, left sided radiculopathy secondary to C6 – C7 disc and osteophytic complex producing stenosis, chronic back pain with right sided radiculopathy, and status post laminectomy and fusion at L3–L4.

In 2004 petitioner underwent a carpal tunnel decompression on the right. On 3/24/04 petitioner underwent an L4–L5 right sided interlaminar approach epidural steroid injection. On 10/14/04 petitioner underwent an L4–L5 right sided interlaminar approach epidural steroid injection. On 12/24/04 petitioner underwent an L4–L5 right sided intra-laminar-approach epidural steroid injection. Dr. Narla performed these injections due to petitioner's chronic lumbar back pain, bilateral radiculopathy, and status post L3–L4 lumbar laminectomy and fusion in the past.

On 9/27/04 petitioner presented to Dr. Pineda complaining of a recent flareup of his back pain with pain radiating into his back and right buttocks. On 10/6/04 Dr. Bansal drafted a letter to respondent after performing a review of the Job Site Evaluation on 9/29/04, and Functional Capacity Evaluation completed on 9/14/04 and 9/15/04. He opined that petitioner was currently unable to fully meet all the physical requirements of a laborer/truck driver. Petitioner presented to the Functional Capacity Evaluation with chronic low back pain and was status post lumbar fusion in June 1999. Petitioner performed at approximately a light physical demand level, which was below the required demand level for performance of full job duties as listed by his written job description.

On 10/8/04 petitioner followed up with Dr. Narla for his chronic cervical pain with left-sided radiculopathy and chronic lumbar back pain with bilateral radiculopathy. Dr. Narla noted that petitioner was on an increased dose of fetanyl which did not make a significant difference. Petitioner was also on Norco at that time. Dr. Narla recommended some physical therapy and back strengthening exercises. Dr. Narla noted that petitioner's MRI of the lumbar spine showed a diffuse herniation at L2–L3 and a residual or recurrent disc bulge asymmetric to the right at the L3–L4 and L4–L5 levels. Also noted was lumbar stenosis at the same levels.

On 10/28/04 petitioner followed up with Dr. Narla. Petitioner was asking to be returned to full duty work. Dr. Narla noted that the FCE of 9/16/04 was very clear that petitioner was only performing at approximately the light physical demand level, which is below the required demand level of his job. Petitioner told Dr. Narla that he had been doing his regular job without any restrictions. Dr. Narla was of the opinion that petitioner would need a repeat FCE before he would allow him to go back to work full duty.

Petitioner was off work in the fall of 2004 up until a repeat functional capacity evaluation was done on 12/7/04 that finally allowed him to go back to work. On 12/23/04 petitioner underwent an epidural steroid injection to his lumbar spine. At that time he was still using fetanyl patches and was taking narcotics. Petitioner testified that he never took medication while he was at work. He stated that he never went to work under the influence of medication.

On 1/11/05 petitioner had been back to work for one month. While petitioner was performing his work duties on 1/11/05 he sustained an injury. On 1/11/05 petitioner was assigned the job of picking up Christmas trees from the curbs of City residents. Petitioner spent the day picking up Christmas trees and throwing them into the truck over the truck sideboard that was about 7 feet high from the ground. Prior to the injury petitioner testified that he had picked up and thrown into the truck between 65-70 trees. When petitioner was picking up a tree he grabbed the branches with his left hand, and the base with his right hand. As he threw the tree over the side board it bounced back towards him. Petitioner alleges that he turned his neck to the left and twisted his back. He alleged that the tree struck him in the right side of his neck and right shoulder. Petitioner let the tree fall and called for the grapple truck to come pick it up. Petitioner also testified at trial that he felt a pop in his low back when he twisted.

Following the injury, petitioner returned to the garage and completed an incident report. Petitioner completed a "City of Springfield Risk Management Employee's Accident/Injury Report". He reported an accident on 1/11/05 at 1:00 pm. at Mossman and Park Ave. He indicated that he injured his right arm and shoulder. He wrote that "I stopped to pickup Christmas tree and lifted it over my head to throw on truck but it fell back and hit the ground." Petitioner testified that he also reported the accident verbally to Dan Wavering, the supervisor. He stated that he gave him a detailed explanation. He testified that he told Wavering what happened when the tree fell, including the twist and pop in his back. Petitioner completed the rest of the work day. Petitioner did not call Waverling as a witness.

Petitioner returned to work the next day. He stated that the work was hard that day and he had difficulty getting up out of bed. He testified that he had a lot more pain in his neck, right shoulder, low back, and legs. Petitioner testified that he had difficulty doing his assigned job. Petitioner testified that when he came back to

the garage to get a piece of equipment Wavering was in his office, and invited him in. He testified that they talked about his pain. He also testified that Wavering asked him if he could finish the day, and he said he could. Petitioner testified that Wavering told him to take off after that and go see a doctor.

Petitioner testified that he tried to get in to see Dr. Russell, who he had seen before, and could not get in for a couple months. As a result, he asked respondent to assist him with a referral. Petitioner testified that although he had problems with his neck and low back prior to 1/11/05, his pain scale for both his neck and low back was a 2/3 on a scale of 10.

On 1/18/05 petitioner presented to Dr. Bansal. He reported that on 1/11/05 he was lifting up Christmas trees to throw over the side of a tandem truck when the tree fell back on him, jerking his right arm. He reported considerable pain in his cervical neck area, trapezius area, and right upper arm. He reported that lifting or raising his arm overhead aggravated his pain. He reported numbness and tingling in his right hand. He made no mention of an low back complaints. Dr. Bansal assessed cervical neck pain and trapezius pain. He referred petitioner to Dr. Smucker. X-rays of the cervical spine revealed degenerative disc disease most notable at the C6–C7 level, and lesser at the C5–C6 level.

On 1/19/05 petitioner presented to Dr. Smucker, at the request of Dr. Bansal, regarding neck and arm pain. Petitioner gave a history that on 1/11/05 while he was working for respondent, he was lifting a Christmas tree out of someone's yard. As he was doing this, the weight of the tree overcame him, pulling down his right arm, causing neck and shoulder pain, with sharp radiation into the right arm. He stated that his condition had not improved over the weeks since the injury. He made mention of any low back pain. Dr. Smucker examined petitioner. His impression was cervical strain/sprain, and possible right upper extremity radiculopathy. Dr. Smucker ordered x-rays, and an MRI of the cervical spine. He also prescribed physical therapy. He ordered an EMG of the right upper extremity. He restricted petitioner to no overhead work.

On 1/24/05 petitioner followed up with his primary care physician Dr. Hansen. Petitioner complained of neck and right arm pain. He made no mention of any low back complaints.

On 1/27/05 petitioner underwent an MRI of the cervical spine. The impression was degenerative changes that included moderate central disc bulges at C3–C4 and C4–C5; minimal diffuse disc bulge at C5– 6; and large diffuse disc bulge at C6–C7. Petitioner made no complaints regarding his lumbar spine.

Beginning in late January 2005 petitioner began a course of physical therapy at Progressive Wellness. Petitioner made complaints of neck and right arm pain. He made no complaints regarding his low back. On 2/9/05 the therapist at Progressive Wellness Center, Aly, noted in a report that petitioner reported no

improvement with physical therapy treatment. However, Aly noted that petitioner demonstrated very significant objective improvements in his cervical range of motion. When Aly tried to modify the treatment because petitioner was not reporting any improvement, he refused. Petitioner asked Aly to prescribe the fetanyl patch. Aly said that the petitioner seemed disappointed when she told him his range of motion was improving.

On 2/10/05 petitioner returned to Dr. Smucker. Dr. Smucker noted that petitioner underwent an EMG/NCS that revealed an acute right C7 radiculopathy. Petitioner stated that his right arm was weak and he was experiencing pain in his neck, radiating through the shoulder and diffusely into the right upper extremity. He made no mention of any low back complaints. Dr. Smucker's impression was an acute right C7 radiculopathy. Dr. Smucker recommended that physical therapy be put on hold and petitioner initiate cervical epidural steroid injections. Petitioner was released to return to work with no overhead work.

On 2/17/05 petitioner underwent a right C7–T1 translaminar epidural steroid injection performed by Dr. Smucker. Petitioner told Dr. Smucker that the injection only gave him very transient relief. Dr. Smucker referred petitioner to Dr. Russell for a surgical consult. On 3/14/05 Dr. Smucker released petitioner to full duty work without restrictions. Petitioner made no mention of any low back complaints.

Petitioner had a history of being suspended by respondent on three separate occasions for a total of 13 days before he was terminated on 3/28/05. Petitioner was suspended from 4/24/02 through 4/30/02 for leaving the work place in a work vehicle for personal reasons without permission. Petitioner claimed that he was needed at the school for his son. Respondent called the school and they had no record of petitioner signing in at the school. Petitioner was suspended from 6/1/04 through 6/3/04 after being in an accident and hitting a Chevy van with respondent's truck. The Accident Review Committee for the Department of Public Works deemed the accident as being "avoidable". It was noted that petitioner had been involved in 8 accidents over the past three years in a City vehicle. Petitioner was suspended from 11/30/04 through 12/6/04 for leaving his work location (home) without permission during work hours.

Petitioner presented to the Medical Offices of Dr. Bansal, and had a conversation with Dr. Bansal that turned very loud on occasion. He also used his index finger to strongly tap the desk while trying to get his point across to Dr. Bansal on several occasions.

On 3/23/05 petitioner was involved in an accident in the vicinity of Monroe/College, involving a City vehicle. Petitioner rear-ended another vehicle, and was ticketed for failure to reduce speed. This brought petitioner's accidents in City owned vehicles to 9 since 8/24/01.

On 3/28/05 petitioner, at the direction of Dennis McDaniels, was working in the garage sweeping up the floor. Petitioner swept the debris into piles. He testified that he could not bend over to sweep up the debris because of restrictions he had from the doctor. He testified that he then called a street sweeper to come sweep it up. Mike Palazzolo, Superintendent of Auto Maintenance, had supervision over the garage and those working it in, including petitioner on 3/28/05. Palazzolo asked petitioner twice to sweep up the piles of debris and he declined. Both petitioner and Palazzolo alleged that the other spoke in an inappropriate tone. Palazzolo testified that the City has 5 street sweepers, 2 of which were broken, and 3 of which were out on the streets and not expected to return until the end of the shift. Palazzolo testified that he told petitioner he could either pick up the debris as directed or punch out and go home. Palazzolo testified that petitioner told him he did not work for him and walked out. He reported the incident to petitioner's supervisor , Joe Greer.

On 4/5/05 petitioner presented to Dr. Brian Russell. Petitioner had treated with Dr. Russell prior to the injury on 1/11/05. Petitioner gave a history of loading a Christmas tree into a truck when it got caught and he strained his neck and his shoulder. Petitioner reported right sided neck and right-sided arm pain since the injury. Petitioner made no complaints of any low back pain. Dr. Russell performed an examination and reviewed an MRI scan that showed some degenerative changes in petitioner's cervical spine, worse at the C5–C6 and C6 C7 level. He ordered a cervical myelogram and CT scan.

On 4/20/05 petitioner was discharged by respondent as a result of his 9 accidents causing damage to both City vehicles and other driver's vehicles, as well as his suspensions for misconduct in which progressive discipline had not resulted in petitioner demonstrating corrective action to improve his job performance.

On 4/22/05 petitioner underwent a cervical myelogram. The impression was that the study was limited somewhat by an artifact caused by the size of petitioner's shoulders, and the fact that petitioner could not tolerate the conventional radiographic imaging. The images demonstrated the cervical spine canal to be relatively narrow on a developmental basis. There was significant superimposed multilevel degenerative disc disease and spondylosis worst at C6–C7.

On 5/4/05 petitioner presented to the emergency room at Memorial Medical Center. Petitioner reported that he jammed his finger last night while going after a ball while playing basketball. Swelling was noted to petitioner's left thumb and into his hand. Petitioner was discharged in stable condition. He was assessed with a sprain of the finger.

On 5/10/05 petitioner returned to Dr. Russell. Dr. Russell was of the opinion that with petitioner's history of neck problems, back problems and a history of kidney cancer, that he was not sure that petitioner was going

to be able to return to full duty. Dr. Russell talked about neck surgery and what it would entail. On 6/7/05 petitioner underwent an MRI of the lumbar spine. The impression was mild retrolisthesis at L4–L5 with interval development of mild diffuse disc bulge at this level compared with 2001. Also noted was a more focal component of disc protrusion/asymmetric disc bulge right posteriolaterally at L4 – L5 resulting in moderate to severe right lateral recess stenosis. Persistent moderate to severe spinal canal stenosis at L2–L3 was noted which appeared slightly more progressed when compared with 2001. On 6/29/05 petitioner returned to Dr. Russell complaining of worsening low back pain. At that time, Dr. Russell reviewed an MRI from earlier that month. It showed moderate to severe spinal stenosis related to facet arthritis, mild disc bulge at the L3–L4 level, and canals widely patent. At L4–L5 there was a disc bulge which had not progressed compared to the previous MRI.

On 7/26/05 Dr. Russell drafted a letter to petitioner's attorney, Mark Wells, in response to a letter Wells sent him dated 6/28/05 requesting information on petitioner. Dr. Russell noted that petitioner was an old patient of his who he had previously seen and performed a lumbar fusion on. He noted that petitioner had a chronic, long-standing history of back pain, characterized by exacerbations, usually with heavy activity. He noted that he saw petitioner in the spring of 2005, after he injured himself lifting a heavy Christmas tree. Dr. Russell noted that petitioner carries a diagnosis of cervical degenerative disc disease, cervical spondylosis, as well as degenerative disc disease and spondylosis involving his lumbar spine. Dr. Russell was of the opinion that petitioner's condition was primarily one that was degenerative in nature. He wrote that aggravations of this condition are usually brought on by lifting, bending, and twisting types of activities, such as the episode that he described while working for the city. Dr. Russell was of the opinion that because of the extensive degenerative changes that petitioner displays both in his cervical and lumbar spine, he did not believe that petitioner was going to be able to work in a position that requires heavy physical and manual labor. He believed that if petitioner continued to do so he would have additional exacerbations in both his neck and lumbar spine requiring time off of work, and possibly even leading to additional surgery. Dr. Russell was of the opinion that petitioner's current reason for being off work was related to the extensive degenerative condition in his spine, both cervical and lumbar.

On 7/18/05 petitioner presented to Dr. Jung who examined him and assessed a lumbar degenerative disc disease status post lumbar fusion, and lumbar spondylolisthesis and lumbar disc bulging. On 8/1/05 and 9/21/05 petitioner underwent a right sided L4-L5 interlaminar epidural steroid injections performed by Dr. Jung. On 10/25/05 petitioner underwent EMG nerve conduction studies of both lower limbs. The impression was a chronic right sided L4 radiculopathy. On 11/14/05 petitioner underwent a CDL physical examination for

employment with Illinois Department of Transportation as a maintenance worker. The physical exam results showed that petitioner appeared fully capable of meeting the job requirements with minimal risk of injury. He was given a DOT certification for one year. Petitioner testified that the CDL allowed him to drive large trucks. He stated that he did not apply for any truck driving jobs.

On 1/24/06 Dr. Narla performed an L4 L5 interlaminal approach right sided epidural steroid injection. On 3/1/06 petitioner returned to Dr. Russell. In the interim he had undergone an EMG which suggested some chronic right-sided L4 root irritation. Petitioner was using a narcotic patch at the time. On 3/14/06 Dr. Narla performed a C6-C7 cervical epidural steroid injection.

On 6/9/06 Dr. Russell saw petitioner again. Petitioner continued to have chronic pain in his back; leg pain; pain in his hands, wrists, and shoulders; generalized weakness, and good strength in his upper extremities: and normal motion of his neck. Petitioner stated that at times his legs give out. Dr. Russell was optimistic about surgery helping petitioner. He referred petitioner back to Dr. Narla for pain management. On 6/29/06 Dr. Narla performed an L4-L5 interlaminar approach epidural steroid injection. On 7/25/06 petitioner underwent a C6-C7 epidural steroid injection performed by Dr. Narla. On 8/29/06 Dr. Russell prescribed a cane for petitioner. On 8/31/06 Dr. Narla performed an L4–L5 right-sided interlaminar approach epidural steroid injection.

On 11/17/06 petitioner underwent an MRI of the lumbar spine. The impression was postoperative changes; possible large central and right lateral disc herniation at L4-L5; and image degradation secondary to screw fixation. That same day petitioner underwent an MRI of the cervical spine that revealed mild to moderate diffuse disc bulge at C3–C4; moderate central focal disc bulge at C4 C5; mild diffuse disc bulge at C5 C6; and a new moderate central disc protrusion and posterior osteophyte formation when compared to the 4/22/05 MRI of the cervical spine. On 12/19/06 petitioner returned to Dr. Russell. He complained of intermittent pain in both arms, and worsening degenerative changes at C6-C7, and L4-L5. Petitioner stated that it felt like his neck was bothering him more at that time than his low back was. Dr. Russell was still a little hesitant recommending any surgery. He referred petitioner for a EMG, and referred him to Dr. Pineda for his low back problems. He also ordered a repeat myelogram that showed spinal stenosis at L4–L5, and moderate disc bulges at the L2-L3 and L3-L4 levels.

On 1/16/07 petitioner underwent a CT of the lumbar spine. The impression was postsurgical changes, spinal stenosis at L4-L5, and moderate disc bulges at L2-L3 and L3–L4.

On 2/22/07, petitioner underwent a decompression at L4 – L5 and an extended fusion. Dr. Russell performed the surgery to decompress the nerves in the low back in attempt to relieve some of petitioner's symptoms. Dr. Russell was of the opinion that the surgery was a success for a while. Petitioner continued to follow up with Dr. Russell.

On 4/4/07 petitioner underwent a CT scan of his cervical spine. The impression was degenerative changes with foraminal compromise at C6-C7. On 7/10/07 Dr. Russell reviewed MRI scans of petitioner cervical spine that were performed on 6/25/07. They showed that at the C6-C7 level petitioner had some posterior end plate hypertrophy, chronic disc changes, and bilateral foraminal narrowing worse on the left, but no spinal cord impingement. On 10/24/07 Dr. Russell again talked about cervical spine surgery with petitioner that consisted of an anterior cervical discectomy and interbody fusion.

On 10/3/07 petitioner underwent an anterior cervical discectomy and interbody fusion performed by Dr. Russell. Dr. Russell performed this procedure to decompress the nerves and try to improve petitioner's arm pain. Petitioner followed-up postoperatively with Dr. Russell. At first, it looked like he was doing pretty well. An MRI of the cervical spine taken 11/5/07 revealed degenerative changes with foraminal compromise at C6–C7.

On 11/13/07 petitioner underwent a Section 12 examination by Dr. Martin Lanoff, at the request of the respondent. Dr. Lanoff performed a record review. He also performed a physical examination. Petitioner gave a history of lifting a Christmas tree, when it fell back and it knocked into him. He stated that he twisted at the time. He reported that a coworker came to help him and knocked him to the ground as well. Petitioner reported that he had pain within one week of the accident. Petitioner stated that he underwent a fusion to his lumbar spine in June 1999, and was fully functional prior to the injury on 1/11/05, and 70% improved. Dr. Lanoff noted that the medical records show that petitioner was taking a significant amount of medication prior to the injury on 1/11/05. Although the medical records indicate the opposite, petitioner denied any history of cervical discomfort before 1/11/05. Petitioner stated that the fusion in February 2007 helped somewhat. Petitioner stated that he had been on disability since 2006. Petitioner told Dr. Lanoff that he had been married for seven years with two children aged 19 and 18. He reported that the epidural injections into his cervical and lumbar spine did not help much. Dr. Lanoff noted 5/5 Waddell's findings on examination. Dr. Lanoff did not believe petitioner was an operative candidate. Dr. Lanoff was of the opinion that there is no diagnosis for petitioner except that his subjective complaints are out of proportion to the objective findings. He was of the opinion that petitioner may have had a mild soft tissue injury of the cervical spine that should've improved within 6 to 8 weeks following the accident in January 2005, with or without treatment. He opined that petitioner has a

significant pre-existing chronic pain situation, which is more likely the explanation for his ongoing symptoms. He opined that petitioner has no disability whatsoever from any work related injury. Dr. Lanoff was of the opinion that any possible disability would be due to a pre-existing condition. Dr. Lanoff did not believe petitioner sustained a lumbar injury as a result of the injury in January 2005. He related all petitioner's lumbar complaints to his pre-existing condition. Dr. Lanoff was of the opinion that petitioner should be released to full, unrestricted duty at maximum medical improvement as a result of the accident in January 2005. He opined that all restrictions and problems of petitioner's lumbar spine are related to his pre-existing condition.

On 1/9/08 petitioner filed his Application for Adjustment of Claim with respect to his alleged injury on 1/11/05. He alleged injuries to his shoulder, back and neck "throwing Christmas trees into back of truck, tree fell off hitting shoulder". Petitioner alleged injuries to his shoulder, back and neck. Petitioner put down on the Application that he signed the Application on 1/19/05, despite the fact that it was not filed for three more years.

On 2/19/08 petitioner followed up with Dr. Russell. Dr. Russell noted that petitioner was still experiencing some discomfort in his shoulder, specifically the left. Dr. Russell recommended a MRI of the shoulder. On 2/27/08 petitioner underwent an MRI of the left shoulder. The impression was supraspinatus tendinosis; tendinosis of the intra-articular biceps tendon; osteoarthritis of the glenohumeral joint and acromioclavicular joint; and os acromiale.

On 3/5/08 petitioner was discharged from physical therapy after canceling his last four appointments. On 4/29/08 petitioner returned to Dr. Russell and was doing pretty well. He stated that his back bothered him, and he had pain in his hips, and some weakness in his legs. Dr. Russell reviewed the MRI of the left shoulder that appeared to show some tendinitis in the rotator cuff and biceps tendon. Dr. Russell recommended a short dose of steroids for petitioner's low back.

On 5/15/08 petitioner presented to Dr. Western at the request of Dr. Russell for his left shoulder/arm pain. Petitioner gave a history of lifting a 100 pound Christmas tree, and after he threw it into the back of the truck it fell backwards towards him. He reported that he rotated his head away to try and have it avoid hitting him. He stated that it hit him on the side of the neck, head, and shoulder. Petitioner stated that in the past couple months everything has flared up on him. Dr. Western examined petitioner and assessed shoulder joint pain. Petitioner did not have any low back complaints.

On 8/15/08 petitioner returned to Dr. Russell and complained of persistent pain in the left shoulder, and pain in his low back radiating into the front of both thighs. That same day petitioner saw Dr. Narla who assessed lumbar disc degeneration and cervical brachial syndrome. Petitioner complained of persistent pain

radiating into the left shoulder, as well as lumbar back pain radiating into the front of the thighs. Petitioner was taking hydrocodone. On 9/9/08 petitioner reported that his knees were weak and achy. He complained of a knot in the center of his neck, and stated that his left arm was bugging him. He stated that his shoulder aches and he gets numbness and tingling in his left arm and hand. On 9/10/08 petitioner underwent an MRI of the lumbar spine. The impression was postsurgical and degenerative changes. Petitioner also underwent an MRI of the cervical spine that showed stable appearance of the cervical spine since 11/5/07 with mild canal stenosis at C4-C5.

On 6/16/09 petitioner returned to Dr. Russell complaining of pain just about everywhere, including his neck pain and shoulder discomfort. Dr. Russell ordered a repeat MRI of petitioner's lumbar spine. On 7/28/09 petitioner reported pain every day pulling across his neck and his arms. He stated that his balance was off and nothing really helps the pain. Dr. Russell noted some spinal stenosis at the L2 – L3 level. Dr. Russell was of the opinion that petitioner had an exacerbation of his symptoms, but still had good strength and told him to continue to keep exercising, and watch his lifting.

On 6/30/09 petitioner underwent an MRI of his lumbar spine that showed an L2–L3 moderate to severe stenosis along with disc bulge and facetal hypertrophy. The findings were very similar to the MRI on 9/10/08. On 8/31/09 petitioner complained to Dr. Narla of pain radiating down into both legs. He stated that he uses a cane for walking purposes. On 9/29/09 Dr. Narla performed a trial of an epidural injection at L2–L3. On 12/8/09 petitioner underwent another L2-L3 epidural steroid injection performed by Dr. Narla.

On 2/2/10 Dr. Narla performed a C6–C7 right-sided epidural steroid injection. On 2/23/10 petitioner underwent another L2–L3 left-sided epidural steroid injection performed by Dr. Narla. On 4/6/10 petitioner returned to Dr. Russell. He stated that his right shoulder hurt, and his knees were giving out on him. Petitioner reported some weakness anteriorly in the shoulder. Dr. Russell told petitioner to continue exercising, and undergo physical therapy. On 4/30/10 petitioner underwent an MRI of the cervical spine. The impression was postoperative changes at C6–C7, as well as multilevel degenerative changes, mildly advanced compared to the 2008 study. On 5/25/10 petitioner returned to Dr. Russell complaining of pain in both arms. He stated that it felt like he had a big knot in the back of his neck. He also had bilateral leg pain, worse on the left, and right thigh pain. Petitioner also had some left arm, and left shoulder discomfort. Dr. Russell was of the opinion that he was seeing a lot of the same symptoms. On 6/3/10 petitioner underwent an MRI of the lumbar spine. The impression was severe canal and foraminal stenosis at L2-L3, and postoperative changes from L3 to L5 with foraminal compromise severe at L4-L5. On 7/6/10 petitioner returned to Dr. Russell with results of the new MRI that showed stenosis at the L2–L3 level getting a little bit worse. Petitioner was using a cane at that time

and stated that it was hard for him to stand, or walk for an extended period. Dr. Russell recommended that petitioner hold off on any additional surgery. On 7/21/10 petitioner underwent an MRI of the right shoulder. The impression was high grade partial thickness tear of the supraspinatus tendon, superior/superior – posterior and posterior labral tear with parallel process, and acromioclavicular joint osteoarthritis. On 11/9/10 petitioner returned to Dr. Russell complaining of some chronic neck pain, chronic back problems, pain in the middle of his back, headaches, and hip difficulty. Petitioner complained that his back seemed to be bothering him the worse.

On 11/8/10 petitioner underwent a Section 12 examination performed by Dr. David Fletcher. Petitioner completed a medical history questionnaire and a pain drawing. A mental status screening examination was performed. Additional observations, measurements, and tests were also performed. The medical and social histories were reviewed. Petitioner reported that his symptoms first began to develop on 1/11/05. He reported an injury lifting a Christmas tree and tossing it into a tandem truck on 1/11/05. He stated that a tree got caught in the sideboards and fell back down on his neck and shoulders. He reported that he twisted his body when this occurred and he felt a pop within his low back. He complained of considerable cervical, trapezius, and right upper arm pain. He also complained of numbness and tingling in his right hand. He described his level of pain when first injured as a 10. He rated his current pain as an 8. Dr. Fletcher noted that the medical records showed that petitioner had a lumbar fusion and acute peroneal neuropathy at the fibular head in September 2003, and a second lumbar fusion in February 2007. He also noted that petitioner had an anterior cervical discectomy and interbody fusion at C6 C7 in December 2007. Petitioner reported that he uses a cane every day, all day, and uses a tens unit three times per week. Petitioner was grossly neurologically intact on examination. Dr. Fletcher performed a functional capacity evaluation and determined that petitioner was currently working with in the light physical demand level. He noted pain behaviors intermittently throughout the testing. He felt that restrictions of occasional lift limit of 20 pounds, with limited bending were appropriate. He also believed that petitioner would benefit from being able to sit/stand as needed, and should avoid squatting. He recommended a home exercise program for core strengthening and lumbar stability. Dr. Fletcher did not believe that any further treatment was going to bring petitioner back to full duty for respondent. Dr. Fletcher diagnosed cervical radiculopathy, lumbar radiculopathy, status post cervical fusion, and status post lumbar fusion. Dr. Fletcher believed petitioner had reached maximum medical improvement. Dr. Fletcher reviewed medical records from 1/11/05 through 2/7/08.

On 12/21/10 Dr. Narla performed an L2–L3 interlaminar approach epidural steroid injection.

On 2/8/11 petitioner last followed up with Dr. Russell before his deposition. Petitioner reported a lot of neck and back pain. He stated that he was using a cane. He complained of chronic back pain and chronic neck pain. Dr. Russell set him up for additional physical therapy. Petitioner continued to have good strength.

On 5/6/11 the evidence deposition of Dr. Russell was taken on behalf of petitioner. Dr. Russell opined that the trauma described by petitioner as occurring on 1/11/05 was sufficient to produce symptoms petitioner complained about with respect to his low back given the fact that petitioner had a severely degenerative back that was aggravated by the incident. Dr. Russell opined that the incident on 1/11/05 caused an increase or exacerbation in petitioner's low back symptoms. Dr. Russell opined that the reason he performed surgery on 2/22/07 was because of petitioner's pain. Dr. Russell opined that petitioner was going to continue to have chronic back problems and chronic neck problems into the future. Dr. Russell opined that based on the history petitioner provided concerning the injury on 1/11/05, that that incident was sufficient to produce the symptoms petitioner complained about with respect to his neck and right shoulder. Dr. Russell opined that the injury was also sufficient to aggravate petitioner's pre-existing cervical spondylosis. Dr. Russell opined that the injury on 1/11/05 increased petitioner's pre-existing symptoms in his cervical spine, and this increase in symptoms necessitated the surgical intervention he performed on petitioner's cervical spine on 12/3/07. Dr. Russell opined that the treatment he performed on petitioner's low back and cervical spine was reasonable and necessary. Dr. Russell was of the opinion that petitioner could work in a very sedentary level, with no lifting in excess of 10 or 15 pounds, and frequent position changes. Dr. Russell believed that these physical limitations would prevent petitioner from returning to work in any real fashion.

On cross-examination Dr. Russell stated that he had treated petitioner prior to 4/5/05, and had done two surgeries on petitioner's low back before that. Dr. Russell admitted that prior to 1/11/05 petitioner had chronic low back pain that was gradually and progressively getting worse. Dr. Russell testified that if his history or memory was incomplete, additional facts could or might change his opinions. Dr. Russell was of the opinion that since petitioner had had back surgery and decompression prior to January 2005, that he had leg complaints before that date. Dr. Russell testified that for as long as he has seen petitioner, petitioner has had chronic complaints. Dr. Russell was of the opinion that if he had referred to a pinched nerve in petitioner's neck, that could be due to the kind of stenosis he later discovered on an MRI. Dr. Russell recalled that on 3/27/01 he believed petitioner had cervical radiculopathy that was due to degenerative spondylosis. Dr. Russell recalled Dr. Narla doing cervical epidurals at C6-C7 for cervical pain, left-sided radiculopathy secondary to a C6–C7 disc and osteophytic complex producing stenosis after 2002, and was of the opinion that these findings were consistent with his findings subsequent to 1/11/05.

Dr. Russell opined that he would not be surprised that the MRIs of the cervical and lumbar regions done on 12/24/02 showed spondylitic disease at C6–C7 with the neural foraminal stenosis. Dr. Russell opined that what he found in 2005 was degenerative disc disease that involved the spine in both the lumbar and cervical regions. He further opined that this condition was already symptomatic and chronic prior to 1/11/05, and was getting progressively worse. Dr. Russell opined that petitioner's complaints of neck and left arm pain in 2003 were consistent with those that he had made after 1/11/05. Dr. Russell opined that petitioner was on fetanyl patches prior to 1/11/05. He further opined that for petitioner to have exacerbated his pre-existing symptoms he would've expected petitioner to have made complaints in the days and weeks immediately following the injury on 1/11/05. Dr. Russell opined that when he saw petitioner on 4/5/05 all petitioner did was tell him about his chronic back complaints. He opined that petitioner did not tell him that he exacerbated his back complaints as a result of the injury on 1/11/05.

Dr. Russell was of the opinion that petitioner has a congenitally narrow central canal. Dr. Russell was of the opinion that with degenerative disc disease it will gradually get worse over time, and even after surgery it will continue to worsen. Dr. Russell opined that as it progresses, as in petitioner's case, it gets to the point where normal activities of life make it symptomatic, and that is where it is with petitioner, and was probably there on 1/11/05. Dr. Russell opined that if on 5/4/05 petitioner was playing basketball, and the manner was not consistent with the game of HORSE or something of that sort, that would be inconsistent with what petitioner was telling him. Dr. Russell opined that petitioner has degenerative disease from one end of the spine to the other. Dr. Russell opined that this disease had been going on for at least 10+ years and getting worse. Dr. Russell agreed that petitioner did not tell him until 6/29/05 that he felt his low back injuries were due to the incident on 1/11/05. Dr. Russell testified that he was surprised that petitioner passed an exam for a commercial drivers license examination on 11/14/05 to be employed by the Illinois Department of Transportation as a highway maintenance worker. Dr. Russell opined that when petitioner first came to see him on 4/5/05 his pain was in his right arm, and not his left.

Dr. Russell opined that on 2/20/07 and on 12/3/07 the surgeries performed to petitioner's low back and cervical spine, respectively, were performed because of his progressive history of low back pain, neck pain, and left arm pain, and not because of any true radiculopathy. Dr. Russell opined that he could not make a causal connection between petitioner's left shoulder complaints and the accident on 1/11/05. Dr. Russell opined that when he saw petitioner on 6/16/09 that petitioner was on disability at that point, and not working.

Following Dr. Russell's deposition he continued to treat petitioner for his chronic neck and lumbar spine pain. Petitioner also continued to treat with Dr. Narla. On 6/3/11 Dr. Narla's impression was L2-L3 lumbar

canal stenosis producing left sided radiculopathy, that was helped by previous injections. He was also of the opinion that petitioner had cervical spondylosis with bilateral foraminal stenosis, that had only minimally progressed since the 2008 cervical MRI scan. He noted that it was helped by cervical epidural injections.

On 7/13/11 petitioner returned to Dr. Wottowa. He demonstrated full range of motion of both shoulders with positive impingement signs on the right, none of the left. Recent x-rays of his right shoulder were basically negative. Dr. Wottowa's impression was right shoulder rotator cuff tendinosis. He injected petitioner's right subacromial space. On 8/2/11 Dr. Narla performed an L2–L3 interlaminar approach, right to midline epidural steroid injection. On 8/23/11 Dr. Narla performed a C6–C7 left-sided epidural steroid injection.

On 5/15/12 petitioner returned to Dr. Russell. He was doing fairly well. He still had some pain, particularly in his right leg. A vascular surgeon ruled out vascular disease. Petitioner had good strength. He complained of some pain in his right elbow proximally into the right arm and shoulder. Dr. Russell suspected tendinitis. He ordered EMGs and nerve conduction studies. On 5/23/12 petitioner presented to Dr. Narla. His impression was that the nerve conduction studies of the upper limbs showed very borderline residual carpal tunnel compression on the right side, a mild cubital tunnel compression of the ulnar nerve on the right side involving both sensory and motor components, mostly demyelinating in nature. Dr. Narla performed an injection in the tennis elbow. On 6/13/12 petitioner returned to Dr. Narla having sharp pains in his lower back, shooting down to both of his legs. Dr. Narla was of the opinion that petitioner's pain was very similar to what he had before. He noted that since the injections had helped some before he decided to perform a left-sided L2–L3 lumbar epidural steroid injection on 6/26/12. He continued petitioner on the fetanyl patch and hydrocodone.

11/30/12 petitioner underwent a repeat MRI of his lumbar spine. The impression was marked multilevel degenerative changes most severe at L2–L3 with severe central canal stenosis associated to a focal kyphotic deformity in that region. This was noted as being unchanged when compared to prior examinations. On 12/18/12 petitioner underwent a cervical epidural injection at C6–C7 performed by Dr. Narla. On 1/7/13 petitioner underwent an MRI of the cervical spine that showed multilevel degenerative changes with no significant central canal stenosis. Multilevel moderate to severe neural foraminal encroachment was noted. On 4/17/13 petitioner returned to Dr. Russell with some complaints of neck and arm pain, as well as numbness. He still had good strength. Dr. Russell noted no acute radiculopathy, but did note diffuse degenerative changes. On 7/23/13 Dr. Narla performed a C6–C7 right-sided epidural injection. On 8/13/13 Dr. Narla performed a L2–L3 right-sided interlaminar approach epidural steroid injection. On 10/23/13 petitioner returned to Dr. Russell after repeat EMG's of both upper and lower extremities. Dr. Russell was of the opinion that most of petitioner symptoms would be coming from an ulnar neuropathy.

On 2/11/14 Dr. Narla performed another L2-L3 right-sided and intralaminar approach epidural injection. On 2/25/14 Dr. Narla performed a C6–C7 right-sided epidural injection. On 4/4/14 petitioner presented to Dr. Narla. He reported that six weeks ago he fell and had an ankle fracture on the right side. He stated that he was walking with a cane. He rated his pain as an 8/9 on a scale of 10. Petitioner stated that he had a hard fall and overall the pain in his back and neck had increased. He denied any radiating pain any greater than before. Dr. Narla's impression was cervical pain status post anterior discectomy and fusion at C6–C7; L2–L3 stenosis above the level of the fusion; and ankle fracture following a fall six weeks ago which needed internal fixation.

On 8/1/14 the evidence deposition of Dr. Fletcher was taken on behalf of petitioner. Dr. Fletcher specializes in occupational medicine. Dr. Fletcher was of the opinion that petitioner could not return to his job for respondent. Mr. Nessler, petitioner's attorney, stipulated that he sent petitioner to Dr. Fletcher, and respondent did not. Dr. Fletcher stated that he based his opinion in large part on the history given to him by petitioner, and if that history was incorrect or incomplete his opinions could change. Dr. Fletcher testified that he did not review the accident report. Dr. Fletcher stated that the materials he reviewed were provided to him by petitioner and his attorney, and he did not request any additional materials. Dr. Fletcher noted that petitioner was grossly neurologically intact when he examined him, and with the exception of range of motion his objective physical examination was normal. Dr. Fletcher testified that petitioner had some symptom magnification present when he saw him. Dr. Fletcher opined that in the months immediately following the January 11, 2005 incident petitioner did not make any low back complaints. He testified that petitioner did not make any low back complaints until approximately 6 months after the injury. Dr. Fletcher agreed that petitioner had had a chronic low back condition for a long time prior to the injury. Dr. Fletcher admitted that he did not review any medical records prior to 1/11/05. Dr. Fletcher testified that his opinions are based on the fact that petitioner told him he was doing well up until the injury on 1/11/05. Dr. Fletcher opined that if petitioner had aggravated his degenerative disc disease and stenosis in the lumbar area on 1/11/05 he would've expected low back complaints in the days or weeks immediately thereafter. Dr. Fletcher opined that based on the fact that petitioner was having epidural injections in late December 2004 and taking narcotics at that time, that would be inconsistent with petitioner doing well, as he reported. Dr. Fletcher had no knowledge of petitioner getting certified for a commercial drivers license in order to perform work for companies or entities using a heavy truck, but based on his examination in 2010, with the exception of the use of narcotic medication, petitioner was physically capable of doing this as long as he was able to get up and move out of the truck. Dr. Fletcher believed that prolonged sitting would be a concern. Dr. Fletcher testified that petitioner's claim that he was unable to bathe or do toileting tasks, required partial bed rest, and could not leave home without assistance, was not exactly how he appeared to him in his office that day. Dr. Fletcher opined that petitioner's pain ratings of 10

were consistent with his symptom magnification. He also noted that petitioner's pain drawing, that did not follow an anatomical pattern, was also an indication of symptom magnification. Dr. Fletcher noted that petitioner failed a number of validity reliability criteria during his testing. He identified seven of them. Dr. Fletcher testified that with the restrictions he gave petitioner, jobs that would be available included parking lot attendant, security person, and any kind of service job at a counter where you could sit or stand.

On 9/17/14 the evidence deposition of Dr. Lanoff was taken on behalf of respondent. Dr. Lanoff is certified in both physical medicine and rehabilitation physiatry, as well as pain medicine. Dr. Lanoff opined that the petitioner had pre-existing neck pain with left-sided radiculopathy prior to the injury on 1/11/05, for which he benefited from epidural steroid injections. Dr. Lanoff was of the opinion that petitioner's pre-existing neck pain was chronic, and he was on lots of very strong pain medication that included fetanyl patches and Norco prior to 1/11/05. He also noted that prior to the accident in January 2005 petitioner had two prior back surgeries that included a laminectomy and a fusion. Dr. Lanoff was of the opinion that petitioner had significant chronic low back pain before his injury on 1/11/05, but made no mention about any low back complaints. Petitioner talked about cervical trapezius and upper arm pain, as well as numbness and tingling in his hand. Dr. Lanoff noted that petitioner also did not have any complaints regarding his low back when he presented to Dr. Smucker on 1/19/05. Dr. Lanoff found the it significant that Dr. Smucker's report did not include any mention of the petitioner's considerable cervical history. Dr. Lanoff was of the opinion that the fact that petitioner did not make any mention of back pain to any of his treaters until 3 to 4 months after the injury on 1/11/05 supports a finding that it is much more likely that his complaints are related to his chronic low back pain and not an injury on 1/11/05.

Dr. Lanoff opined that petitioner's stenosis at L4-L5 and the central disk protrusion, as well as the related surgery were not related to the accident with the Christmas tree because there was no back injury, and petitioner did not note a worsening of his preexisting low back pain after the accident for a number of months, and had a negative MRI 5-6 months later. Dr. Lanoff opined that if petitioner needed cervical surgery after the accident, it was just progression of his preexisting chronic condition. Dr. Lanoff determined on examination many positive Waddel signs. Dr. Lanoff opined that petitioner did not need any further surgery. He further opined that as a result of the accident petitioner would have reached maximum medical improvement as it relates to his neck 6-8 weeks after the accident. He opined that petitioner did not sustain a low back injury as a result of the accident.

Petitioner testified that after he underwent surgery to his cervical spine after the injury on 1/11/05 he felt better, but then had a recurrence of pain in his neck 6 to 8 months after the surgery. Petitioner testified that after he underwent surgery to his lumbar spine after the injury on 1/11/05 he had a recurrence of back pain one year

after the surgery. Petitioner stated that currently has pain in his neck, shoulders, and low back. He stated that his range of motion in his neck is limited, and he can only turn his head 90° to both the left and the right. Petitioner stated that he feels pain when he turns his neck. With respect to his low back petitioner demonstrated that he could turn about 90° to the left, and a little less to the right. Petitioner reported that he felt pain when he rotates his low back. He denied this type of pain before 1/11/05. Petitioner admitted that he had restricted motion of his lumbar spine before 1/11/05 because of the surgery. However he said it was worse now. Petitioner testified that he is unable to bend over because he is limited as a result of the fusion and the pain in his legs. He testified that before the injury he was able to bend over. Petitioner testified that about four months before his surgery he began experiencing shooting pain and tingling in his legs when walking. He denied that the symptoms were present before 1/11/05. Petitioner testified that sometimes he needs help walking, and occasionally needs a cane. He stated that he uses his cane mostly around the house and when he feels weakness and shocking in his legs. Petitioner reported that he has good days and bad days. He stated that he did not need a cane before 1/11/05. Petitioner reported that he is worse today than he was a year ago.

Petitioner denied working for anyone else since he was terminated by respondent. Petitioner testified that he worked for respondent for 17 years and has no skills besides labor skills. Petitioner graduated from high school, but has no college. Petitioner testified that before working for respondent he was a security officer with American Savings bank for a few years. He also worked for the Secretary of State in maintenance before he got the security officer job. Petitioner does not feel that he could work maintenance today.

Petitioner rated the pain in his neck at a 7/10. He rated his back pain as a 9/10, but said the day of trial was a good day. Petitioner testified that he does not feel capable of performing the tasks he used to perform for respondent. Petitioner reported that his right shoulder was painful, and it gives him headaches.

Petitioner testified that he is still treating with Dr. Russell and Dr. Narla. He also testified that he still uses fetanyl patches and Norco, just like before the injury on 1/11/05.

F. IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY?

Petitioner claims that his current condition of ill-being as it relates to his lumbar spine, cervical spine, and right shoulder is causally related to the injury he sustained on 1/11/05. Respondent claims that petitioner only sustained a temporary aggravation of his preexisting cervical condition that resolved 6-8 weeks after the injury.

Prior to the accident on 1/11/05 petitioner had a very significant history of treatment to his cervical spine, lumbar spine and shoulder dating back to 1997. In 1991 petitioner injured his lumbar spine and in 1994 petitioner underwent a lumbar laminectony at L3-L4. On 2/18/97 petitioner was released to full duty work

without restrictions. On 5/15/98 petitioner had low back complaints. For this ESI's were recommended and petitioner was taken off work. A few weeks later he was released to light duty work with no lifting in excess of 25 pounds. He was diagnosed with spinal stenosis. His prognosis was only fair.

Petitioner's lumbar spine and spinal stenosis conditions worsened and he remained on light duty work. As a result, on 2/24/99 he was taken off work and in June of 1999 underwent a lumbar fusion for his spinal stenosis. This was performed by Dr. Pineda and Dr. Russell. In February of 2000, petitioner sustained another accident when he fell on the ice and experienced more back pain and radiating pain. He was continued off work and continued treating for his lumbar spine and spinal stenosis. In March of 2000 he was also assessed with a disc herniation at L3-L4.

On 4/3/00 petitioner was released to full duty work. Then on 7/900 he was in a motor vehicle accident and complained of cervical and lower back pain, as well as some mild discomfort in the posterior aspect of his right leg. He was assessed with a cervical and lumbar strain. In July of 2000 petitioner continued to complain of pain on a daily basis that was quite severe. He also complained of burning sensation on the right, and noted that he was using a cane. At that time Dr. Wagner opined that petitioner had lumbar stenosis, and that it was a progressive problem that would continue to progress irrespective of his activities. He opined that petitioner's stenosis was not related to his work.

On July of 2000 petitioner also complained of pain centering around both sides of his neck, extending into the upper shoulders. He also complained of exacerbating back pain and aching legs. Dr. Russell assessed a cervical strain. Petitioner was again taken off work for his back pain. In August 2000 petitioner reported occasional neck and shoulder discomfort. At this point petitioner was seeking disability and Dr. Russell concurred because he believed petitioner would never be able to go back to work in a position that required significant lifting, standing or bending. In February of 2001 Dr. Russell again reiterated that he did not believe petitioner was going to be employable. Petitioner had neck pain that Dr. Russell assessed was due to degenerative spondylosis. In April of 2001 petitioner complained of aching shoulders and neck. He also reported that he had severe low back pain and could not walk with anything except a cane. In May of 2001 petitioner again complained of trouble with his back, neck and shoulders. In June of 2001 petitioner asked Dr. Russell to take him off work, and Dr. Russell did. In July of 2001 Dr. Russell completed disability forms for petitioner with respect to his cervical spine and radiating pain into the left arm. In August of 2001 Dr. Russell restricted petitioner from lifting greater than 30 pounds and getting out of the truck to stretch after an hour of driving.

In November of 2001 petitioner had another motor vehicle accident. He complained of some neck pain and back pain. He was assessed with a paraclavicular/lumbar strain. In December of 2001 petitioner complained of a lot of focal back pain and neck pain following the motor vehicle accident.

Petitioner had a lumbar spine MRI in December of 2001 that showed posterior lumbar interbody fusion at L3 and at L4 with laminectomy at these levels. Diffuse disc bulges at L2-L3 and L4-L5 were also noted, as well as mild central canal stenosis, and possible foraminal narrowing bilaterally at L4-L5, greater on the right. An MRI of the cervical spine performed at the same time revealed degenerative endplate and osteophytic changes at C6-C7 andC7-T1, possibly resulting in some degree of foraminal stenosis, greater on the left. Mild disc bulges were also noted at C4-C5 and C6-C7. An EMG of the lower limbs done in April of 2002 showed evidence of chronic poly radiculopathy in the L3 and L4 distribution of the right side.

Thereafter, petitioner underwent epidural steroid injections to his lumbar spine on 4/15/02 , and to his cervical spine on 5/9/02. In December of 2002 Dr. Narla opined worsening of petitioner's cervical spine with left-sided radiculopathy, and progressive lumbar back pain with bilateral lower limb numbness. MRIs of the cervical and lumbar spine were taken, and Dr. Narla opined chronic cervical pain with left sided radiculopthy and chronic low back pain with bilateral radiculopathy. A repeat EMG of the lower limbs was performed in January 2003 that was similar to the one in April of 2002 with the addition of definite irritation of the L3-L4 nerve roots on the right side.

By this point in time, petitioner was using fetanyl patches and taking Zanaflex. More lumbar and epidural injections were performed in January and February of 2003. By September of 2003 Dr. Smucker diagnosed a long standing history of low back problems, based on petitioner's ongoing complaints of low back pain. He assessed suspect right lumbar radiculopathy. Additional ESI's were performed to petitioner's lumbar and cervical spine in October of 2003. An FCE performed in October of 2004 revealed that petitioner could perform work at the light physical demand level, which was below the required demand level for performance of his full duty job. Despite this Dr. Bansal opined that petitioner could return to his full duty job. Petitioner underwent 2 ESIs to his lumbar spine in October and December of 2004 after presenting to Dr. Pineda in September of 2004 complaining of another recent flareup of his back pain with pain radiating into his back and right buttocks.

Petitioner sought additional treatment for his chronic cervical spine pain with left-sided radiculopathy and chronic lumbar back pain with bilateral radiculopathy. At this time petitioner was on an increased dose of fetanyl and this was not making much difference. Petitioner was also taking Norco. Dr. Narla recommended physical therapy and back strengthening exercises at that time. He noted that petitioner's most recent MRI showed a diffuse herniation at L2-L3 and a residual or recurrent disc bulge asymmetric to the right at the L3-L4

and L4-L5 levels. Also noted was lumbar stenosis at these levels. Despite Dr. Narla's findings petitioner asked to be returned to full duty work. Dr. Narla noted that the FCE performed in September 2004 showed he was only performing at the light physical demand level, which did not meet the current demands of his job. Petitioner told Dr. Narla that despite these findings he had been doing his regular job without any restrictions. Dr. Narla would not release him to full duty without a repeat FCE. A repeat FCE done December of 2004 showed petitioner could return to full duty work. Despite this full duty release petitioner continued treating for his lumbar spine and underwent yet another ESI on 12/23/04, slightly more than just two weeks before his injury on 1/11/05. Additionally, at the time of the injury on 1/11/05 petitioner was still using fetanyl patches and taking narcotic medications.

After returning to work for only a month petitioner sustained an injury on 1/11/05, while throwing Christmas trees in a truck. Petitioner completed an incident report following the injury. He only alleged injuries to his right arm and shoulder. No mention was made of any injury to petitioner's lumbar or cervical spine.

Petitioner's first treatment following the injury was with Dr. Bansal on 1/18/05. He reported that he jerked his right arm while throwing trees into the truck on 1/11/05. He complained of pain in his cervical neck area, trapezius area and right upper arm. Petitioner made no complaints with respect to his lumbar spine. In fact petitioner made no complaints regarding his lumbar spine until 5/10/05, five months after the injury. Even when he voiced his complaints regarding his lumbar spine at that time he did not attribute them to the injury on 1/11/05. He did not do this until 6/29/05. When petitioner presented to Dr. Russell on 4/5/05 he only reported that he strained his neck and shoulder, and had right sided neck pain and arm pain since the injury. He made no mention of any lumbar spine injury as a result of that injury.

Based on this history Dr. Lanoff opined that petitioner did not sustain a lumbar injury a result of the injury in January of 2005. He related all of petitioner's lumbar complaints to his preexisting condition. He found it significant that petitioner made no mention of any worsening of his preexisting back complaints until months after the injury, and had a negative MRI of the lumbar spine 5-6 months after the injury.

The arbitrator finds it significant that Dr. Russell opined a causal connection between petitioner's injury and his current condition of ill-being as it relates to his lumbar spine despite petitioner making no mention of the injury on 1/11/05 causing him low back complaints when he presented to Dr. Russell on 4/5/05. Even Dr. Russell opined that petitioner made no mention that the low back complaints he had on 4/5/05 were related to the injury on 1/11/05. Additionally, the arbitrator finds it significant that Dr. Russell opined that in order for petitioner to have exacerbated his preexisting lumbar spine symptoms he would have expected petitioner to have

made complaints in the days and weeks immediately following the injury on 1/11/05, which petitioner did not. Dr. Russell further opined that petitioner's lumbar spine condition was already symptomatic and chronic prior to 1/11/05, was getting progressively worse, and petitioner was using fetanyl patches and narcotics to manage his pain at the time of the injury. For these reasons the arbitrator does not give much weight to Dr. Russell's opinions that petitioner's current condition of ill-being could be related to the injury on 1/11/05.

Another causal connection opinion between petitioner's lumbar spine and the injury on 1/11/05 was offered by Dr. Fletcher. Petitioner was referred to Dr. Fletcher's by his own attorney. Petitioner gave Dr. Fletcher a history of twisting his body and feeling a pop in his low back when he tossed a tree into the truck and it got caught in the sideboards and fell back down on his neck and shoulders. He also reported that he was doing well until the injury on 1/11/05, and had no lumbar spine complaints in the months leading up to the injury. Based on the credible evidence the arbitrator finds both of these histories inconsistent with the credible medical records. Additionally, the arbitrator finds it significant that Dr. Fletcher did not review any of medical records prior to 1/11/05, and noted that petitioner had some symptom magnification when he presented to him for evaluation and a pain drawing that did not follow an anatomical pattern. Dr. Fletcher opined that if petitioner had in fact aggravated his preexisting degenerative disc disease and stenosis in the lumbar area on 1/11/05 he would have expected low back complaints in the days and weeks immediately thereafter. However, the arbitrator finds no such complaints regarding his lumbar spine were made in this time frame, or for many more months. Dr. Fletcher was also of the opinion that petitioner's epidural steroid injection in December of 2004 and taking narcotics for his lumbar spine at the time of the injury on 1/11/05, would be inconsistent with the history petitioner provided him when he examined him, and said he was doing well before the injury on 1/11/05.

Based on the above, as well as the credible evidence the arbitrator finds the petitioner's current condition of ill-being as it relates to his lumbar spine is not causally connected to the injury he sustained on 1/11/05. The arbitrator bases this opinion on the fact that petitioner was actively treating for his low back since the early 1990's and continued actively treating for his low back as recently as weeks before the injury when he underwent an epidural steroid injection to his lumbar spine on 12/23/04 and was using high dose fetanyl patches and was taking narcotics for his pain at that time. Additionally, the arbitrator bases this finding on the fact that petitioner provided no history of injuring his low back on 1/11/05, and sought no treatment for his lumbar spine following the injury on 1/11/05 until months after the alleged injury. The arbitrator also bases this finding on the opinions of Dr. Lanoff, Dr. Fletcher, and Dr. Russell who opined that they would have expected petitioner to have low back complaints in the days and weeks following the injury if he had in fact aggravated his preexisting low back injury on 1/11/05, but no such complaints were made until months after the injury. Lastly, the

arbitrator bases this finding on the fact that petitioner did not make any mention of any low back complaints, or connection of the same to the alleged injury on 1/11/05 until after he was fired on 4/20/05.

Next, the arbitrator addressed the relationship between petitioner's current condition of ill-being as it relates to his cervical spine and hisright shoulder, and the accident on 1/11/05. As with his lumbar spine condition, petitioner had a significant history of treatment for his cervical spine dating back to 7/9/00 when he sustained an injury to his cervical spine following a motor vehicle accident wherein he was struck from behind by a vehicle going 40 miles per hour. His complaints continued and his first cervical MRI was in December of 2001 that showed disc bulging, degenerative endplate and osteophyte changes, and some foraminal stenosis. In 2002 he was diagnosed with chronic cervical pain with left-sided radiculopathy. When this condition did not improve petitioner underwent epidural steroid injections and treated as recently as 10/8/04 for his chronic cervical pain with left-sided radiculopathy. At that time petitioner was using fetanyl patches and narcotics for his chronic cervical spine condition.

Following the injury petitioner reported that he injured his right arm and shoulder when he completed his incident report on 1/11/05. When petitioner first sought treatment on 1/18/05 he reported that he jerked his right arm and he had considerable pain in his cervical neck area, trapezius area, and right upper arm. X-rays taken that day revealed degenerative disc disease at C5-C6 and C6-C7, worse at C6-C7. Petitioner's right arm and shoulder complaints continued and a repeat MRI of the cervical spine revealed disc bulges from C3-C7 and degenerative changes.

These findings were consistent with those on the MRI performed in 2001. Thereafter, petitioner underwent a course of physical therapy and by 2/9/05 it was noted that petitioner demonstrated very significant objective improvement in his cervical range of motion. Petitioner would not let the therapist modify the treatment and seemed disappointed that his range of motion was improving. An EMG performed 2/10/05 showed an acute right radiculopathy for which petitioner underwent ESIs. Petitioner reported transient relief.

On 3/23/05 petitioner was involved in an unrelated accident in respondent's vehicle. Petitioner rear-ended another vehicle.

On 4/5/05 Dr. Russell assessed a strain of petitioner's neck and right shoulder. On 5/10/05 Dr. Russell discussed what neck surgery would entail. In July 2005 Dr. Russell was of the opinion that petitioner's condition was primarily one that was degenerative in nature. He was of the opinion that petitioner's current reason for being off work was related to the extensive degenerative condition in his cervical and lumbar spine. He did not opine that it was due to the injury on 1/11/05.

On 11/4/05 petitioner underwent a CDL physical examination for employment with IDOT as a maintenance worker and was found fully capable of meeting the job requirements with minimal risk of injury. This certification allowed petitioner to drive large trucks.

Petitioner continued with periodic treatment for his cervical spine like he did before the injury on 1/11/05. This treatment included a cervical epidural steroid injections in March of 2006, and an MRI of the cervical spine in November of 2006 that showed progression of petitioner's degenerative cervical spine condition since 4/22/05. In 2007 petitioner's degenerative cervical condition showed continuing worsening degenerative changes and bilateral foraminal narrowing worse on the left, not the right. As a result of these changes petitioner underwent an anterior cervical fusion and interbody fusion to decompress the nerve. Following this surgery petitioner continued to treat for his left shoulder, not his right.

It was only after this surgery that petitioner filed his Application for Adjustment of Claim with respect to his injury on 1/11/05. Petitioner filed his Application on 1/9/08, almost three years after the injury.

In 2009 petitioner again resumed treating for his chronic cervical spine condition. This treatment included ESIs. In February of 2010, over five years after the injury, petitioner began treating for his right shoulder, and continued treating for his left shoulder.

Dr. Russell opined that history petitioner provided regarding the incident on 1/11/05 was sufficient to produce the symptoms complained about with respect to his neck and right shoulder, and sufficient to aggravate his preexisting cervical spondylosis. He further opined that any pinched nerve in petitioner's neck could be due to the stenosis on petitioner's MRI. He noted that on 3/27/01 he believed petitioner had cervical radiculopathy that was due to degenerative spondylosis, and petitioner treated for this condition after 1/11/05. Dr. Russell opined that his finding in 2005 was degenerative disc disease that was already symptomatic and chronic prior to 1/11/05 and was getting progressively worse. He opined that petitioner's complaints in left neck in 2003 were consistent with those after 1/11/05. Dr. Russell also opined that petitioner had a congenitally narrow central canal, and with this degenerative disease it will gradually get worse over time, and even after surgery will get worse, as it did in petitioner's case. Dr. Russell was also surprised that petitioner passed an exam for a commercial driver's license on 11/4/05, based on his subjective complaints. In 2012 Dr. Russell noted no acute radiculopathy but did note diffuse degenerative changes for which petitioner continued to treat.

Dr. Lanoff opined that any need for cervical surgery after the accident was due to the progression of his preexisting chronic condition.

Based on the above, as well as the credible evidence the arbitrator finds the petitioner's current condition of ill-being as it relates to his right shoulder and cervical spine are not causally related to the injury he sustained on 1/11/05. The arbitrator bases this finding on the opinions of Dr. Russell and Dr. Lanoff. The arbitrator finds the petitioner sustained a neck strain and temporary aggravation of his preexisting cervical spine that had resolved by 3/23/05 when petitioner sustained an intervening motor vehicle accident in respondent's vehicle. Prior to this the therapist had noted that petitioner's movement in his range of motion was improved, and he had relief following the injection on 2/17/05. Following the unrelated motor vehicle accident in March of 2005, petitioner did not undergo any real active treatment until after being terminated by respondent and undergoing the IDOT CDL physical examination for a maintenance worker on 11/14/05, which found him capable of meeting all job requirements of an IDOT maintenance worker.

J. WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY? HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES?

Having found petitioner has failed to prove his current condition of ill-being as it relates to his lumbar spine condition is causally related to the accident on 1/11/05 the arbitrator finds all treatment for his lumbar spine was not reasonable or necessary to cure or relieve petitioner from the effects of his injury on 1/11/05.

Having found petitioner's current condition of ill-being as it relates to his cervical spine and right shoulder through 3/23/05 is causally related to the accident on 1/11/05 through the arbitrator finds all treatment for petitioner's cervical spine and right shoulder through 3/23/05 was reasonable or necessary to cure or relieve petitioner from the effects of his injury on 1/11/05. The arbitrator finds all treatment petitioner received for his cervical spine and right shoulder after 3/23/05 was not reasonable or necessary to cure or relieve petitioner from the effects of his injury on 1/11/05.

Respondent shall pay reasonable and necessary medical services for petitioner's cervical spine and right shoulder from 1/11/05 through 3/23/05, 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?

Petitioner claims he was temporarily totally disabled from 3/28/05 through 7/27/15, a period of 504 weeks. Respondent claims the petitioner is not entitled to any temporary total disability benefits.

Having found petitioner sustained a temporary aggravation of his preexisting cervical spine and right shoulder condition that had resolved by 3/23/05, the arbitrator finds the petitioner is not entitled to any temporary total disability benefits. The arbitrator notes that following the accident on 1/11/05 petitioner missed no work until he was terminated for cause on 4/20/05.

L. WHAT IS THE NATURE AND EXTENT OF THE INJURY?

As a result of the injury on 1/11/05 petitioner sustained a temporary aggravation of his preexisting cervical spine condition that by 3/23/05 was essentially unchanged from what it had been prior to 1/11/05. Petitioner also sustained a strain to his right shoulder. After 3/23/05, petitioner had no further complaints regarding his right shoulder until 2010, and continued treating for his preexisting degenerative disc disease in his cervical spine condition that was found to be essentially unchanged from his cervical spine condition before 1/11/05 . Petitioner stopped working for respondent on 3/28/05. It is unknown what activities petitioner took part in after being terminated for cause by respondent on 4/20/05, other than undergoing an IDOT CDL physical examination for a maintenance worker position on 11/14/05. The results of that examination showed petitioner was capable of meeting all job requirements of an IDOT maintenance worker.

Based on the above, as well as the credible evidence, the arbitrator finds the petitioner sustained a 3% loss of use of his person as a whole pursuant to Section 8(d)2 of the Act, as a result of the injury he sustained on 1/11/05.

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 Causal connection	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Lourdes Diaz,
Petitioner,

vs. No. 14 WC 18044

McDonald's,
Respondent.

16IWCC0673

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical expenses, temporary total disability and prospective medical care, and being advised of the facts and law, reverses the Decision of the Arbitrator, which is attached hereto and made a part hereof.

Petitioner, a 32-year old shift manager, filed separate claims alleging back injuries on two different dates: the first on 11/22/13 (14 WC 18043), and this claim, on May 23, 2014 (14 WC 18044). Both claims were tried together, and separate arbitration awards were written. The only claim subject to this Review is Petitioner's May 23, 2014 claim.

By way of background, Petitioner alleged she first injured her low back and right leg on November 22, 2013 when she picked up a heavy box at work. She did not seek immediate medical attention, and the following day she left on a weeklong driving vacation to Texas. Upon her return, Petitioner sought medical care at Greater Elgin Family Care Center on December 4, 2013, and began a course of conservative treatment which included exercises, physical therapy, medications, and right hip injections. On February 14, 2014, Petitioner underwent a lumbar MRI which revealed a herniated L4-5 disc. On March 3, 2014, Dr. George

Radice documented Petitioner's claim that her drive to Texas had worsened her condition and increased her pain and numbness. At that time, Dr. Radice recommended Petitioner not work, but she did not follow his advice and continued working.

The Arbitrator issued a decision in claim number 14 WC 18043, denying all benefits and finding Petitioner did not prove a work-related accident on November 22, 2013. The Arbitrator found the lack of any corroborating history of a work injury in Petitioner's medical records until almost four months later to be, "compelling." Neither party sought review of the arbitrator's decision in 14 WC 18043.

In the instant claim, however, the Arbitrator found Petitioner did prove a May 23, 2014 accident, noting the corroborating history of a work accident in Sherman Hospital's records. The Arbitrator found Petitioner's condition of ill-being and need for an L4-5 micro lumbar discectomy were causally related to her alleged May 23, 2014 work accident, finding that no recommendation for surgery had been made prior to that date.

Petitioner testified that on May 23, 2014, she reinjured her back when she pulled a dumpster on wheels approximately two feet. That day, she told her coworkers that her back was hurting, and asked her supervisor if she could leave early. Her request was denied, and she worked the rest of her shift. After Petitioner finishing her shift, she sought treatment at the emergency room of Sherman Hospital. As noted, their records documented that Petitioner suffered an acute exacerbation of pre-existing back pain she moved a large heavy garbage can at work. Five days later, Dr. Sajjad Murtaza also reported that Petitioner's May 23, 2014 injury caused an exacerbation of symptoms from her November 22, 2013 injury. Petitioner continued performing her regular duties at work during this time, until June 3, 2014.

At the time of her alleged accident on May 23, 2014, Petitioner was still under treatment from her November 2013 injury. She had been given referrals to see a neurosurgeon and a pain management physician, though she had not seen either. Not long before May 23, 2014, Petitioner had received a May 7, 2014 letter from Respondent's claim examiner informing her that her November 22, 2013 workers' compensation claim had been denied.

The Commission reverses the Arbitrator's finding of causal connection in Petitioner's May 23, 2014 claim for several reasons. First, the Commission finds Petitioner's testimony in this claim to be less credible than did the Arbitrator.[1] Petitioner told Dr. Murtaza that her employer could not provide light duty work; however, this not true. Petitioner admitted on cross-examination that Forte never told her that Respondent could not accommodate her restrictions, and she also admitted that, as a supervisor over four or five employees during her work shifts, she had authority to instruct them to perform activities if she needed assistance. Petitioner's supervisor Pedro Forte, whose testimony the Commission finds credible, testified that Respondent could have accommodated Petitioner's 10 lb. restriction at all times since May 23, 2014.

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[1] It is noted that, in denying Petitioner's first claim (14 WC 18043), the Arbitrator found Petitioner's credibility lacking.

Petitioner's testimony is contradicted by other evidence in the record. She testified that she provided doctor's restrictions to Forte, but she was vague as to the time and place this allegedly occurred. Her testimony was contradicted by Forte, who denied Petitioner ever gave him work restrictions.

Petitioner reportedly told Dr. Dixon that her back and right leg pain and numbness symptoms first began on May 23, 2014. However, medical records from Greater Elgin Family Care Center and Elgin Physical Health Center confirm that she had been complaining of these symptoms for months before that date. Petitioner also testified that Dr. Dixon never released her to light duty work. Dr. Dixon's records confirm that he did.

The Commission finds that Petitioner's condition of ill-being on and after May 23, 2014 pre-existed that date. For months before that, Petitioner had been diagnosed with sciatica, radiculopathy and an L4-5 herniated disc with impingement. The physical therapy and hip injections which she had received prior to May 23, 2014 were unsuccessful and she had been given referrals to see a neurosurgeon and pain management doctor.

While Petitioner's symptoms may have briefly spiked on May 23, 2014, they returned to her baseline shortly thereafter. On May 27, 2014, Petitioner reported to Dr. Nichole LaVanway during a hospital follow-up call that she was, "Doing well." The day after that, Dr. Murtaza found Petitioner able to work with restrictions – an improvement over Dr. Radice's March 3, 2014 recommendation that Petitioner not work at all.

Respondent's Section 12 expert, Dr. Harel Deutsch, opined that Petitioner's need for treatment pre-existed May 23, 2014, and that there was no change in her condition after that date. She continued working her usual job, and regardless, Respondent had light duty work available. The Commission finds that Petitioner has not proven entitlement to any temporary total disability benefits as a result of her alleged accident of May 23, 2014.

Finally, and most importantly, the Commission's finding that Petitioner has not proved causal connection to a May 23, 2014 injury is based not only on the opinions of Dr. Deutsch, but also, Dr. Geoffrey Dixon. On May 4, 2015, Dr. Dixon opined that Petitioner's need for surgery was directly and causally related to her November 2013 injury, not any May 23, 2014 injury.

IT IS THEREFORE ORDERED BY THE COMMISSION that the September 2, 2015 Decision of the Arbitrator in this matter, 14 WC 18044, is hereby vacated and all benefits to Petitioner are denied.

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.

16IWCC0673

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.

DATE OCT 2 1 2016

o-09/13/16
jdl/mcp
68

Joshua D. Luskin

Charles J. DeVriendt

Ruth W. White

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

DIAZ , LOURDES
Employee/Petitioner

Case# **14WC018044**

14WC018043

McDONALD'S
Employer/Respondent

16IWCC0673

On 9/2/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.27% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5015 ESR LAW GROUP LLC
EDWARD S RUEDA
33 N LASALLE ST SUITE 3350
CHICAGO, IL 60602

5074 QUINTAIROS PRIETO WOOD & BOYER
LEO R PLUCINSKY
233 S WACKER DR 70TH FL
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(B)/8A

Lourdes Diaz
Employee/Petitioner

Case # **14 WC 18044**

v.

Consolidated cases: **14 WC 18043**

McDonald's
Employer/Respondent

16IWCC0673

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Doherty**, Arbitrator of the Commission, in the city of **Chicago**, on **7/29/15**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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. XX Other **prospective medical care**

FINDINGS

On **5/23/14,** 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 of **5/23/14.**

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 **32** years of age, *single* with **2** dependent children.

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

Respondent shall be given a credit of $**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 and prospective medical care

Respondent shall pay Petitioner the reasonable and necessary medical expenses incurred in the care and treatment of her causally related conditions pursuant to Sections 8 and 8.2 of the Act. In addition, Respondent shall authorize and pay for the reasonable, necessary and causally related recommended surgery and its attendant care as prescribed by the treating physicians pursuant to Sections 8 and 8.2 of the Act.

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $320.00 per week for 60 1/7 weeks, commencing 6/4/2014 through 7/29/2015, as provided in Section 8(b) of the Act.

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

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

Carolyn Doherty
Signature of Arbitrator

8/31/15
Date

SEP 2 - 2015

16IWCC0673

FINDINGS OF FACT

At trial, the 32 year old Petitioner testified via interpreter. Petitioner is alleging two accident dates in two separately filed consolidated claims. The first alleged date of accident is 11/22/13. That accident is addressed under separate Decision in case 14 WC 18043. With regard to the alleged accident of 11/22/13, the Arbitrator found that Petitioner failed to prove that she had a work related accident on 11/22/13 and denied benefits in that matter. The second alleged date of accident is 5/23/14 and is the subject of this Decision in case 14 WC 18044.

At trial, Petitioner testified that she had worked 9 years for Respondent as a shift manager and was performing the duties of shift manager on 5/23/14. Her duties as a shift manager included opening the store in the morning, quality control, counting money and managing employees. She testified that her honesty was never questioned and that she was not disciplined at work during her 9 years of employment.

Petitioner testified that on 5/23/14 she was at work performing her usual duties and went outside the restaurant at 5 am to change the sign from breakfast to lunch. Petitioner testified that while outside she pulled a dumpster on wheels about 2 feet and experienced pain in her lower back and right leg. At trial, Petitioner testified to having back and right leg pain prior to and at the time of the accident on 5/23/14, which was alleged to have developed as a result of the alleged work accident on 11/22/13, which is the subject of consolidated case 14 WC 18043. Petitioner further testified that she was treating for the pre-existing back and leg pain in the months prior to the accident of 5/23/14 in the form of conservative care including exercises, physical therapy, medication, lumbar MRI, and right hip injection. PX 1, PX 4. Petitioner had also been recommended for low back injections prior to the accident of 5/23/14. PX 1. Petitioner had not been given a surgical recommendation prior to 5/23/14. Petitioner testified that she had been working full duty with occasional assistance from co-workers.

Petitioner testified that although her low back and right leg pain was present prior to and at the time of the accident of 5/23/14, her low back and right leg pain increased after the 5/23/14 accident and was much "stronger." Petitioner testified that she reported this accident "right away" to Pedro Forte via a conversation at the restaurant. Petitioner testified that she asked if she could go home but was told she could leave between 12 and 1 pm. Petitioner worked until 12 noon on 5/23/14.

Petitioner testified that she went to the same Elgin Care Center on 5/23/14 and reported low back and right leg pain but was sent to the ER at Sherman Hospital as she was told the Elgin facility "did not work with workers' comp." At the ER on 5/23/14, the documented history reads, "31 year old female with history of low back pain presents to the emergency room with an acute exacerbation of the pain caused this morning when she moved a large heavy garbage can at her place of employment. She complains of pain in the right lower back with radiation down her right leg down to the level of her toes… she states she has a history of "bulging discs" caused by a work-related injury in November of last year. She takes Neurontin for her pain along with ibuprofen at times." PX 2. On exam it was noted that gait was antalgic secondary to pain and there was moderate tenderness to palpation in the right lower lumbosacral soft tissue region. The neuro exam was noted as normal. Petitioner was assessed with back pain, lumbar strain, disc herniation, sciatica. She was prescribed medication including a Medrol Dosepak and flexeril. PX 2.

The ER records from Sherman also indicate that Petitioner was seen in 2007 for complaints of low back pain after a car accident. Petitioner was given pain medication and released. PX 2.

On 5/28/14, Petitioner went to ION Orthopedics on the referral of a friend and saw Dr. Murtaza. Petitioner complained of right low back and right leg pain. Dr. Murtaza noted Petitioner's prior back and leg pain following the 11/22/13 incident at work as well as her conservative care for those injuries. He further noted that the conservative care did not provide significant relief. Dr. Murtaza then notes, "Then last Friday, on 5/23/14, she states that she was pulling a garbage can at work when she noticed increased pain in her lower back which radiated up into the thoracic region, as well as worsening pain down the right leg. She states that she told work, but they had her continue working and finally 7 hours later she went to the emergency room as she could not stand up very well. Since states that, since then, her pain has been increased to a 9/10, stating it is constant with a burning sensation in the posterior aspect of her right lower extremity which radiates from the buttock down to the lateral aspect of the foot. She denies any numbness or tingling into the toes. She also has significant pain in the right lower back with radiation into the thoracic region on the right. ... she also complains of pain in the right knee when bending." PX 3.

Dr. Murtaza noted pain and tenderness on exam. He reviewed the MRI of 2/14/14 and noted the findings of minimal to mild bilateral neuroforaminal stenosis from L3-S1 with disc bulge and protrusion at L4-5 pressing the thecal sac and abutting the L5 nerve root. Dr. Murtaza assessed Petitioner as having a "lumbar disc bulging which is flattening the thecal sac and causing significant right-sided lower back and right lower extremity pain with symptoms of lumbar radiculopathy." He prescribed right L4-5 and L5-S1 epidural injections and more physical therapy. He placed restrictions including no carrying, lifting, pushing or pulling greater than 15 pounds and limited bending and squatting.

Petitioner testified that she gave Pedro Forte a copy of the work restrictions but that her restrictions were not accommodated and she was not given any assistance with her job duties. Mr. Forte testified that Petitioner has never presented him with any light duty restrictions and that if she had, those restrictions would have been accommodated as was company policy.

Petitioner had L4-5 and L5-S1 injections on 6/5/14. PX 3. On 6/18/14, Petitioner stated that the injections provided no relief and that after injection she had more pain the goes down into her right lower extremity to the foot and a significant amount of weakness and give-way strength. Petitioner was taken off work until she could have an EMG which was prescribed by Dr. Murtaza. Petitioner had the EMG on 7/9/14 which confirmed the right radiculopathy at L5-S1. PX 3. On 7/17/14, Dr. Murtaza recommended a second injection using a right transforaminal approach at L5-S1 which Petitioner underwent on 7/24/14. Nothing little symptom relief from injections, on 8/4/14, Dr. Murtaza recommended consult with a spine surgeon. Petitioner was sent to Dr. Dixon.

On 8/4/14, Petitioner was examined again by Dr. Murtaza and advised him that Respondent did not provide her light duty within her restrictions. Dr. Murtaza sent Petitioner to Dr. Dixon. On 9/5/14, Dr. Dixon recommended L4-5 micro lumbar diskectomy based on exam, MRI evaluation and the EMG. PX 3. Petitioner was to remain off work.

Petitioner attended a Section 12 exam with Dr. Deutsch on 10/3/14. Dr. Deutsch agreed with the diagnosis and the surgical treatment plan suggested by Dr. Dixon. RX 4. However, Dr. Deutsch opined

that Petitioner's condition pre-existed the alleged accident of 5/23/14 and that the alleged accident of 5/23/14 did not change Petitioner's pre-existing condition. In his opinion, Petitioner's complaints of back and right leg pain were consistent before and after the 5/23/14 alleged work accident. RX 4. Finally, he determined that Petitioner could work light duty within the 15 pound restriction given by Dr. Murtaza.

Dr. Dixon again recommended surgery in December 2014 keeping Petitioner off work. Dr. Murtaza kept Petitioner off work in February 2015 while awaiting surgery. PX 3. On 5/4/15, Dr. Dixon continued his surgical recommendation and noted that Petitioner could "remain working light duty with a 10 pound weight restriction" pending completion of her treatment. PX 3. Petitioner denied receiving this light duty release. Petitioner did not return to work for Respondent.

Petitioner testified that she currently has low back and right leg pain and that she wants to undergo the recommended surgery.

CONCLUSIONS OF LAW

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

C. Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent? E. Was timely notice of the accident given to Respondent? F. Is Petitioner's current condition of ill-being causally related to the injury? O. Is Petitioner entitled to prospective medical care?

At trial, Petitioner credibly testified that she was at work on 5/23/14 moving a heavy garbage container when she felt acute pain in her low back and right leg. Petitioner testified that she told her supervisor Pedro Forte and requested permission to leave work. Permission was denied. Petitioner finished her shift and went to the ER on the same day. The emergency room records of 5/23/14 document a consistent history buttressing Petitioner's testimony. Specifically, the ER records document "31 year old female with history of low back pain presents to the emergency room with an *acute exacerbation of the pain* caused this morning when she moved a large heavy garbage can at her place of employment. Based on Petitioner's credible testimony as buttressed by the ER records and on her testimony that she advised Pedro Forte the same morning of her injury, the Arbitrator finds that Petitioner sustained an accident arising out of and in the course of her employment for Respondent on 5/23/14 and that Respondent received timely notice of this accident and claimed injury.

The Arbitrator further notes the ER records which further document "She complains of pain in the right lower back with radiation down her right leg down to the level of her toes... she states she has a history of "bulging discs" caused by a work-related injury in November of last year." There is no question that Petitioner had a pre-existing low back and right leg condition as of 5/23/14 and that the pre-existing condition began as of 11/22/13. The Arbitrator's finding of a failure to prove a work accident on 11/22/13 giving rise to her condition in consolidated case 14 WC 18043 does not negate the fact that Petitioner had a pre-existing low back and right leg condition as of the date of the separately alleged work accident of 5/23/14. As of 5/23/14, Petitioner was working full duty for Respondent. Petitioner testified that she felt an acute increase in her low back and right leg complaints when she pushed the garbage container at work on 5/23/14. Her accident and acute increased symptomology are well documented in the ER records. Petitioner's increased symptoms were also documented in the treating records of Dr.

Murtaza and Dr. Dixon. Petitioner received additional treatment and diagnostic testing including injections and an EMG which confirmed her radiculopathy. It is clear to the Arbitrator that Petitioner's pres-existing condition was aggravated by the accident of 5/23/14 such that a surgical recommendation is now pending which was not recommended prior to the accident of 5/23/14. Accordingly, the Arbitrator further finds that Petitioner's current condition of ill-being in her low back and right leg are causally related to the accident and injury of 5/23/14.

Based on the findings of accident, causal connection and on the concurring opinion of Dr. Deutsch with regard to the recommended surgical treatment, the Arbitrator further finds that Petitioner is entitled to the requested surgical treatment prescribed by Dr. Dixon. The Arbitrator finds that Respondent shall authorize and pay for the recommended surgical treatment and its attendant care pursuant to Sections 8 and 8.2 of the Act.

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

Based on the findings of accident and causal connection, the Arbitrator further finds that Respondent shall pay Petitioner the reasonable and necessary medical expenses incurred in the care and treatment of her causally related condition as of 5/23/14 pursuant to Sections 8 and 8.2 of the Act. Respondent shall receive credit for amounts paid, if any.

K. What temporary benefits are in dispute? TTD

Based on the Arbitrator's findings on the issues of accident and causal connection and on the off work or unaccomodated light duty restrictions given to Petitioner, the Arbitrator finds that Petitioner is entitled to temporary total disability for a period of 60-1/7 weeks commencing 6/4/14 through 7/29/15. Respondent shall receive credit for amounts paid, if any.

M. Should penalties and fees be imposed on Respondent?

Based on the record in its entirety, the Arbitrator finds that Respondent's conduct was not so unreasonable or vexatious so as to justify the imposition of penalties and fees under the Act. Petitioner's request for penalties and fees is denied.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

David Boyd,

Petitioner,

vs. NO: 14WC 10384

American Steel Foundries,

16IWCC0674

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner, herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, 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 12, 2016, is hereby affirmed and adopted.

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

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

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

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

DATED: OCT 25 2016
MJB/bm
o-10/18/16
052

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

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

BOYD, DAVID
Employee/Petitioner

Case# **14WC010384**

AMERICAN STEEL FOUNDRIES
Employer/Respondent

16IWCC0674

On 2/12/2016, 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 0.42% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4463 GALANTI LAW OFFICES
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PO BOX 99
EAST ALTON, IL 62024

0385 BONALDI CLINTON & DAVIS LTD
NICHOLAS J LOGRASSO
2900 FRANK SCOTT PKWY WEST
BELLEVILLE, IL 62223

STATE OF ILLINOIS)
)SS.
COUNTY OF Madison)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

David Boyd
Employee/Petitioner

Case # 14 WC 010384

v.

Consolidated cases: N/A

American Steel Foundries
Employer/Respondent

16IWCC0674

An *Application for Adjustment 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 **12/15/2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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. [ ] 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, **02/10/2014**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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 **$47,768.18**; the average weekly wage was **$991.04**.

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 $**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 $** **See request for hearing and trial stipulation** under Section 8(j) of the Act.

ORDER

For the reasons set forth in the attached Findings of Fact and Conclusions of Law, the arbitrator finds that Petitioner failed to prove that he sustained accidental injuries to his upper extremities due to repetitive work activities that arose out of and in the course of his employment with Respondent.

For the reasons set forth in the attached Findings of Fact and Conclusions of Law, the arbitrator also finds that Petitioner's current condition of ill being is not causally related to the alleged 02/10/2014 work accident. Accordingly, Respondent is not responsible for payment of any outstanding medical bills, including those contained in Petitioner's exhibit number four, and all prospective medical treatment, including Dr. McKee's proposed right carpal tunnel surgery, 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.

Edward Lee
Signature of Arbitrator

2/9/16
Date

FEB 1 7 2016

ICArbDec19(b)

The Arbitrator makes the following findings of fact:

Petitioner alleges repetitive trauma injuries to both hands, which manifested on 02/10/2014, the date Petitioner's treating physician, Dr. Craig McKee, diagnosed right carpal tunnel syndrome and subtle bilateral ulnar neuropathy.

Dr. McKee' testified for Petitioner via deposition. (PX3). Dr. McKee is a board certified plastic surgeon. (PX3, p. 5).

Petitioner began treating with Dr. McKee on 12/03/2013 when he was complaining of right hand pain as well as numbness and tingling in the right thumb, index, middle and ring fingers. (PX1, p. 15). Petitioner testified that his symptoms were at their worst in the morning when he first woke up, rather than while working, that his symptoms weren't too bad while working unless he was grasping something very hard and that he wasn't really bothered by his symptoms overall unless he was grasping something. After initially testifying that work was the only thing that caused him to experience symptoms, Petitioner testified that he experienced symptoms outside of work with activities such as opening jars and bottles or holding things, such as a plate. Petitioner also testified that he had pain, numbness and tingling prior to working at American Steel.

Petitioner told Dr. McKee he'd been a welder for 23 years at American Steel, but did not describe any forceful or repetitive gripping. (PX1, p. 15). Dr. McKee recommended splinting (PX1, p. 16). Dr. McKee testified that Petitioner did not mention a work injury or assert that his symptoms were work-related on 12/03/2013. (PX3, p. 15-16).

Petitioner followed up with Dr. McKee on 1/13/14 complaining of persistent right carpal tunnel symptoms. (PX1, p. 14). Petitioner told Dr. McKee he had a carpal tunnel splint at home but didn't wear it often. (PX1, p. 14). Dr. McKee instructed Petitioner to wear his splint at night and ordered a nerve conduction study. (PX1, p. 13- 14). Dr. McKee testified that he did not relate Petitioner's symptoms or diagnosis to his work at American Steel on 01/13/2014. (PX3, p. 16).

Petitioner underwent a nerve conduction and EMG study on 02/04/2014 at Gateway Regional Medical Center, which was administered by Dr. Riaz A. Naseer, who said it showed showed severe right carpal tunnel syndrome and subtle ulnar neuropathy across the elbow bilaterally. (PX2, p. 1).

On 02/10/2014 Dr. McKee diagnosed severe right carpal tunnel syndrome and subtle bilateral ulnar neuropathy, although Dr. McKee noted that Petitioner had no symptoms related to ulnar neuropathy. (PX1, p. 12). Dr. McKee recommended a right open carpal

tunnel release. (PX1, p. 12). Dr. McKee testified that he also did not relate Petitioner's symptoms or diagnosis to his work at American Steel on 02/10/2014. (PX3, p. 16).

Petitioner returned to Dr. McKee on 02/17/2014 stating that he was "going to file a work comp claim and see what happens." (PX1, p. 11-12). Petitioner told Dr. McKee that he had been a welder for 23 years, that he had to press the thumb valve often and that the device he used was not heavy. (PX1, p. 11). Petitioner did not describe any forceful or repetitive grasping. Dr. McKee wrote that, based on this job information, "it is reasonable that it contributes to his carpal tunnel symptoms." (PX1, p. 11). Dr. McKee later testified that was simply his way of saying that Petitioner was experiencing symptoms at work. (PX3, p. 17).

Petitioner saw Dr. Richard T. Katz for an independent medical examination at Respondent's request, pursuant to Section 12 of the Act, on 04/11/14. (RX1, p. 13). Dr. Katz testified for Respondent via deposition. (RX1). Dr. Katz is board certified by the American Board of Physical Medicine and Rehabilitation as well as the American Board of Electrodiagnostic Medicine. (RX1, p. 4).

Dr. Katz testified that Petitioner complained of numbness and tingling in the thumb, index and middle fingers as well as pain in the proximal wrist and elbows when he saw him on 04/11/2014. (RX1, p. 19). Dr. Katz took an occupational history from Petitioner, which he testified revealed no risk factors for carpal tunnel syndrome. (RX1, p. 16-17, 19, and RX2, p. 3). Petitioner did not describe any forceful or repetitive grasping. Dr. Katz also testified that his physical exam revealed no abnormal findings. (RX1, p. 20). Dr. Katz performed electrodiagnostic testing on Petitioner's bilateral upper extremities as well as his left lower extremities, which showed right carpal tunnel syndrome as well as a generalized peripheral neuropathy condition. (RX1, p. 20-21, and RX2, p. 14). Dr. Katz diagnosed right carpal tunnel syndrome atop a generalized peripheral neuropathy, which manifested in slowing in several nerves of the left lower and bilateral upper extremities. (RX1, p. 23-24).

Dr. Katz testified that he did not believe Petitioner had left carpal tunnel syndrome or cubital tunnel syndrome in either upper extremity. (RX1, p. 24). Dr. Katz also testified that Petitioner would benefit from right carpal tunnel surgery, but opined that the right carpal tunnel syndrome was not work related and stated that the need for surgery was not caused or contributed to by Petitioner's work at American Steel. (RX1, p. 27-30).

Petitioner saw Dr. McKee most recently on 10/07/2014 when he was still reporting right carpal tunnel symptoms. (PX1, p. 2). Petitioner told Dr. McKee that he operated a welding torch with his thumb and said that he held the torch, which weighed 5-10lbs, with two hands and welded all day. (PX1, p. 2). Petitioner did not describe any forceful or repetitive

grasping. Dr. McKee wrote that he would confirm what he previously stated in his 02/17/2014 office note. (PX1, p. 2). Dr. McKee testified that he never diagnosed left carpal tunnel syndrome, that Petitioner never complained of cubital tunnel symptoms in either upper extremity, and that he never recommended surgery for left carpal tunnel syndrome or cubital tunnel syndrome in either upper extremity. (PX3, p. 28-29). Dr. McKee also testified that he has not seen Petitioner since 10/07/2014 and would need to re-examine Petitioner in order to determine what, if any, further treatment, including surgery, is currently indicated. (PX3, p. 29).

Petitioner returned to see Dr. Katz for a repeat independent medical examination at Respondent's request on 02/20/2015 when he was still complaining of numbness in the right thumb, index and middle fingers. (RX1, p. 30-31). Dr. Katz testified that he could not elicit any reflex responsiveness in Petitioner's lower extremities, noting that this lack of reflexes combined with the diffuse slowing in several different nerves on electrodiagnostic testing was "very important." (RX1, p. 31). Dr. Katz explained that the lack of reflexes in the lower extremities combined with the abnormal shape of Petitioner's toes shown in figure two on page nine of his report (RX2) was further evidence that Petitioner has a generalized peripheral neuropathy condition. (RX1, p. 27-28, 32-33).

At the 12/15/2015 arbitration hearing, Petitioner testified that he has been a welder at American Steel for 23 years. Petitioner described his job as stick welding on a rod, welding on castings and side frames. Petitioner did not testify to performing any forceful, heavy or repetitive gripping.

With respect to the accident and causal connection issues, Dr. McKee testified that he is not trained in ergonomics or job analysis with respect to repetitive motion injuries. (PX3, p. 13). Dr. Katz testified that he is trained in job analysis and ergonomics and has experience going into industries to perform assessments for work related risk factors for carpal tunnel syndrome, which he has done at American Steel 8-10 times. (RX1, p. 10). Drs. McKee and Katz both agreed that carpal tunnel syndrome is often of genetic, congenital and/or idiopathic origin. (PX3, p. 14-15, and RX1, p. 15).

Dr. McKee testified that he has never reviewed a written job description, job analysis report or video in connection with Petitioner's position at American Steel, has never visited American Steel and has never viewed anyone, including Petitioner, performing the welder position at American Steel. (PX3, p. 23-24). Dr. McKee also testified that he does not know the time and amount of flexion/extension, the frequency of flexion/extension, the amount of time Petitioner's upper extremities were at rest between tasks, the type and amount of force to Petitioner's upper extremities, the type and amount of gripping, pulling, pushing,

carrying and lifting or the type, intensity or duration, if any, of vibratory exposure Petitioner was exposed to in the performance of his job as a welder at American Steel over the years. (PX3, p. 25-26). Dr. McKee further testified that he is not familiar with Petitioner's attendance/absentee record at American Steel and does not know the number of hours Petitioner worked in an average workday or workweek. (PX3, p. 26).

Dr. Katz testified that he has visited American Steel many times and is personally familiar with the activities involved in the performance of Petitioner's work as a welder there. (RX1, p. 16-18). Dr. Katz also testified that he has reviewed Petitioner's medical records and testing, including those of Dr. McKee. (RX1, p. 18). Dr. McKee testified that he has not reviewed Dr. Katz's electrodiagnostic testing and that he could explain what a generalized peripheral neuropathy condition is, but "not very well." (PX3, p. 27).

Dr. McKee agreed that he could not rule out that Petitioner's generalized peripheral neuropathy condition accounts for some or all of his symptoms, and testified that a generalized peripheral neuropathy condition might explain the bilateral subtle ulnar neuropathy findings on Dr. Naseer's electrodiagnostic studies. (PX3, p. 27-28). Dr. Katz testified that Petitioner has a generalized peripheral neuropathy condition, which is well established. (RX1, p. 27). Dr. Katz based this diagnosis on Petitioner's lack of lower extremity reflexes, his toe joint instability/formation and the generalized slowing in all nerves studied on electrodiagnostic testing, including the left lower extremity and bilateral upper extremity nerves. (RX1, p. 27-28).

Dr. McKee testified on direct examination that he believed it was reasonable that Petitioner's job activities aggravated his carpal tunnel symptoms. (PX3, p. 12-13). On cross-examination, Dr. McKee testified that his statement in his 02/17/2014 office note that "it is reasonable that it [Petitioner's work at American Steel] contributes to his carpal tunnel symptoms" was simply his way of saying that petitioner was experiencing symptoms while at work. (PX3, p. 17). Dr. McKee also testified to writing a letter to Petitioner's attorney, David Galanti, on 05/13/2014 wherein he stated: "I would not be able to make a statement saying his work caused his carpal tunnel syndrome." (PX3, p. 18).

Dr. McKee was asked the following question on cross examination: "So you would agree that you could not state within a reasonable degree of medical certainty that Mr. Boyd's carpal tunnel syndrome was caused or aggravated by his work at American Steel?," to which he responded: "I believe that's correct, yeah, when you put those sentences together, correct."

(PX3, p. 21). Dr. McKee then explained that when he wrote a letter to Petitioner's attorney, David Galanti, on 10/30/2014 stating that it was reasonable that Petitioner's work at

American Steel contributes to his carpal tunnel syndrome, that this was his way of saying Petitioner experienced symptoms at work. (PX3, p. 37). Dr. McKee further testified that Petitioner's work at American Steel caused a temporary exacerbation of Petitioner's symptoms, rather than a change in his underlying pathology. (PX3, p. 37).

Dr. Katz testified on direct-examination that considering Petitioner's well established peripheral neuropathy, which puts patients, such as Petitioner, at a considerably greater risk for development of carpal tunnel syndrome, and his lack of exposure to work related risk factors by report and based on Dr. Katz's examination of the workplace, that Petitioner's right carpal tunnel syndrome was not work related to a "reasonable or overwhelming degree of medical certainty." (RX1, p. 27-29). Dr. Katz testified on cross-examination that although repeated forceful gripping is a risk factor for carpal tunnel syndrome, he did not note sufficiently repetitive or high force gripping in his prior inspections of the job. (RX1, p. 43-44, 47). Dr. Katz testified on re-direct-examination that there was no change in his causation opinion based on Petitioner's attorney's cross-examination. (RX1, p. 49).

Therefore the arbitrator makes the following conclusions of law:

1. The arbitrator finds that Petitioner failed to prove that he sustained accidental injuries to his upper extremities due to repetitive work activities that arose out of and in the course of his employment with Respondent. The arbitrator also finds that Petitioner failed to establish that his current condition of ill being is causally connected to the alleged repetitive trauma injury manifesting on 02/10/2014 or his work at American Steel Foundries. The arbitrator finds Dr. Katz's opinions, including his causation opinion, to be well qualified, credible and persuasive. The arbitrator also notes that Dr. McKee's opinion does not support causal connection.

2. Consistent with the above conclusion of law, the arbitrator finds that Respondent is not liable for any medical bills, including those contained in Petitioner's exhibit number four.

3. All prospective medical treatment, including Dr. McKee's proposed right carpal tunnel surgery, is denied.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

John Lizon,

Petitioner,

vs. NO: 09 WC 43267

Post General Contractors, LLC,

Respondent.

16IWCC0675

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 and penalties and attorney's fees, modifies and corrects the Corrected 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.

First, Respondent argues that the Arbitrator lacked jurisdiction under Section 19(f) of the Act to change her original decision and find that Petitioner was entitled to maintenance benefits from May 8, 2015 through August 21, 2015.

The Commission notes that the Arbitrator issued a decision on November 6, 2015 awarding maintenance benefits from December 4, 2012 through August 21, 2015. In that decision, the Arbitrator explained that Petitioner had been paid maintenance benefits from December 4, 2012 through May 7, 2015 and that Petitioner "seeks fifteen (15) additional weeks of maintenance benefits from May 8, 2015 through the date of trial." The Arbitrator noted that Petitioner failed to offer any job search logs into evidence documenting a self-directed job search from May 8, 2015 to August 21, 2015 and that he testified that he believed he cannot return to work in any physical capacity. Based on those findings, the Arbitrator determined that Petitioner had failed to meet his burden of proof for an award of maintenance benefits from May 8, 2015 through August 21, 2015, the date of arbitration.

The parties filed 19(f) petitions noting that the award was inconsistent with the explanation given in the decision. As a result, the Arbitrator granted the 19(f) petitions and on December 7, 2015, she issued a Corrected Decision in which she again awarded maintenance benefits from December 4, 2012 through August 21, 2015 and explained that Petitioner had been paid maintenance benefits from December 4, 2012 through May 7, 2015. The Arbitrator noted that:

> "[m]aintenance benefits were stopped after the Petitioner was evaluated by Dr. Kevin Walsh. Petitioner seeks fifteen

> (15) additional weeks of maintenance benefits from May 8, 2015 through the date of trial, August 21, 2015. Petitioner testified that he continued to search for work after May 8, 2015. The Arbitrator concludes that Petitioner is entitled to maintenance benefits from December 4, 2012 to August 21, 2015."

On review, Respondent argues that the Arbitrator did not have jurisdiction under Section 19(f) to "substantially change her original decision and find that Petitioner met his burden of proof with respect to maintenance benefits from May 8, 2015 to August 21, 2015." (Respondent's Statement of Exceptions and Supporting Brief, pg.10) The Commission agrees.

Section 19(f) of the Act states, in pertinent part that:

> "the Arbitrator or the Commission may on his or its own motion, or on the motion of either party, correct any clerical error ***or*** errors in computation within 15 days after the date of receipt of any award by such Arbitrator or any decision on review of the Commission and shall have the power to recall the original award on arbitration or decision on review, and issue in lieu thereof such corrected award or decision." (emphasis added) 820 ILCS 305/19(f) (2013).

There is no question that the original decision contained an anomaly in the form of contradictory statements regarding maintenance benefits. In correcting that anomaly, the Arbitrator changed her reasoning and, as such, substantially changed her decision beyond the correction of a clerical or computational error. However, while the Commission finds that the Arbitrator exceeded the bounds of Section 19(f) of the Act, the Commission finds, after a complete review of the record, that Petitioner is entitled to maintenance benefits through August 21, 2015 and modifies the Arbitrator's Corrected Decision to reflect as such.

The Commission notes that the record establishes that Petitioner has been diligent and cooperative during vocational rehabilitation and in his self-directed job searches. Mary Schmit, the vocational rehabilitation counselor hired by Respondent to help Petitioner find employment, testified that Petitioner was diligent but unsuccessful in finding employment. (T.176) The vocational rehabilitation records show that despite Petitioner's cooperation and diligence, he was unable to find employment. (RX19) Ms. Schmit testified that Petitioner remained employable in the construction industry even though the industry was "recovering" and there is a "lot of competition for the jobs that are available." (T.178-179) Ms. Schmit admitted that it could be even more difficult for Petitioner with his permanent restrictions. (T.179) Ms. Schmit also testified that she spoke to one of the adjustors on Petitioner's case, Jeff Magin, and suggested that Petitioner "consider taking junior college estimating class" since "estimating construction positions tend to be physically easier and less demanding, he wouldn't have a big concern." (T.179-180) She explained that the adjuster did not go along with her recommendation. (T.180) Finally, Ms. Schmit testified that, in her experience, "when clients are cooperative with the vocational process, they do continue their maintenance benefits." (T.188)

It is clear to the Commission that while Ms. Schmit provided job search services to Petitioner, she failed to provide any vocational rehabilitation. She had recommended vocational rehabilitation in the form of an estimating course, but Respondent refused. The bottom line is

that Petitioner is still unemployed with permanent restrictions and vocational rehabilitation denied by the insurance company. Based on the Petitioner's ongoing diligence and lack of success during his job search, the Commission finds that Petitioner is entitled to maintenance benefits from May 8, 2015 through August 21, 2015.

Next, Respondent argues that the Arbitrator erred in awarding penalties and attorney's fees in this case. Again, the Commission agrees.

The Petitioner was given multiple opportunities by the Arbitrator to present evidence as to an underpayment of temporary total disability benefits. At each opportunity, Petitioner restated that 19(b) petitions were filed and that said petitions were evidence of late payments.

Nowhere in the record is there evidence, documentary or testimonial, which delineates the days and dates of late payment. Without such information, the Commission would be forced to speculate as to the date that the Respondent was late in payment and the time that Petitioner was forced to wait for payment.

The Commission is not free to speculate as it relates to the alleged dilatory acts of the Respondent. The Commission must have some evidence which delineates the date that payment was due and the date that payment was actually received. Had Petitioner testified with such specificity and Respondent failed to offer rebuttal, the Commission would have considered Petitioner's prayer for penalties. Based upon the record before us, Petitioner has failed to prove an entitlement to penalties. The Commission therefore vacates the award of penalties and attorney's fees.

So that the record is clear, and there is no mistake as to the intentions or actions of this Commission, we have considered the record in its entirety. We have reviewed the facts of the matter, both from a legal and a medical / legal perspective. Furthermore, we have considered all of the testimony, exhibits, pleadings and arguments submitted by the Petitioner and the Respondent. Finally, one should not and cannot presume that we have failed to review any of the record made below. Though our view of the record may or may not be different than the arbitrator's, it should not be presumed that we have failed to consider any evidence taken below. Our review of this material is statutorily mandated and we assert that this has been completed.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on December 7, 2015 is corrected and modified as stated above, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $800.00 per week for a period of 141-4/7 weeks, from December 4, 2012 through August 21, 2015, in maintenance benefits.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner permanent partial disability benefits of $664.72 per week for 250 weeks (less permanent partial disability credit of $7,200.00), because the injuries sustained resulted in permanent partial disability of 50% loss of use of the person as a whole, as provided in Section 8(d)(2) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall be given a credit of $148,457.14 for temporary total disability benefits, $100,571.45 for maintenance

benefits and $7,200.00 as a permanent partial disability advance for other benefits, for a total credit of $256,228.59.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $23,300.00. 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: OCT 25 2016
MJB/ell
o-08/30/16
52

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

LIZON, JOHN
Employee/Petitioner

Case# **09WC043267**

POST GENERAL CONTRACTORS LLC
Employer/Respondent

16IWCC0675

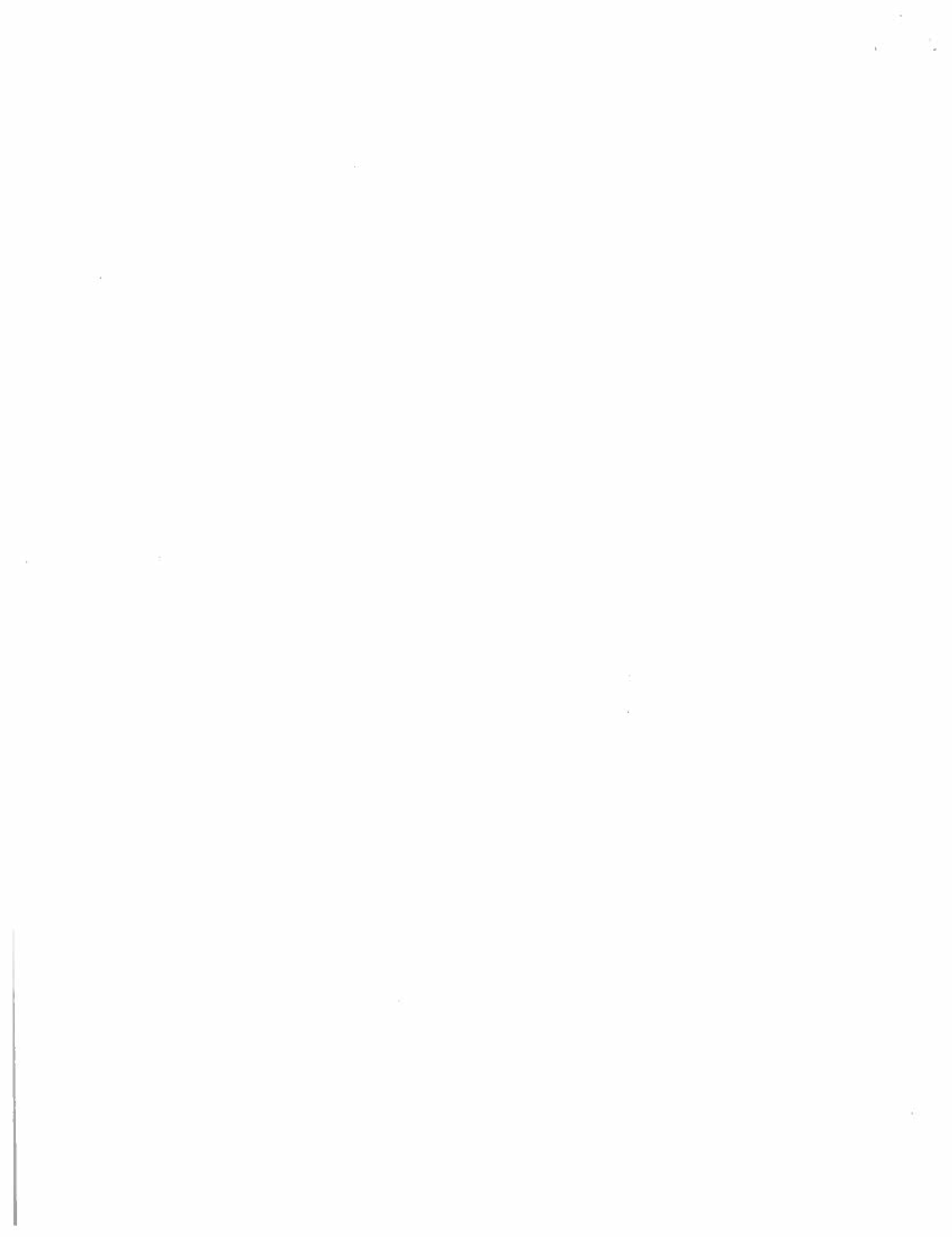
On 12/7/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.41% 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:

1993 ROMANUCCI & BLANDIN LLC
FRANK A SOMMARIO
321 N CLARK ST SUITE 900
CHICAGO, IL 60654

0507 RUSIN & MACIOROWSKI LTD
ERIC MONTOYA
10 S RIVERSIDE PLZ SUITE 1530
CHICAGO, IL 60606



STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
CORRECTED ARBITRATION DECISION

John Lizon
Employee/Petitioner

Case # 09 WC 43267

v.

Post General Contractors, LLC
Employer/Respondent

Consolidated cases:

16IWCC0675

An *Application for Adjustment 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 Lynette Thompson-Smith, Arbitrator of the Commission, in the city of Chicago, on 8/21/15. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

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

C. [ ] Did an accident occur that arose out of and in the course of 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 [ ] 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 05-14-2009, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

In the year preceding the injury, Petitioner earned $62,400.00; the average weekly wage was $1,200.00 .

On the date of accident, Petitioner was 38 years of age, married , with 2 children under 18.

Respondent shall be given a credit of $148,457.14 for TTD, $ 0 for TPD, $100,571.45 for maintenance, and $7,200 (PPD advance) for other benefits, for a total credit of $256,228.59 .

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

ORDER

Respondent shall pay Petitioner maintenance benefits from December 4, 2012 to August 21, 2015.

The Respondent shall pay Petitioner permanent partial disability benefits of $664.72/week for 250 weeks (less PPD credit of $7,200), because the injuries sustained resulted in permanent partial disability of 50% loss of the man as a whole, as provided in Section 8(d)(2) of the Act.

Respondent shall be given a credit of $148,457.14 for temporary total disability benefits, $100,571.45 for maintenance, and $7,200 (PPD advance) for other benefits, for a total credit of $256,228.59.

Respondent shall pay Petitioner penalties of $1,000.00, pursuant to Section 19(k) of the Act, penalties of $10,000.00, pursuant to section 19(l) of the Act, and attorney's fees of $2,548.57, pursuant to 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 at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

FINDINGS OF FACT

The disputed issues in this matter are: 1) causal connection; 2) maintenance; 3) penalties; 4) attorney's fees; and 5) the nature and extent of Petitioner's injuries. *See*, AX1.

Mr. John Lizon, ("Petitioner") was employed by Post General Contractors, LLC. ("Respondent") as a superintendent/project manager. Petitioner testified that his job required him to "run all the trades, take care of job conditions and anything else that was not covered by the subcontractors". Petitioner was hired in October of 2008 and supervised a renovation project at the Shrine Nightclub in Chicago. Petitioner was required to move material including concrete bags, wood and metal studs. Petitioner was also responsible for supervising all the subcontractors, working with plumbing, masonry and ventilation.

On May 14, 2009, the petitioner was working on a ladder when it collapsed. Petitioner fell to the ground and landed on his left shoulder and "smashed" his left hand. Petitioner was taken via ambulance to Mercy Hospital. The admitting diagnosis was left shoulder arm pain and Petitioner complained of pain in his left shoulder, arm and hand. X-rays of the left shoulder and elbow did not reveal any fractures. An x-ray of the left wrist revealed a non-displaced fracture. Petitioner was advised to remain off work and was referred to an orthopedist for further evaluation. PX1.

On May 15, 2009, the petitioner presented to OAD Orthopedics. He was evaluated with respect to his left wrist complaints by Dr. Anup Bendre, an orthopedic surgeon. Dr. Bendre diagnosed the petitioner with a distal, radius fracture and a median nerve injury and recommended surgery. PX2.

On that same day, Petitioner was evaluated by Dr. Aaron Bare, regarding his left shoulder complaints. Updated x-rays of the left shoulder did not reveal any fractures. Range of motion testing in the cervical spine did not reproduce shoulder pain. Dr. Bare diagnosed petitioner with a left shoulder contusion with possible internal derangement. Dr. Bare kept the petitioner off work and advised him to rest his shoulder for three (3) weeks.

On May 19, 2009, Dr. Bendre performed an open reduction and internal fixation of the left distal radius fracture. Petitioner was kept off work and advised to begin physical therapy. On June 5, 2009, the petitioner returned to Dr. Bare for an evaluation of his left shoulder. Petitioner reported that his pain complaints were no better however; he denied any neck pain or radicular symptoms. On May 29, 2009, Dr. Bendre performed new x-rays of the left wrist and advised the petitioner that he could return to work, with restrictions. Ultracet and physical therapy were prescribed.

On June 5, 2009, Dr. Bare ordered an MRI of the left shoulder and on June 9, 2009, the petitioner began physical therapy.

On June 26, 2009, after reviewing the MRI films, Dr. Bare diagnosed Petitioner as having a non-displaced fracture of the acromial end of the distal clavicle. Dr. Bare released the petitioner to return to work with a fifty (50) pound lifting restriction and advised him to continue physical therapy.

Petitioner returned to Dr. Bendre on August 21, 2009, reporting "puffiness"/soreness in the palmar aspect of his index finger, with gripping. Dr. Bendre performed a carpal tunnel injection and advised him to continue therapy and to remain off work. PX2.

Petitioner returned to Dr. Bare on August 21, 2009. Petitioner was pleased with his progress regarding the left shoulder, as he had a full range of motion with intact strength. Petitioner had minimal pain with cross arm adduction. Dr. Bare placed the petitioner at MMI and released him to full duty, with respect to the left shoulder.

Petitioner returned to Dr. Bendre on September 21, 2009, who noted that Petitioner's fracture had healed without complications. Petitioner complained of persistent pain in the volar radial aspect of his wrist brought on/aggravated by holding a bowling ball and pushing a stroller. Dr. Bendre recommended hardware removal surgery, which was performed on October 19, 2009. Dr. Bendre prescribed additional therapy and light duty work restrictions. PX2.

On October 26, 2009, Petitioner sought a second opinion regarding his left shoulder, with Dr. Howard Freedberg of Suburban Orthopedics. Dr. Freedberg diagnosed Petitioner with left shoulder impingement and x-rays revealed a healed distal clavicle fracture. Dr. Freedberg injected Petitioner's left shoulder and recommended additional physical therapy. PX4.

Petitioner continued to treat with Dr. Bendre for his left wrist. On October 30, 2009, additional physical therapy was ordered and Petitioner's light duty restrictions were continued. Petitioner returned to Dr. Bendre on December 7, 2009, who recommended an updated MRI of his left wrist. PX3.

On December 15, 2009, an MRI of the left wrist was read to show post-operative changes of the distal radius, a mild strain of the pronator quadratus muscle and mild degenerative arthritis of the radial clavicle joint. Petitioner stopped therapy for his left wrist on January 5, 2010.

On December 18, 2009, Petitioner was examined by Dr. Sandeep Jejurikar, by request of Respondent. Dr. Jejurikar diagnosed the petitioner as having flexor tenosynovitis which was causally related to his work injury. He also stated that the medical treatment, to date, was reasonable and necessary, that the petitioner required light duty restrictions and would benefits from either more injections or possible surgery. PX12.

On January 5, 2010, Petitioner completed physical therapy on his left wrist and on January 8, 2010, Dr. Bendre reviewed the MRI of the left wrist and discussed the Section 12 exam report with him and the nurse case manager. The doctor offered to either do another surgery or the petitioner could try work conditioning and then a functional capacity evaluation, ("FCE"). Petitioner chose to think about it and in the meantime, Dr. Bendre prescribed work conditioning. PX3, p. 77-79.

On January 11, 2010, petitioner returned to Dr. Freedberg, who diagnosed him with a cervical strain and posterior nerve root irritation. This is noted to be approximately eight (8) months after the accident. Petitioner was advised to continue therapy and remain off work. PX4.

After three days of work conditioning, the petitioner self-terminated the program due to pain complaints. Petitioner returned to Dr. Bendre on January 22, 2010, complaining of pain at the base of his thumb joint. Dr. Bendre opined that Petitioner's pain may be related to flexor tendon adhesions and/or tenosynovitis at the level of the carpal tunnel. Dr. Bendre recommended a tenosynovectomy of the flexor tendons and a carpal tunnel release. PX3.

Petitioner returned to Dr. Freedberg on February 22, 2010, and was released to return to work full duty for his left shoulder. On February 25, 2010, the petitioner underwent a tenosynovectomy of the digital flexor tendon as well as a carpal tunnel release. On March 2, 2010, Petitioner restarted physical therapy at OAD Orthopedics.

On April 19, 2010, Petitioner returned to Dr. Freedberg, reporting that he was feeling 85-90% overall improved. Petitioner was released to return work full duty for his left shoulder. Petitioner completed physical therapy for his left wrist on May 13, 2010 and returned to Dr. Bendre on May 17, 2010 reporting that his complaints were no better after surgery. Dr. Bendre recommended a second opinion or an FCE.

On May 13, 2010, he completed physical therapy on the left wrist at OAD and on May 17, 2010, Dr. Bendre recommended a second opinion or repeat IME and an FCE. Petitioner advised Respondent that he then wanted a second opinion with Dr. Charles Carroll at Northwestern for his left wrist. On May 21, 2010, nurse case manager Linda Savage of Alaris Group was placed on the file by Respondent. Petitioner testified that the respondent did not authorize the FCE or the second opinion with Dr. Carroll. On June 3, 2010, Dr. Freedberg released him at MMI for the left shoulder. PX3, pp. 22-24.

Petitioner returned to Dr. Freedberg on June 3, 2010, complaining of periodic discomfort when holding something or laying down. Petitioner reported that he was not taking medication or undergoing therapy. Dr. Freedberg released the petitioner to return to work in a full duty capacity and placed him at MMI for his left shoulder.

Petitioner underwent an IME with Dr. Sandeep Jejurikar on June 8, 2010 regarding his left wrist. Dr. Jejurikar recommended additional work hardening and an FCE. Dr. Jejurikar believed that the petitioner may require some level of permanent restrictions.

Petitioner returned to Dr. Bendre on June 18, 2010. Work conditioning and a second functional capacity evaluation were ordered. On July 6, 2010, petitioner began work conditioning at AthletiCo. PX3 & 7.

Petitioner testified that on July 8, 2010, a 19(b)/8(a) emergency and penalty petition had to be filed for August 17, 2010, before then Arbitrator Peterson, to reinstate TTD that had not been paid since June 27, 2010. On August 1, 2010, Adjuster Ladonna Allen issued a check in the amount of $3,200.00, for four (4) weeks of TTD arrearage. PX17.

The petitioner completed an FCE on August 5, 2010, which was determined to be valid and stated that the petitioner could function at the "light-medium" (up to 40 pounds) physical demand level. It was recommended that Petitioner have additional work conditioning in order to attain the medium level ability, required by his job duties.

On August 9, 2010, Petitioner returned to Dr. Bendre, complaining of pain in his thumb and index finger. Dr. Bendre released the petitioner to return to work with permanent restrictions of no lifting greater than forty (40) pounds with either extremity and he was placed at maximum medical improvement ("MMI"). PX3.

Petitioner testified that the respondent did not take him back with his restrictions and he did not receive any TTD. Petitioner states that on August 30, 2010, his attorney appeared before then Arbitrator Peterson, where Respondent's attorney advised that he was awaiting a response from the adjuster, as to status of TTD issuance, thus Arbitrator Peterson continued the case to September 2, 2010 for status on the issuance of TTD. Petitioner's attorney also states that on September 2, 2010, respondent's attorney advised that the TTD check was issued and that the adjuster would authorize the second opinion with Dr. Carroll so Arbitrator Peterson returned the case to the call. On September 5, 2010, Petitioner received the TTD that was owed from August 9, 2010. Petitioner testified that he was aware that on October 11, 2010, another 19(b) and penalty petition was filed for October 19, 2010 before Arbitrator Peterson because the adjuster still had not sent written authorization for him to see Dr. Carroll. Petitioner also testified that the respondent was no longer in business and that he could not perform his former job as a project manager, with his current, permanent restrictions. PX17.

Petitioner finally presented to Dr. Charles Carroll IV of NorthShore Orthopedics on November 22, 2010. Petitioner complained of numbness and tingling in his thumb and index finger along with pain

in his index, long and small fingers. Dr. Carroll diagnosed petitioner with carpal tunnel syndrome and recommended an EMG study of Petitioner's left upper extremity. PX9.

Petitioner testified that in late December 2010, there was another delay in TTD payment. He had not been paid since December 19, 2010 and the adjuster had not authorized the EMG, so he was aware that another 19(b) and penalty petition was filed on January 18, 2011 for February 17, 2011 before Arbitrator Peterson. On March 7, 2011, Petitioner received his TTD check for December 20, 2010 through March 7, 2011, in the amount of $8,800.00 which was eleven weeks of benefits. Petitioner testified that at least eleven (11) 19(b) and penalty petitions had to be filed during the course of the case because Respondent continuously did not pay TTD or authorize treatment timely, sometimes for periods of up to eleven (11) weeks at a time. Tr. pp. 49-50, 53; PX17.

Petitioner testified that on April 11, 2011, he received a bill from Respondent's Section 12 examiner, Dr. Jejurikar because the adjuster did not pay the bill. Petitioner testified that in April 2011, there was another issue with TTD being paid timely since April 4, 2011 so another 19(b) and penalty petition was filed on April 21, 2011 for May 17, 2011 before Arbitrator Peterson. On May 2, 2011, petitioner underwent the EMG that Dr. Carroll prescribed on November 22, 2010, almost seven months prior. On May 23, 2011, Petitioner received TTD owed from April 19, 2011 through May 30, 2011, in the amount of $4,800.00. Petitioner testified that on May 24, 2011, the adjuster began sending the TTD checks directly to his attorney so that the attorney could monitor when TTD was late. Tr. pp. 51-54; PX17; PX9, pp. 55, 231-235; PX17.

Petitioner testified that in September of 2011, he was still awaiting written authorization to be sent to Dr. Carroll, to be seen in follow-up after the EMG, so another 19(b) and penalty petition was filed on September 19, 2011 for October 18, 2011 before Arbitrator Dollison. Petitioner testified that he was finally able to see Dr. Carroll on November 29, 2011, who after his review of the May 2, 2011 EMG, which was done six months earlier. He diagnosed him with a median nerve compression, prescribed surgery and continued his work restrictions.

Petitioner testified that in October 2011, there was another issue of TTD not being paid. Another 19(b) and penalty petition was filed on November 30, 2011 for December 15, 2011 before Arbitrator Thompson-Smith because TTD had not been paid since October 10, 2011. Petitioner testified that on December 7, 2011, he finally received TTD from October 11, 2011 through December 7, 2011, in the amount of $6,400.00. On December 27, 2011, the case was returned to the call by Arbitrator Thompson-Smith because Respondent's attorney advised that TTD was paid through December 21, 2011 and that adjuster was awaiting the full November 29, 2011 report of Dr. Carroll, to determine if surgery would be authorized. Tr. pp. 54-56; PX9, pp. 54, 237-238; PX17.

On February 21, 2012, another 19(b) and penalty petition was filed for March 15, 2012 before Arbitrator Thompson-Smith because TTD was not paid since February 1, 2012 and surgery still was

not authorized. On March 27, 2012, a new adjuster named Myrna Castaneda was placed on the file and the case was continued by Arbitrator Thompson-Smith because respondent's attorney advised that TTD was issued by new adjuster and that TTD would be paid timely from now on. Later in the day on March 27, 2012, Petitioner received his TTD check for February 20, 2012 through March 20, 2012, in the amount of $5,371.45.

On May 15, 2012, a new case manager named Marianne Drafkey was placed on the file to procure authorization for Dr. Carroll to perform surgery. On June 11, 2012, Petitioner was able to see Dr. Carroll in a follow-up since his November 29, 2011 visit, and schedule surgery for July 17, 2012. On June 29, 2012, Petitioner had his pre-operation testing, and on July 17, 2012, Dr. Carroll performed surgery, consisting of revision, exploration and decompression of left median nerve at carpal tunnel, hand and forearm and microneuroplasty of median nerve. On July 30, 2012, Dr. Carroll prescribed physical therapy and on August 1, 2012, Petitioner began physical therapy at AthletiCo. Tr. pp. 35-58; PX10, pp. 25-27; PX9, pp. 28-31, PX17.

On September 10, 2012, Dr. Carroll advised him to continue in physical therapy, which Petitioner completed on October 25, 2012. On October 29, 2012, Dr. Carroll prescribed an FCE. On November 14, 2012, petitioner underwent the FCE at AthletiCo which was noted to be valid; and recommended that he could return to work in a sedentary to light physical demand level job with a twenty (20) pound maximum occasional lifting restriction on the left extremity. On December 3, 2012, Dr. Carroll advised him to continue home exercise program and released him at MMI, with permanent restrictions per the November 14, 2012 FCE.

Petitioner testified that his employer did not take him back to work with the restrictions so Respondent began paying maintenance benefits as of December 4, 2012, but did not immediately commence vocational rehabilitation. Tr. pp. 60-64; AX1.

Petitioner testified that on December 11, 2012, he still had pain for both the left shoulder and left wrist. He wanted to see Dr. Freedberg for the left shoulder but needed authorization to be seen and to get another second opinion doctor regarding the left wrist. On March 4, 2013, Arbitrator Thompson-Smith returned the case to the call, since respondent's attorney advised that maintenance was being paid and that he was awaiting a response from the adjuster as to whether they would authorize the appointment with Dr. Freedberg for the left shoulder; and authorize a second opinion doctor for the left wrist. They also needed to do another Section 12 exam or commence vocational rehabilitation.

Petitioner testified that there was another issue with his TTD/maintenance benefits not being paid in late March 2013 so on April 5, 2013, another 19(b) and penalty petition was filed for May 15, 2013 before Arbitrator Thompson-Smith in order to get respondent to authorize appointments, commence vocational rehabilitation, and pay TTD/maintenance.. On April 30, 2013, Petitioner received his TTD/maintenance for March 27, 2013 through April 23, 2013, in the amount of $3,200.00 from the

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new adjuster, Jeff Mazich. On June 4, 2013, Arbitrator Thompson-Smith returned the case to the call because respondent's attorney advised that TTD/maintenance was again being paid and that Ms. Mary Schmit of Triune would be contacting Petitioner's attorney to schedule an initial vocational rehabilitation meeting. PX17.

On May 2, 2011, Petitioner underwent the EMG study, which findings suggested the presence of median neuropathy. Petitioner returned to Dr. Carroll on November 29, 2011 to review the EMG study results and Dr. Carroll diagnosed him as having median nerve compression and recommended a left median nerve exploration and release. He released the petitioner to return to work with a forty (40) pound lifting restriction. PX9.

Petitioner returned to Dr. Carroll on June 11, 2012, complaining of pain in his left hand. Dr. Carroll examined Petitioner's left shoulder and did not find any abnormalities. Petitioner had positive Phalen's and Tinel's tests and was diagnosed with carpal tunnel syndrome. Dr. Carroll recommended a left carpal tunnel revision and release. On July 17, 2012, petitioner underwent a left median nerve decompression and carpal tunnel release and remained off work.

On August 1, 2012 Petitioner began physical therapy at AthletiCo. Petitioner returned to Dr. Carroll on September 10, 2012 complaining of ulnar numbness since the last surgery. Petitioner was advised to continue physical therapy, which he completed. Petitioner returned to Dr. Carroll on October 29, 2012, who recommended work conditioning and an FCE.

On November 29, 2012, Petitioner underwent an FCE at AthletiCo. The examiner noted that the petitioner's physical demands of his pre-injury job as a carpenter were identified as "very heavy" per the Department of Transportation ("DOT"). The examiner did not have a functional job description from the employer. The FCE determined that Petitioner could function at the sedentary to light level of work and he had no limitations with respect to standing, walking, sitting, balancing, stooping, crouching, or climbing. Petitioner was limited to lifting 20 pounds from floor to 31 inches and 10 pounds from floor to 61 inches. Petitioner was able to carry 20 pounds up to 100 feet, push and pull 25 to 35 pounds and climb a ladder up to 8 feet. The test results were deemed valid. PX8.

Petitioner returned to Dr. Carroll on December 3, 2012, who determined that he had reached maximum medical improvement. The doctor released the petitioner to return to work with permanent restrictions per the functional capacity evaluation. PX9.

Petitioner testified that after his release from care, he did not begin searching for work. Petitioner testified that he could not return to respondent's employ as they had ceased operations in 2010. He further testified that several months later, he met with Ms. Mary Schmit, a certified rehabilitation counselor with Triune Health Group. The initial vocational assessment took place on May 13, 2013. According to the initial vocational assessment, the petitioner had worked as a

construction/superintendent for Post General Contractors for eight months before the accident. Petitioner previously worked as a project manager/construction superintendent for another company known as Single Site Solutions for approximately ten (10) years. Petitioner also ran his own home remodeling business for seven (7) years. RX1.

A transferable skills analysis was performed and determined that Petitioner was employable at the sedentary to light physical demand level, based upon his previous work experiences and skills. Ms. Schmit identified positions within that demand level that Petitioner would be qualified to perform. She targeted positions such as construction supervisor, foreman, maintenance manager, construction inspection, lumber estimator and a construction estimator. According to Ms. Schmit's initial assessment, the plan was to have him apply for positions within the construction trade that were within his permanent restrictions.

Petitioner returned to Dr. Howard Freedberg on June 17, 2013, complaining of left shoulder and left wrist pain. Petitioner stated that his left shoulder pain had worsened and complained of pain behind his left shoulder blade. Petitioner reported that his left wrist pain was worse than before surgery with Dr. Carroll. Petitioner had a normal physical examination except for positive tenderness to palpation in the cervical spine. X-rays of the left shoulder were normal. Cervical spine x-rays revealed C4 osteophytes. Petitioner was diagnosed with left shoulder bursitis/tendonitis and cervical referred rhomboid pain. Petitioner was referred to Dr. Dmitry Novoseletsky, a pain management physician for further evaluation. PX5.

On June 25, 2013, the petitioner was evaluated by Dr. Novoseletsky, complaining of constant pain in his shoulder blade area. Dr. Novoseletsky performed a left subscapular injection. Petitioner was instructed to return in two weeks. Petitioner returned to Dr. Novoseletsky on July 9, 2013, stating that the injection helped for three to four days. Petitioner was diagnosed with cervical spondylosis and scapular pain. Petitioner was recommended to have injections at the C3, C4 and C5 level.

Petitioner testified that he began searching for work in the construction industry in July of 2013, contacting 20 to 30 potential employers a week. Petitioner obtained interviews within the first few weeks of searching for work however; he never received a job offer. On cross-examination, Petitioner admitted that he received one job offer from a demolition company. He testified that he did not accept the position as the job required him to help load trucks in addition to his superintendent duties.

Petitioner continued to search for work as a project manager/construction superintendent for the remainder of 2013 and into 2014. The petitioner's job search is documented in the vocational reports. The reports indicate that petitioner received approximately one interview a month for positions in construction/project management field. RXs 2–11.

On July 28, 2014, the petitioner accepted a volunteer position with Projx Construction. Petitioner volunteered from July 28 through August 4, 2014 as a project manager. Petitioner testified that he was not paid. Petitioner testified that the purpose of the volunteer position was to determine if he could physically perform the work that was required. Petitioner testified that he qualified bids, put together schedules and "did stuff on permitting". He testified that he performed all the duties of a project manager.

According to the vocational progress report, the petitioner was not offered a position after the volunteer period ended. Petitioner was told that if the company's business increased, he would be considered for a job. RX12.

Petitioner continued his job search throughout the remainder of 2014. He received several interviews for project management positions. Petitioner did not receive any job offers at this time. RXs 12–15.

On January 16, 2015, the petitioner returned to Dr. Carroll. Petitioner complained of pain in his palm with forceful gripping along with pain and stiffness radiating to the index and small finger. Petitioner's left wrist examination revealed pain with flexion. Petitioner had a normal left shoulder examination. Petitioner was diagnosed with pain from the radioscaphoid joint and an old fracture. Dr. Carroll released Petitioner to return to work, with permanent restrictions of sedentary to light duty. Petitioner told Dr. Carroll that he wanted a referral for a different opinion. Dr. Carroll provided Petitioner with a referral to Dr. Michael Vender. PX10.

Petitioner testified that he continued to search for work in the project management/construction superintendent field. The vocational progress reports document several more interviews for project manager positions. RXs 16-18.

On April 28, 2015, the petitioner underwent an IME with Dr. Kevin Walsh, who determined that the petitioner had a relatively normal physical examination. Petitioner had a negative Tinel's and Phalen's test and good range of motion in his wrist. Petitioner had full strength and range of motion in his shoulders. Dr. Walsh also reviewed a surveillance video and noted that the petitioner was participating in activities of daily living without any obvious restrictions. Dr. Walsh opined that petitioner's pain complaints were disproportionate to his injury, given the healed fracture. Dr. Walsh felt the FCE restrictions were far too limiting for the petitioner's diagnosis and physical examination. Dr. Walsh determined that Petitioner had reached MMI and was capable of returning to work full duty. In his April 28, 2015 Section 12 exam report, Dr. Walsh opined that his diagnoses were consistent with the diagnoses of the prior Section 12 examiners, but that all of Petitioner's current subjective complaints were not related to his May 14, 2009 accident, based on the length of time. Petitioner testified that his appointment was set for 9:00am but when he got there, he was told it was not till 2:00 p.m. so he had to leave and come back. He further testified that once he was seen by Dr. Walsh, the appointment lasted between 5-10 minutes.

On April 30, 2015, Arbitrator Thompson-Smith continued the case because Respondent's attorney advised that he was awaiting receipt of the April 28, 2015 Section 12 exam report. Tr. p. 83; RX21.

Petitioner testified that on May 21, 2015, he received a fax from respondent's counsel that no further maintenance would be paid, based on the Section 12 exam report of Dr. Walsh. On May 28, 2015, Arbitrator Thompson-Smith continued the case for trial to August 21, 2015 and recommended that respondent make an advance permanent partial disability payment.

On June 18, 2015, another 19(b) and penalty petition was filed for July 7, 2015 before Arbitrator Thompson-Smith because Respondent had neither paid the PPD advance or maintenance since May 7, 2015. Petitioner testified that on June 25, 2015, he finally received the December 27, 2013 Section 12 exam report of Dr. Wysocki; and on June 30, 2015, Petitioner and Ms. Schmidt were advised that vocational rehabilitation was being terminated by the respondent.

On June 30, 2015, formal vocational rehabilitation ceased and the petitioner testified that he continued to search for work on his own. He testified that he had a few job interviews but no offers of employment.

Petitioner testified that on July 24, 2015, he received the $7,200.00 PPD advance check. On July 29, 2015, Arbitrator Thompson-Smith noted that the case was already set for trial on August 21, 2015 and continued the pending penalty petition. Tr. p. 86; PX 17; RX 19.

Petitioner testified that he continued to look for jobs after he was advised that the vocational rehabilitation process was being terminated up through the trial date but still did not find any jobs or receive any job offers. Petitioner did not offer any job search logs into evidence from June 30, 2015 to the date of trial. Petitioner testified throughout the case, he would receive unpaid medical bills, several times before they were paid by the adjuster, but that now all medical bills have been paid or are being processed for payment by respondent. Tr. pp. 86-87; PX17; RX12.

Petitioner testified that he was paid TTD from May 15, 2009 through December 3, 2012; and maintenance from December 4, 2012 through May 7, 2015 and that at least eleven (11) 19(b)s and penalty petitions had to be filed during the course of the case because Respondent continuously refused to pay benefits or timely approve medical treatment.

Petitioner testified that he applied for social security disability, but did not remember when he applied. Petitioner believed that Ms. Schmit had recommended that he apply for SSDI. Petitioner also testified that he was denied benefits by the Social Security Administration and has not appealed the decision. Petitioner did not offer the denial letter into evidence.

Regarding his current left shoulder complaints, Petitioner testified that his left shoulder is "a big nuisance" but that he is "not in a great deal of pain". He testified that he experiences left shoulder pain if he sits too long or sleeps on his shoulder and when he drives. He testified that he is not really restricted with doing anything and testified that his strength is "fine" in his left shoulder.

Regarding his left wrist, Petitioner testified that he is in constant pain. He testified that he experiences pain in his index finger and thumb and numbness in his ring and pinky finger. Petitioner testified that he has decreased grip strength in his left hand, although he is not taking any narcotic pain medication for either his left shoulder or wrist. Petitioner testified that he takes non-prescription strength Aleve on a daily basis.

Regarding his current medical treatment, petitioner testified that he still wishes to see Dr. Michael Vender. He testified that he wants his left hand "fixed". Petitioner testified that he wishes to have further medical treatment as he "wants to return to the job he had before".

Petitioner testified that he feels he complied with vocational rehabilitation and that his earning capacity has been diminished, as he can no longer perform his usual and customary trade. Petitioner testified that no doctor has told him that it would be detrimental to his health or safety if he returned to work. Petitioner agreed that he did not have any restrictions on the amount of hours in a day that he could work and no restrictions with respect to sitting, standing or walking or with respect to his right upper extremity.

Petitioner testified that he bowls on a regular basis and that no doctor has told him that he cannot bowl. He testified that he primarily uses his right arm to bowl as he is right-handed. Petitioner admitted that he uses his left hand to stabilize the ball. He testified that he experiences pain when he bowls and drinks more while bowling, due to his pain complaints.

Petitioner believed that he is not physically capable of working and does not believe he can return to work in any capacity. Petitioner testified that he had applied for over 2000 positions and has been on "countless interviews" and "no one will hire me". Petitioner testified that he believes his problem is his education, as he does not have a college degree and the "big contractors" will not hire him.

Petitioner testified that he does not believe he is physically capable of performing a less physically demanding job in a different industry. Petitioner admitted that he only targeted jobs exclusively within the construction industry. These included jobs as a project manager, construction superintendent and construction sales. Petitioner testified that he never applied for any entry level unskilled jobs.

Petitioner denied ever working for Projx Construction. He denied having any contact with Projx prior to his volunteer period from July 28, 2014 to August 4, 2014. Petitioner was asked, on cross-

examination, whether he had ever been to a building located at 657 W. Lake Street in Chicago. Petitioner testified that he has been to that building numerous times as he "has a friend who works there" that he would visit from time to time.

Petitioner acknowledged that his name appeared on several documents, including records from the City of Chicago listing him as the point of contact for Projx Construction. The project was for a renovation at 657 W. Lake Street. Petitioner had no explanation for why he was listed as the main point of contact for Projx. Petitioner denied that he ever did anything more than volunteer for Projx Construction.

Respondent's first witness

Ms. Mary Schmit testified that she is a certified rehabilitation counselor and has worked as such since 2001. She often works with claimants that previously worked in the construction industry. Ms. Schmit testified that she has served as an expert witness in both workers' compensation cases and social security disability hearings. She testified that an individual typically must prove that they are unemployable for gainful wage in any occupation in order to receive social security disability.

Ms. Schmit testified regarding her initial vocational assessment of the petitioner, which was consistent with her report. Based upon Petitioner's skills, age and experiences, Ms. Schmit targeted positions within the construction trade; i.e., construction manager, superintendent, maintenance manager and lumber estimator. RX1.

Ms. Schmit testified that the goal of vocational rehabilitation is to return someone at the best and most appropriate occupation for that individual, provided those jobs are available. She makes every attempt to pursue positions that do not demean her clients and that provide her clients with the most income so that they can recapture the lifestyle they had prior to the injury. RX19.

Ms. Schmit further testified that Petitioner immediately generated interest from employers when he began his job search. He generated his own interviews within the first couple of months of searching for work and had a number of job interviews and second interviews. She testified that all the jobs were within the construction trade and that the petitioner was never encouraged to look for unskilled, entry level, minimum wage positions. She also testified that the petitioner never searched for work in a different industry.

Ms. Schmit testified regarding her opinion letter dated July 19, 2015, stating that Petitioner is employable to a reasonable degree of vocational certainty and that he is employable in a reasonably stable labor market. Ms. Schmit believed that he was still employable in the areas that they targeted, including construction management/supervisor.

Ms. Schmit explained that many jobs were lost in the construction market in Chicago and that over the last five or six years, the availability of construction jobs is only about half of what they were in 2000. She testified that the petitioner presents well and has a good work history and that his project list garnered a lot of attention from employers. She testified that petitioner was one of the final candidates in several of the jobs to which he applied however, he has not received a job offer, to date, due to the significant amount of competition for construction jobs.

Regarding the competition, Ms. Schmit cited to Bureau of Labor Statistics, which demonstrated that the loss of jobs and recovery of those jobs in the construction industry over the last several years has been less strong for construction management positions. She testified that the construction industry has not rebounded from the economic recession as compared to other industries and based upon these statistics, the competition, for construction management jobs, is significant.

Ms. Schmit testified that the petitioner may be a little bit more employable had he obtained a degree, and that it would benefit the petitioner to continue to look for work, as he is a young man and cannot afford to retire. Ms. Schmit testified that the petitioner could find work in the construction industry and that the range of pay would be between $50,000.00 and $75,000.00; based her statistics from the Department of Transportation as well as the Bureau of Labor Statistics for 2014. RX19.

She recommended junior college courses in construction estimating as those jobs were typically less physically demanding although she also testified that she was not instructed to enroll Petitioner in college level courses. She testified that many of those positions are commission only jobs. And finally she testified that the petitioner had performed a diligent job but unsuccessful job search and did everything she asked of him.

Respondent's second witness

Investigator Kevin Knop testified that he has been an investigator for twenty-six (26) years and works as a private investigator for Combined Investigations. He further testified that he was assigned to watch and record the petitioner in October and November of 2013. Mr. Knop's report along with a surveillance videotape, were admitted into evidence. The video showed the petitioner bowling at Fox Bowl on October 11, 2013. Petitioner's name was listed on a scoreboard as he is part of a bowling league for Stella's Pub. The video from November 1, 2013 showed the petitioner retrieving a bowling bag from his car and entering the same building. Petitioner played six games on two different lames. He used his right hand to bowl and left hand to hold the ball. He also used his left hand will drinking, leaning on a table and conducting celebratory high-fives. Mr. Knop personally identified the petitioner as the individual he watched on those days. RX23.

Respondent's third witness

Mr. Kyle Landes also testified that he was working as an investigator with PhotoFax, Inc., in July 2014 and that he was assigned to watch and record the petitioner on July 24, 2014. Mr. Landes' report and video was admitted into evidence. According to the video, the petitioner is seen leaving his house in Wheaton at 7:01 a.m., walking with a folder in his left hand as he entered his vehicle. At 8:18 am, the petitioner arrived at a vacant storefront located at 657 West Lake Street in Chicago and was observed entering an alley. The building was noted to be vacant and unfinished inside.

At 8:41 am, the petitioner was filmed walking to the driver side of his car and grabbing blueprint paper and a water bottle with his left hand. Petitioner then carried the blueprints and entered the building through the back alley entrance. Over the next several hours, petitioner was observed entering and exiting the back alley entrance of the building located at 657 West Lake. Petitioner was filmed conversing with individuals that arrived in the alley throughout that morning. Petitioner was observed entering and exiting the vacant storefront with a folder in his left hand. At 1:30 pm, petitioner was observed exiting the back alley with blueprint paper in his left arm. Petitioner placed the prints into his truck and returned inside the building. Petitioner eventually departed the area at 2:01 pm. RX24.

CONCLUSIONS OF LAW

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

A decision by the Commission cannot be based upon speculation or conjecture. *Deere and Company v Industrial Commission*, 47 Ill.2d 144, 265 N.E. 2d 129 (1970). A petitioner seeking an award before the Commission must prove by a preponderance of credible evidence each element of the claim. *Illinois Institute of Technology v. Industrial Commission*, 68 Ill.2d 236, 369 N.E.2d 853 (1977). Where a petitioner fails to prove by a preponderance of the evidence that there exists a causal connection between work and the alleged condition of ill-being, compensation is to be denied. Id. The facts of each case must be closely analyzed to be fair to the employee, the employer, and to the employer's workers' compensation carrier. *Three "D" Discount Store v Industrial Commission*, 198 Ill.App. 3d 43, 556 N.E.2d 261, 144 Ill.Dec. 794 (4th Dist. 1989).

It is not enough that the petitioner is working when an injury is realized. The petitioner must show that the injury was due to some cause connected with the employment. *Board of Trustees of the University of Illinois v. Industrial Commission*, 44 Ill.2d 207, 214, 254 N.E.2d 522 (1969); see also *Hansel & Gretel Day Care Center v Industrial Commission*, 215 Ill.App.3d 284, 574 N.E.2d 1244 (1991).

Based upon the facts and medical evidence, the Arbitrator finds that the petitioner's current condition with respect to his left wrist and left shoulder is causally related to the accident of May 14, 2009. The

Arbitrator finds that petitioner's cervical spine complaints are not causally related to the accident of May 14, 2009. The petitioner did not testify to any current complaints with respect to his neck. His testimony was limited to his left wrist and left shoulder. The ER records from Mercy Hospital indicate that petitioner only sustained injuries to his left shoulder and wrist.

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

The parties agreed, on the record, that the bills indicated on Arbitrator's Exhibit 1, have been paid or will be paid directly to the providers pursuant to the fee schedule. Based upon the parties' agreement on the record, the Arbitrator finds that there are no disputed issues regarding medical bills.

K. What temporary benefits are in dispute?

The petitioner was paid maintenance benefits from December 4, 2012 to May 7, 2015. Maintenance benefits were stopped after the petitioner was evaluated by Dr. Kevin Walsh. Petitioner seeks fifteen (15) additional weeks of maintenance benefits from May 8, 2015 through the date of trial, August 21, 2015. Petitioner testified that he continued to search for work after May 8, 2015. The Arbitrator concludes that Petitioner is entitled to maintenance benefits from December 4, 2014 to August 21, 2015.

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

Petitioner claims that as a result of the work accident, he is permanently, totally disabled. For the reasons set forth, the Arbitrator finds Petitioner has failed to prove he is permanently, totally disabled as a result of the May 14, 2009 work accident.

There was no credible medical evidence presented by Petitioner indicating that Petitioner is medically permanently, totally disabled. The Arbitrator also finds that the petitioner failed to prove that he is permanently and totally disabled under an odd-lot theory.

An employee is totally and permanently disabled when he is unable to make some contribution to industry sufficient to justify payment of wages to him. *A.M.T.C. of Illinois v. Industrial Commission*, 77 Ill.2d 482, 487 (1979). The employee, however, need not be reduced to total physical incapacity before a permanent total disability award may be granted. *Ceco Corp. v. Industrial Commission*, 95 Ill.2d 278, 286-87 (1983). Rather, the employee must show that he is unable to perform services except those that are so limited in quantity, dependability, or quality that there is no reasonably stable market for them. *Alano v. Industrial Commission*, 282 Ill.App.3d 531, 534 (1996).

If the employee's disability is limited in nature so that he is not obviously unemployable, or if there is no medical evidence to support a claim of total disability, he may qualify for "odd lot" status. *Valley Mould & Iron Co. v. Industrial Commission*, 84 Ill.2d 538,546-47 (1981). An odd-lot employee is one who, though not altogether incapacitated to work, is so handicapped that he will not be employed

regularly in any well-known branch of the labor market. *Valley Mould*, 84 Ill.2d at 547. The burden is upon the claimant to establish the unavailability of employment to a person in his circumstances. Valley Mould at 546-547 (Ill., 1981).

If employees fail to make out a prima facie case that they fall into the "odd lot" category, then it remains incumbent upon them to demonstrate that, given their present condition and in light of their age, training, experience, and education, they are permanently and totally disabled. *ABB C-E Services v. Industrial Commission*, 316 Ill.App.3d 745 (Ill.App. 5 Dist. 2000); citing *Valley Mould*, 84 Ill.2d at 547. They may accomplish this by a showing of diligent but unsuccessful attempts to find work or by proof that because of the above mentioned qualities they are unfit to perform any but the most menial tasks for which no stable market exists. *ABB C-E Services*, 737 N.E.2d at 685.

There are three ways by which employees can demonstrate that they are permanently and totally disabled: (1) by a preponderance of the medical evidence, (2) by showing a diligent but unsuccessful job search, or (3) by demonstrating that because of their age, training, education, experience, and condition, no jobs are available to a person in their circumstances. *Id*, at 686.

The claimant must establish by the preponderance of the evidence that they fall into the odd-lot category. *Meadows v. Industrial Comm'n*, 262 Ill.App.3d 650, 653-654 (holding that "claimant has the burden of proving that he fits into the 'odd lot' category of section 8(f) of the Act"). Applying the analytic framework of the case law, the Arbitrator does not find that the petitioner has established, by a preponderance of the evidence that he falls into the odd-lot category. The Arbitrator finds it significant that the petitioner received a number of interviews during his search for work in the construction industry. In petitioner's own words, he received "countless job interviews" and no offers. On cross-examination, the petitioner testified to one job offer at a demolition company. The job required him to unload trucks in addition to his superintendent duties. Petitioner declined the offer because of the unloading requirement. There was no evidence presented as to the required lifting capabilities for that job.

Petitioner also testified that he volunteered with a company known as Projx Construction. Petitioner testified that he performed all the duties required of a project manager. According to the vocational report from August of 2014, Projx did not have work for the petitioner at that time and advised that they would contact him should their business increase. Petitioner testified that he still maintains contact with Projx Construction, to date.

In reviewing petitioner's job search logs, the Arbitrator finds that the positions targeted were almost exclusively with the construction/project management industry. Both Petitioner and Ms. Schmit agreed that these were the only positions targeted.
The Arbitrator understands that the goal of the vocational rehabilitation process is to return the individual to work at the highest wage possible so the individual can continue his pre-injury lifestyle.

The Arbitrator also acknowledges that it is not always possible to return an individual to work in their usual and customary area of employment.

There is no evidence that Petitioner's job search was ever expanded to include other industries and positions. The Arbitrator notes that this case was tried on all issues. Petitioner also testified that he does not believe he can return to work "in any physical capacity". A claimant may prove by the preponderance of the evidence that they fall into the odd-lot category by demonstrating a diligent but unsuccessful job search. The Arbitrator finds that petitioner's job search was only limited to the construction trade and therefore not considered to be diligent. The Arbitrator finds the evidence to be insufficient to prove that the petitioner falls within the odd-lot category.

Furthermore, Ms. Schmit, the only vocational expert to testify, concluded that Petitioner is employable. She testified credibly and in an unrebutted manner, that the petitioner presented well to employers and garnered significant interest. She testified that Petitioner is motivated and that he is a younger individual (44 years old at the time of hearing). The job search logs revealed that Petitioner received interviews almost monthly and in some cases, petitioner was one of the final candidates to be selected for a position. Based upon this evidence and testimony, the Arbitrator cannot conclude that the petitioner is unemployable.

Even if the Arbitrator were to find that petitioner proved by a preponderance of the evidence that he falls into the odd-lot category, expert to testify and offer opinions on petitioner's employability as well as his skills and experience. Her testimony was unrebutted.

Ms. Schmit testified credibly that the petitioner is employable in a reasonably stable labor market. She testified credibly regarding petitioner's skills, age and work experience. Ms. Schmit testified that petitioner's age (44 years old) would not have a negative impact upon his ability to find work. The Arbitrator notes that the petitioner has many skills, including supervisory experience. Petitioner also ran his own business for several years. He was required to supervise all of the trades at a job site, maintain schedules, order supplies, document payroll and other duties of a business owner. The Arbitrator adopts Ms. Schmit's opinion that the petitioner is employable in a reasonably stable and well-known sector of the labor market.
The Arbitrator also relies upon the surveillance video taken on July 24, 2014. The video shows the petitioner entering and exiting a vacant building located at 657 W. Lake Street in Chicago over the course of several hours. Petitioner is seen carrying blueprints in and out of the building. Petitioner admitted that he has been to that address several times in order to "visit a friend". The Arbitrator notes that this video was taken before the petitioner began his volunteer period with Projx construction. After the investigator testified and the video was played, the petitioner did not offer any rebuttal testimony to explain his activities on that day. The Arbitrator questions what the petitioner was doing at the vacant building with blueprints prior to the volunteer period with Projx and considers this in her evaluation of the petitioner's credibility.

Since petitioner has failed to prove that he is permanently and totally disabled, the Arbitrator must consider whether Petitioner qualifies for an wage differential award under Section 8(d)1. The Arbitrator finds insufficient evidence to award a wage differential under Section 8(d)1. The Arbitrator finds that the petitioner has likely lost access to his usual and customary employment. However, there was no credible evidence to establish what petitioner is capable of earning in some suitable employment. The Arbitrator cannot base a wage differential award on speculation. Without credible evidence to establish an appropriate wage in some suitable employment, the Arbitrator declines to award a wage differential under Section 8(d)1.

Petitioner sustained injuries to his left wrist and shoulder. Petitioner does not have any permanent disability with respect to his left shoulder. He testified that his pain is more of a "nuisance" and that he has no issues with his shoulder strength or range of motion. Petitioner has not had treatment for his left shoulder in several years. Petitioner has a significant disability with respect to his left wrist, which resulted in permanent lifting restrictions.

Based upon the medical evidence and testimony, the Arbitrator finds that petitioner has sustained a loss of trade or profession. The Arbitrator finds that the petitioner sustained permanent, partial disability to the extent of 50% loss of use of person as a whole representing a loss of trade or profession.

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

Illinois courts have refused to assess penalties under sections 19(k) and (l) of the Act where the evidence indicates that the employer reasonably could have believed that the employee was not entitled to the compensation withheld. *See, Board of Education v. Industrial Commission*, 93 Ill.2d 1, 442 N.E.2d 861 (1982); *See also, Avon Products, Inc. v. Industrial Commission*, 82 Ill. 2d 297 (1980) and *Brinkmann v. Industrial Commission*, 82 Ill. 2d 462 (1980). "Where a delay has occurred in payment of workmen's compensation benefits, the employer bears the burden of justifying the delay, and the standard we hold him to is one of objective reasonableness in his belief." *Id. See also, City of Chicago v. Industrial Commission*, 63 Ill. 2d 99 (1976).

The Illinois Supreme Court has explicitly found an obligation on the part of Respondents to diligently obtain information regarding a Petitioner's claim in *Board of Educ. v. Industrial Comm'n*, 93 Ill. 2d 1, 66 Ill. Dec. 300, 442 N.E.2d 861 (1982). In *Board of Educ.*, the court found that the Chicago Board of Education "had or should reasonably have had in its possession" sufficient evidence, that "would have disclosed that the grounds for challenging temporary total disability liability were insubstantial at best," and therefore fees and penalties were warranted. The Supreme Court also found that the Board's "failure to obtain that information did not entitle the Board to assert later that it acted in good faith because it was ignorant of the evidence in favor of the employee." *See, Board of Educ. v. Industrial Comm'n*, 93 Ill. 2d 1, 66 Ill. Dec. 300, 442 N.E.2d 861 (1982).

The petitioner has requested penalties and fees to be awarded. While the respondent argues that the petitioner's three paragraph penalty petition does not specify the time periods in which penalties and fees were being claimed for a delay in payment of TTD or maintenance; the petitioner testified to the necessity of his attorney filing 19(b)'s and penalty petitions, for such delays. The 19(b) petitions were included as an exhibit at trial. The Arbitrator notes that the 19(b)'s do not indicate the time periods in which TTD or maintenance was delayed. Although Petitioner could not testify with any specificity as to all of the time periods in which his TTD or maintenance checks were delayed, he did testify sufficiently and in an unrebutted manner, to prove the chronic delays in payment of his benefits and authorization to necessary medical treatment, by the respondent. The Arbitrator finds that the petitioner has met his burden of proving entitlement to penalties with respect to the Act.

The Arbitrator finds that penalties of $1,000.00 pursuant to Section 19(k) of the Act, penalties of $10,000.00, pursuant to section 19(l) of the Act, and fees of $2,548.57, pursuant to section 16 of the Act, should be imposed upon the Respondent. The Arbitrator does not find Dr. Walsh's opinion to be persuasive and that the respondent's reliance on Walsh's opinion, to terminate Petitioner's benefits was misplaced. The respondent has previously utilized several other doctors for its Section 12 examinations of Petitioner, who offered credible, professional opinions regarding his medical condition and the Arbitrator finds that the respondent's chronic delays in paying Petitioner's temporary total disability payments rises to the level of arbitrary and capricious and acts in bad faith, on the part of the respondent, therefore penalties and attorney's fees are awarded.

John Lizon
09 WC 43267

16IWCC0675

ILLINOIS WORKERS' COMPENSATION COMMISSION
CORRECTED ARBITRATION DECISION
09WC43267
SIGNATURE PAGE

Signature of Arbitrator

November 25, 2015
Date of Decision

DEC 7 - 2015

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

Erica Hamlin,

Petitioner,

vs. NO: 15 WC 10269

16IWCC0676

Meijer,

Respondent.

DECISION AND OPINION ON REVIEW

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

For the reasons set forth below, the Commission modifies the Arbitrator's Decision by finding causal connection and awarding medical expenses and prospective medical expenses. The Commission further finds that the Petitioner is entitled to temporary total disability benefits of $254.16 per week for the period of March 1, 2015 through August 3, 2015.

So that the record is clear, and there is no mistake as to the intentions or actions of this Commission, we have considered the record in its entirety. We have reviewed the facts of the matter, both from a legal and a medical / legal perspective. We have considered all of the testimony, exhibits, pleadings and arguments submitted by the Petitioner and the Respondent. One should not and cannot presume that we have failed to review any of the record made below.

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

On direct examination, the Petitioner testified that she worked for Respondent as a food service clerk in the bakery. Besides baking, Petitioner would put loads away, lift heavy boxes, pull out carts, and obtain supplies from the back of the bakery. On February 19, 2015 towards the end of her shift, she went into the freezer to pull frozen foods out and twisted her left leg when she turned to leave the freezer. She finished her shift and did not inform any one at her place of employment about the aforementioned incident. (Tr. 14-17).

Petitioner further testified that her leg was hurting her that night and she self-treated. She reported to work the next day and subsequently informed her team leader, Emil Begovic, about her work accident the day before. Mr. Begovic had just returned from a vacation. The Petitioner continued to work that day and for the next few days. As time went on and she was doing her work, she felt a pull and pain in her left knee. Over the next five days she self-treated her left knee. Petitioner did encounter Mr. Begovic those five days at work. The Petitioner testified that she informed Mr. Begovic that her leg still hurt from her injury but that she could not afford to take a day off. (Tr. 17-20).

The Petitioner testified that from February 20, 2015 through February 26, 2015 while she continued to work, she would have lunch with her boyfriend at Respondent's place of business. She was limping and still in pain during that time. The Petitioner and her boyfriend would have conversations with Mr. Begovic during Petitioner's lunchtime, and Petitioner would inform Mr. Begovic that her leg was still hurting her. (Tr. 29-34).

The Petitioner testified that on February 27, 2015 she called off work to her team leader, Mr. Begovic, and informed him that her left leg was hurting so much from her injury that she could not get out of bed. (Tr. 20-22).

The Petitioner further testified that she first sought medical attention on March 1, 2015 at Elmhurst Hospital after feeling pain after walking a few steps from her kitchen sink to her bathroom. She denied hitting her knee on anything, tripping, or twisting her knee again. Petitioner screamed and her boyfriend and son subsequently provided aide to her. After Petitioner's emergency room visit, she started treating at Chicago Hand & Orthopedic Surgery Center. She treated with Dr. Taruna Crawford who recommended knee surgery. The Petitioner has not been released back to work and has been off work from March 1, 2015 though the date of the arbitration hearing. (Tr. 22-26).

As of the date of hearing, the Petitioner testified to having throbbing pain in her entire kneecap, and a very tender spot on the inside of her left knee. Her leg still gives out, and there is popping every time she gets up. She also has leg cramps, and walks with a limp. (Tr. 34-36).

Respondent called Brian Garcia, Petitioner's boyfriend, to testify. Mr. Garcia testified that he heard the Petitioner cry and scream on March 1, 2015 when her knee popped. Mr. Garcia also testified that he encountered Petitioner's team leader, Mr. Begovic in March and April of

2015. Mr. Garcia recalled speaking with Mr. Begovic about Petitioner, her knee condition, and in regard to Petitioner reporting her accident in March of 2015. (Tr. 44-46).

The Respondent also called Mr. Begovic to testify. He worked for Respondent as a prepared foods team leader which covers the bakery and deli. Mr. Begovic was on vacation February 19, 2015 (the day of Petitioner's work-related accident), and returned to work on February 20, 2015. He testified that he did not recall having a conversation with Petitioner in regards to her work accident on February 20, 2015. In fact, Mr. Begovic testified that he was not made aware of Petitioner's work accident until March 4, 2015 when Petitioner called him to inform him of said accident. (Tr. 46-50, 51-53).

Mr. Begovic further testified that he encountered the Petitioner's boyfriend, Mr. Garcia, on April 22, 2015 at Respondent's place of business and that they discussed Petitioner's left knee situation. Mr. Begovic noted that Mr. Garcia told him that the Petitioner did not file an accident report "because her injury was not serious." They also discussed how the Petitioner had not had surgery yet, and they were looking to get insurance to cover her surgery. (Tr. 53-58).

On cross-examination, Mr. Begovic testified that he noticed the Petitioner limping the day he returned from vacation - February 20, 2015. He further testified that he never inquired about Petitioner's limp that he witnessed between February 20, 2015 through February 26, 2015. According to Mr. Begovic, the Petitioner never told him about the circumstances of her limping. (Tr. 59-62, 64-66).

Medical records submitted into evidence demonstrate that the Petitioner went to the emergency room on March 1, 2015 regarding a left knee injury that had previously occurred at work. The Petitioner reported hearing a 'pop' in her left knee while she was lifting boxes while working in the bakery. The MRI results of the left knee demonstrated a tear in the medial meniscus, low grade MCL sprain, partial ACL tear, and a small knee effusion. (Px2).

Medical records from the Chicago Hand & Orthopedic Surgery Centers were also submitted into evidence. The Petitioner reported a history of an onset of pain in the left knee on February 19, 2015 while moving boxes at work. Her symptoms worsened when on March 1, 2015 she felt a 'pop' in her left knee. Her treating physician noted: [Petitioner] "sustained a work-related injury with onset of pain and swelling in the left knee while lifting boxes while at work." Her diagnosis was a medial meniscus tear. Arthroscopic surgery was later proposed to treat her condition. The Petitioner was instructed to continue using crutches for aid and ambulation. (Px3).

Petitioner was examined for an Independent Medical Examination pursuant to Section 12 of the Act by Dr. David Garelick on May 27, 2015. Dr. Garelick noted in his subsequent report that symptom magnification played a role in his conclusions because it called into question the Petitioner's reliability. The evidence of symptom magnification was her crying during the physical exam, the fact that she still used crutches three months after sustaining a meniscal tear, and her significant guarding on the physical exam. Dr. Garelick further opined that it was more probable than not that if Petitioner's injury occurred on February 19, 2015 then she would not have been able to continue working until February 26, 2015 as evidenced by the significant

amount of disability manifested by Petitioner at the time of his examination. Further, he opined that while an injury which causes a meniscus tear may not manifest itself fully for one to two days following an injury, it would not have taken a week like as seemed to have occurred in Petitioner's situation. Dr. Garelick wrote that it was more likely that the 'pop' in Petitioner's left knee that occurred at her home on March 1, 2015 was the inciting incident that caused her left knee condition. Dr. Garelick noted that Petitioner necessitates a knee arthroscopy and either a meniscal resection or a meniscal repair. (Rx1).

Based upon the totality of the evidence and the factual findings above, the Commission finds that Petitioner's left knee injury was causally related to her work accident on February 19, 2015, and awards medical expenses, prospective medical expenses, and temporary total disability benefits as set forth below.

The Commission finds that the Petitioner was injured while moving boxes at work towards the end of her shift on February 19, 2015. Although she did not report her work injury that day, the Petitioner reported her accident and injury the next day to her team leader, Mr. Begovic. The Commission finds Petitioner's testimony credible that she reported her accident to Mr. Begovic and periodically gave him updates on her condition before she was kept off of work by her treating physician.

The Commission further finds Mr. Begovic's testimony to be questionable. Incredibly, Petitioner's team leader denied any knowledge of Petitioner's accident prior to Petitioner's phone call on March 4, 2015 even though Mr. Begovic testified that he noticed the Petitioner limping on February 20, 2015 and for the next six days. The Commission notes that the Petitioner testified to informing Mr. Begovic of her work accident and injury on February 20, 2015. The Commission deems it less than plausible that a supervisor would notice his employee limping for six days and never inquire as to the employee's injury, or that the injured employee would not discuss the issue with her supervisor. Moreover, Mr. Begovic' s recollection of the conversation that he had with Mr. Garcia regarding Petitioner's alleged failure to report her accident before March 4, 2015 also lacks credibility. Again, it is less than plausible that Mr. Garcia would state that Petitioner did not report her accident because it was not that serious, while at the same time acknowledge that Petitioner was attempting to obtain health insurance because she needed surgery. An injury necessitating surgery would generally be considered a serious injury.

Furthermore, the treating medical records submitted into evidence corroborate Petitioner's testimony in that they reflect that Petitioner sustained a work injury on February 19, 2015 while in the process of lifting boxes at work. The Commission further finds Petitioner's treating physician's opinion to be more persuasive than Dr. Garelick's opinions. Dr. Garelick noted that Petitioner's reliability was called into question because of her symptom magnification. One aspect of his noted symptom magnification was that Petitioner was using crutches three months after sustaining the meniscal tear. However, the Petitioner was instructed to use crutches for assistance with ambulation per her medical records. The fact that Petitioner cried and had significant guarding on the physical exam is also not persuasive given the fact that Dr. Garelick agreed that Petitioner needed surgery. His opinion was that it was more probable than not that if Petitioner's injury had occurred on February 19, 2015, then she would not have been able to

continue working until February 26, 2015 as evidenced by the significant amount of disability manifested by Petitioner at the time of his examination. Dr. Garelick failed to account for the subsequent 'pop' in Petitioner's left knee at Petitioner's home on March 1, 2015. That was the impetus for her to seek medical attention. Further, Dr. Garelick's opinion regarding the delayed meniscus tear manifestation is not persuasive. The Commission finds that it is plausible for Petitioner to have had further manifestation of her first injury after one week, especially considering the fact that Petitioner did not have medical treatment after her initial injury on February 19, 2015.

The Commission finds that the 'pop' and pain that Petitioner experienced in her left knee in her home on March 1, 2015 did not break the causal connection between the original work-related injury on February 19, 2015 and her ensuing condition.

The Commission further finds that Petitioner should be awarded medical expenses detailed in Petitioner's exhibits (1) and (2), according to the fee schedule. The Commission also finds that Petitioner should receive further treatment for her left knee, to include surgery and reasonable treatment recommended by Petitioner's orthopedic physician.

The Commission finds that Petitioner is entitled to temporary total disability from March 1, 2015 through August 3, 2015 for 22 and 2/7 weeks at the rate of $254.16/ week, which represents the first day that Petitioner was off of work until the date of the arbitration hearing. The Commission further finds that penalties and fees are not awarded because the Respondent had a good faith defense, namely Dr. Garelick's opinion that Petitioner's work accident was not the cause of her condition.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's Decision, filed on December 1, 2014, is hereby modified as to the finding of causal connection for Petitioner's left knee injury.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner be awarded prospective medical in the form of surgery to her left knee.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner be awarded medical expenses at the fee schedule rate for expenses incurred as a result of her left knee injury.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $254.16 per week for a period of 22 and 2/7 weeks (March 1, 2015 through August 3, 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 pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that penalties and fees are denied.

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 is remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

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

DATED: OCT 2 6 2016

TJT/gaf
O: 8/30/16
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

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

HAMLIN, ERICA
Employee/Petitioner

Case# **15WC010269**

MEIJER
Employer/Respondent

16IWCC0676

On 9/30/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.10% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1759 MARTAY LAW OFFICE
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CHICAGO, IL 60602

5018 ALLEN KOPET & ASSOCIATES
LYNN COMBS
33 N LASALLE ST SUITE 2110
CHICAGO, IL 60602

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Erica Hamlin
Employee/Petitioner

v.

Meijer
Employer/Respondent

Case # **15** WC **10269**

Consolidated cases: ____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Deborah L.**Simpson**, Arbitrator of the Commission, in the city of **Chicago**, on **August 3, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

N. [ ] Is Respondent due any credit?

O. [ ] Other ____

FINDINGS

On the date of accident, February 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* sustain an accident that arose out 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 $**19,824.64**; the average weekly wage was $**381.24**.

On the date of accident, Petitioner was **44** years of age, *single* with **-0** dependent children.

ORDER

The Petitioner failed to prove that the injury she sustained on February 19, 2015 when she twisted her knee is causally connected to the current condition of ill-being with respect to her torn meniscus and the need for surgery. The injury she sustained on March 1, 2015 is the reason for her current condition and it is not related to her work injury ten days earlier. Therefore Petitioner failed to prove a compensable accident, benefits pursuant to Section 8 of the Act are denied. Fees and Penalties are denied as well.

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

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

Deborah L. Simpson
Signature of Arbitrator

Sept. 29, 2015
Date

ICArbDec19(b)

SEP 3 0 2015

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Erica Hamlin,	)	
	)	
Petitioner,	)	
	)	
vs.	)	**No. 15 WC 10269**
	)	
Meijer,	)	
	)	
Respondent.	)	
	)	

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

The parties agree that on February 19, 2015, the Petitioner and the Respondent were operating under the Illinois Worker's Compensation or Occupational Diseases Act and that their relationship was one of employee and employer. They agree that the Petitioner gave the Respondent notice of the accident which is the subject matter of the dispute within the time limits stated in the Act. They further agree that in the year preceding the injuries, the Petitioner earned $19,824.64, and that her average weekly wage was $381.24.

This matter comes for hearing on the Petitioner's motion for hearing pursuant to Section 19(b) of the Act. At issue in this hearing is as follows: (1) Did the Petitioner sustain accidental injuries that arose out of and in the course of employment; (2) Is the Petitioner's current condition of ill-being causally connected to this injury or exposure; (3) Is the Respondent liable for the unpaid medical bills for Elmhurst Memorial Hospital $1,051.96, Chicago Hand and Ortho $468.00, Elmhurst Radiology $226.00 and $27.00 , and MRI $4,212.00 and Prescriptions in the amount of $16.29 and $12.69 ; (4) Is Petitioner entitled to TTD from March 1, 2015 through August 3, 2015; (5) Should penalties and attorney's fees be imposed against the Respondent; and (6) Is the Petitioner entitled to prospective medical treatment.

STATEMENT OF FACTS

Petitioner testified she was first hired at Respondent in July, 2011 as a food service clerk in the bakery. (R14) In that job she had to put loads away; lift heavy boxes; pull out L-carts; and get supplies. She worked from 2011 until February 18, 2012 and worked full time, full duty with no injuries. She had no injuries at work or to her left leg or knee before February 19, 2015.

According to Petitioner on February 19, 2015 she reported to work at 8:00 AM and continued to work most of that day. (R15, 16) At about 3:45 P.M. that afternoon, toward the end of her shift, she went into the freezer. As she was lifting a box off the top shelf, she turned to

leave the freezer and she twisted her left leg. She finished working the rest of her shift. Petitioner testified that she did not report the injury that day to anyone at work. That evening her left leg and knee were hurting, and she used Ben-gay, took Aleve, and elevated the left leg. Petitioner testified that there were no witnesses to this work injury.

Petitioner stated that she reported to work the next day. (R17) Her team leader is Emil Begovic. According to the Petitioner she had a conversation in the early morning in the store right outside his deli area where there is a cheese island that he was filling. (R18) He had come back from vacation and saw Petitioner limping, and she told him "I twisted my leg in the freezer." Petitioner continued to work that day and the next few days, even though she noticed she had pain in the left knee. (R19) Petitioner testified that she continued to use Ben-gay and Aleve, elevated her leg, and put ice packs on it.

Petitioner testified that she used to have lunch, at work, with her boyfriend. He came to the store. During the 5 or 6 days she worked after February 19th, she was limping and noticed she had pain in her left leg and knee. (R29) In those 5 or 6 days during lunch-time with her boyfriend, she claimed she had conversations with Mr. Begovic, and he would ask how she was doing, and she would tell him her leg was still hurting.

On February 27, 2015 Petitioner did not report to work, but called that day off, if she did not call in she would get points. (R20) Petitioner stated that she called about 6:30 to 6:45 A.M. and talked to Mr. Begovic, her team leader. She testified that she "told Emil, I said, my left leg is hurting real bad from the injury; and I said, I can't get out of bed; and he says, OK. I hope you feel better." When she made the call to Mr. Begovic on February 27th her boyfriend, Brian Garcia was with her. (R21)

Petitioner testified that on March 1, 2015, she was home, in her kitchen standing by the sink. She turned and she heard and felt a pop in her knee. She screamed from the pain. She stated that she had only walked five steps. Her boyfriend and her son helped her to the couch then took her to the hospital. This was the first time she sought medical attention for her knee.

On Sunday, March 1, 2015, after Petitioner experienced the popping sound and sensation in her knee she went to Elmhurst Memorial Hospital. Petitioner said that she told hospital personnel that she got injured at work, and then at home she was at the kitchen sink and turned to go to the bathroom about ten steps away, and as she took about 3 or 4 steps her left leg gave out and she heard a "pop." She screamed and started crying and her boyfriend came into the room along with her son and helped her to the couch and then took her to the emergency room. (R22) Petitioner said that she took about 4 or 5 steps from the kitchen sink to where the bathroom was. She denied tripping or twisting her knee. She also denied hitting her knee on anything. She had emergency care at Elmhurst Hospital on the first, and then came under the care of Chicago Hand and Ortho, Dr. Taruna Crawford beginning on March 2, 2015. (R23) (RX 2, PX 3)

Petitioner saw Dr. Crawford multiple times and eventually she had an MRI. She still continues to see Dr. Crawford to date. She has a visit scheduled with Dr. Crawford on September 1, 2015. Dr. Crawford recommended knee surgery for the medial meniscus tear. (R24) The surgery has not been performed. She has not been released to return to employment by her doctor. She has been off work since March 1, 2015 up until the date of this hearing

August 3, 2015. Petitioner asked that if the Arbitrator held in her favor that Respondent pay temporary compensation while she has been off work. (R25)

Petitioner testified that she has had no new injury to her left knee or leg since February 19, 2015. Other than the surgery Dr. Crawford has recommended, she still takes Aleve and does leg exercises prescribed by Dr. Crawford. (R26) She still puts ice on the knee and elevates her leg. Sometimes she has to use crutches to walk.

Petitioner was shown as Exhibit 4, e-mails that were sent from Meijer and from the insurance adjuster. (R27) The e-mails are all dated after March 1, 2015. Prior to March 1st there was no actual written report.

Petitioner called Respondent to get approval of the MRI that Dr. Crawford ordered. Petitioner testified that she had a telephone conversation with Mr. Begovic about March 3rd or 4th of 2015, so he could do a written report regarding the accident that Petitioner had on February 19, 2015. (R28) She believes a written report was made after that conversation, but she has never seen a copy. Vicki, the person who is in charge of cashiers and customer service called Petitioner to give her a work comp number.

Petitioner testified that currently she notices that her left leg and knee still has pain and gets throbbing pain in the whole knee cap, and there is a real tender spot on the inside of the left knee. (R34) The knee gives out, and she has a "popping" every time she gets up and a lot of leg cramps. Today she walks with a limp. She never had these complaints before her work injury on February 19, 2015. (R35)

Petitioner testified that she was examined by Dr. David H. Garelick, at the request of the Respondent pursuant to Section 12 of the Act.

On cross-exam Petitioner testified that she still lives with her boyfriend, Brian Garcia. She did not elect to take group health insurance or short term disability benefits even though they are offered by the Respondent. She is claiming a work injury on February 19, 2015 to the left knee and that is the only injury. Mr. Emil Begovic is her team leader. (R36) Mr. Begovic was on vacation on February 19th. There are other team leaders in the store and she knows who some of them are. She did not report the injury to any other team leader. She did not work on Sunday, March 1, 2015. (R37) She last worked February 26, 2015. She did not seek any medical care until she went to Elmhurst on Sunday, March 1, 2015. She sought care on March 1st after the occurrence in the kitchen. (R38) Mr. Garcia drove her to Elmhurst Memorial Hospital. That was the first time she was taken off work. Mr. Begovic called on March 4, 2015 so he could do a written report.

Petitioner was shown as Petitioner's Exhibit #1 various medical bills. (R30) The Petitioner identified these as bills she had received for medical treatment for her knee. She asked that if the Arbitrator held in her favor these bills be either paid or reimbursed according to the Illinois Medical Fee Schedule.

Petitioner was also shown Petitioner's Exhibit #2, identified as two (2) bills from Elmhurst Memorial Hospital for the MRI of the left knee for $4,212.00, and emergency care for $1,051.90. (R31) As far as she knows these bills remain unpaid. Petitioner asked that if the

Arbitrator held in her favor that these bills be paid by the insurance company per the Illinois Medical Fee Schedule. (R32)

Petitioner was shown Petitioner's Exhibit #3, Identified as the medical records from Chicago Hand and Ortho, the medical billing for $468.00. (R33) Again Petitioner asked if the Arbitrator held in her favor, that this bill be paid per the Illinois Medical Fee Schedule.

Brian Garcia was called to testify by Respondent. He testified that he was present pursuant to the Subpoena served on him by Respondent. He admitted that he is the boyfriend of Petitioner, and they live together. (R43) He heard Ms. Hamlin cry and scream in pain on March 1st after her knee popped in the kitchen. He drove Petitioner to Elmhurst Hospital on March 1st after the knee popping incident. Petitioner did not work that day for Respondent. (R44) When asked if the witness saw Emil Begovic on April 22, 2015, he indicated that he did run into him on occasion in March and April no specific dates were offered. (R45)

Emil Begovic testified for Respondent as well. He is employed by Respondent as a prepared foods team leader which covers the deli and bakery. He stated that there are procedures in place for when someone is injured; a report has to be filed and forwarded to the superior. (R47-48) He is familiar with Petitioner, and she works in the bakery. He spoke to Petitioner on the phone on March 4, 2015. She called to get a claim number for an MRI for her knee. She alleged an injury on February 19, 2015. This was the first time she documented the alleged work accident. (R49) That was the first date he was made aware of the alleged injury on February 19th.

Mr. Begovic was on vacation on February 19, 2015, he did not work that day. He returned to work on February 20, 2015. He did not recall having a conversation with Petitioner near the cheese island on the day that he returned to work from his vacation. (R50) He stated that If there was a reported work accident he would have immediately filled out a report, but he did not. Ms. Hamlin was still working until February 26, 2015. Mr. Begovic did not recall receiving a telephone call from Petitioner on February 27, 2015 regarding her inability to work on that day (R. 51) He testified that "if someone calls off of work we notify the superiors that there has been a call off in our department." (R52)

According to Mr. Begovic he did not know Petitioner was claiming a work injury on February 19th until March 4, 2015. There are other team leaders working when he is on vacation. Petitioner could have reported the incident to any of the team leaders.

Mr. Begovic does remember seeing Petitioner's boyfriend, Brian Garcia, in the store on April 22, 2015. (R53) They did have a conversation. (R54) He asked Mr. Garcia how Petitioner was doing, and Mr. Garcia stated that her knee popped at one point at home. Mr. Begovic remembered that Mr. Garcia said he was in the basement and heard Erica scream upstairs in the kitchen when it happened. Mr. Begovic also remembered that he did have a conversation with Mr. Garcia about accident reporting information. (R55) This was the purportedly the same conversation on or about April 22, 2015 in the store. Just the two of them were present. Mr. Begovic claims that Mr. Garcia informed him that Erica did not file an accident report because her injury was not serious. (R56) Mr. Begovic also claims that Mr. Garcia informed him that she had not had the surgery yet, that they were both looking into getting insurance to pay for her knee and pursuing areas to get that procedure done. (R58)

On cross-exam the witness testified about a conversation on April 22, 2015. The conversation took place in front of the bakery. Mr. Garcia was there to shop. He recalls that date because he was doing inventory, saw Mr. Garcia and approached him. (R59) He asked how Erica was doing, and Mr. Garcia said the injury was not serious. They were talking about surgery for the injury at this time. When he came back to work on February 20th the witness stated she never mentioned anything about an injury to him. He testified that he did notice she was limping on February 20th, (R60) but she never told him about an injury, and he never asked. He continued to notice she was limping between February 20th and February 26th, but he never asked her about it. (R61) He testified that on February 27th he does not recall getting a phone call from Petitioner, but it was possible that he did. He did not recall if she worked that day. (R.61-62) He agreed that she was required to call in, otherwise she would be docked points. (R. 63)

An accident report was eventually filled out on March 4, 2015 after a phone conversation, but he does not have a copy. There is one in the file. It says I took a statement from Erica over the phone that she went into the freezer and twisted her knee while working." (R. 63-64) He admitted that he did see the Petitioner limping between February 20th and February 26th when he saw Petitioner at work. (R64, 65)

When Petitioner was called on re-direct she had heard Mr. Begovic testify. She reiterated that spoke to Mr. Begovic on February 27, 2015, and that Mr. Garcia was at the phone with her. She stated that she told Mr. Begovic why she wasn't going to be at work. (R68) She believes that Mr. Begovic called her on March 4, 2015 to get a report done. A statement was taken from her by him. She told him how she was injured on February 19, 2015. She has not seen a copy of that report. She never signed anything.

The conversation between Mr. Begovic and Petitioner on February 20, 2015, about a work injury Petitioner suffered, that Mr. Begovic does not remember did take place. It was in the cheese area by the cheese island. (R. 69-70)

The Elmhurst Memorial Hospital records (PX 2) note the work injury to Petitioner's left knee in the bakery area. There is no history of any prior injury to the knee. The records are dated March 1, 2015. The records note "I hurt my knee at work." Petitioner was told to use ice; elevate the knee and a stay off the knee.

An MRI of the left knee dated March 7, 2014, concludes "complex predominantly vertically oriented tear in the medial meniscus; low grade MCL sprain; partial ACL tear versus ACL sprain; and small knee effusion. The report notes "left knee pain, pain mostly medially; past twisting injury 02/19/2015."

The medical records from Chicago Hand and Orthopedic (PX. 3) note the work injury on February 19, 2015, and "on March 1, 2015, she felt a pop in the left knee with immediate worsening of her pain." After noting the details of Petitioner as to how the injury occurred, Dr. Crawford wrote "this is a work related condition." The Dr. did not give a basis or an opinion as to whether the mechanism Petitioner described, as pain starting after lifting boxes at work. there is no notation that Petitioner twisted her knee, squatted and injured her knee, tripped and fell on her knee or that she banged her knee on something. Dr. Crawford, after reviewing the MRI, recommended left knee arthroscopic partial meniscectomy and therapy.

Petitioner continued to see Dr. Crawford through July 20, 2015, with the next scheduled visit September 1, 2015, and the doctor wrote estimated return to work "pending surgery."

The Arbitrator reviewed the several e-mails. (PX 4)

The Arbitrator also reviewed the medical report from Dr. David H. Garelick, Respondent's Section 12 examiner dated May 27, 2015. (RX 2) The report notes what records Dr. Garelick reviewed and included questions from defense counsel.

A history was taken by Dr. Garelick and he noted "She [Petitioner] states she reported this[the injury in the freezer] to her supervisor the next day. However, in the memo from Ms. Combs dated May 15, 2015, it states that she did not report this to the team leader until March 4, 2015. The alleged injury was unwitnessed."

Dr. Garelick performed an exam and wrote Petitioner's condition of ill-being is that she has a root tear of the posterior horn of the medial meniscus.

The doctor wrote causation was the real issue, and he believed the "pop" at home was the "inciting incident that caused this condition." Dr. Garelick noted that if the injury had really occurred on February 19, 2015, Petitioner could not have continued to work until February 26, 2015. This was supported by the significant amount of disability manifested by the Petitioner at the time of the Section 12 examination. (RX 2) The Dr. noted that at the time of the examination the Petitioner could hardly walk, therefore, one would believe that if the accident had actually occurred on February 19, 2015, Petitioner would have been in such pain that she could not have continued to work as she did.

Dr. Garelick also noted that there was some symptom magnification, which played a role in his conclusions. He noted that the symptom magnification included the Petitioner crying during the physical exam, the fact that she was still using crutches at the time of the examination which was three months after the injury and the significant guarding on the physical examination which is not consistent with a meniscus tear. He noted that patients with meniscal tears certainly have pain after the initial injury, but the pain more or less resolves to allow them to participate fully with the examination process within a few weeks. Knee range of motion returns to normal, gait does not necessitate the use of touchdown weight beating with crutches. (RX 2)

Even with these observations Dr. Garelick believes that the Petitioner's condition necessitates a knee arthroscopy and either a meniscal resection or a meniscal repair. He also agreed that Petitioner could not work in the bakery department, she could however return to work in a sedentary capacity. The need for the sedentary work is not because of a work accident but because of the injury she sustained on March 1, 2015, at home when her knee "popped." (RX 2)

The parties introduced various exhibits. Petitioner introduced medical bills as Exhibit #1; medical records with billings from Elmhurst Memorial Hospital as Exhibit #2; Exhibit #3 medical records from Chicago Hand and Ortho Surgery Center, including the medical billing; and as Exhibit #4, the e-mails that Petitioner testified to at hearing. (R72-75)

Respondent introduced wage records; the medical report from Dr. Garelick as Exhibit #2; and time and date work records for Petitioner as Exhibit #3. (R76-78)

CONCLUSIONS OF LAW

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

The burden is on the party seeking the award to prove by a preponderance of credible evidence the elements of the claim, particularly the prerequisites that the injury complained of arose out of and in the course of the employment. *Hannibal, Inc. v. Industrial Commission*, 38 Ill.2d 473, 231 N.E.2d 409, 410 (1967)

Longstanding Illinois law mandates a claimant must show that the injury is due to a cause connected to the employment to establish it arose out of employment. *Elliot v. Industrial Commission*, 153 Ill. App. 3d 238, 242 (1987).

The burden of proof is on a claimant to establish the elements of his right to compensation, and unless the evidence considered in its entirety supports a finding that the injury resulted from a cause connected with the employment, there is no right to recover. *Board of Trustees v. Industrial Commission*, 44 Ill. 2d 214 (1969).

On the issue of an intervening cause, the courts have consistently held that for an employer to be relieved of liability by virtue of an intervening cause, the intervening cause must completely break the causal chain between the original work-related injury and the ensuing condition. *Boatman v. Industrial Commission*, 256 Ill.App.3d 1070, 628 N.E.2d 829, 195 Ill.Dec. 365 (1st Dist. 1993).

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

Petitioner testified that while moving boxes in the freezer on February 19, 2015 that she injured her left knee when she twisted turning to leave the freezer. Petitioner did not report the incident to anyone that day, she finished her shift and went home. She reported to her treating doctor, Dr. Crawford that she was moving boxes when she began having pain in the left knee. No one was present in the freezer to witness the incident. She reported that on February 26, 2015 there was a big load with three pallets. She reported a progressive worsening of her symptoms. She is experiencing severe pain in her knee since March 1, when she felt a pop in her left knee with immediate worsening of the pain."

Petitioner testified that after the twisting incident she was able to walk, with a limp and she was able to continue working. Petitioner continued working from February 20, 2015 through February 26, 2015. She iced her knee, put Ben-gay on it and took Aleve. It was ten days later, on March 1, 2015, while she was in her kitchen when she turned to walk to the bathroom when she heard the "pop," felt the "pop" and experienced immediate worsening of her pain such that she had to be helped to the couch by her son and her boyfriend and eventually sought medical

treatment at Elmhurst Hospital. Petitioner admitted that the last time she had worked for Respondent before the popping incident was February 26, 2015.

Emil Begovic, her supervisor, was not there on February 19, 2015 when the Petitioner claims she injured her knee. He does not deny having a conversation with Petitioner the next day regarding her knee and how it was injured, he just does not recall having it. He implied that the conversation did not take place because he would have written a report regarding the injury immediately per the Respondents injury policy, and he did not write a report. He does remember that the Petitioner was limping when he returned from his vacation on February 20, 2015.

Petitioner proved by a preponderance of the evidence that she sustained an accidental injury to her left knee on February 19, 2015.

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

Petitioner testified that even though she had pain and was walking with a limp she was able to work. She managed the pain with Aleve and Ben-gay and used ice and elevation for the swelling that she noticed. After the incident on March 1, 2015 she was not able to walk without crutches and experienced significantly more pain.

Petitioner's treating doctor recorded that Petitioner reported injuring her knee moving boxes. No mention of the twisting that Petitioner described at the hearing is noted. Dr. Crawford also noted that the Petitioner continued working, limping and there was progressive worsening of her symptoms. She notes Petitioner described severe pain after her knee popped on March 1,2015 which caused immediate worsening of her pain and symptoms. Dr. Crawford wrote that this was a work related injury, however she does not address the issue of the "pop" that Petitioner heard and felt, which caused the worsening of her symptoms to the point she needed assistance walking and sought medical treatment and how that relates to a work injury.

No one denies that Petitioner has a medial meniscus tear that requires surgical treatment. The question is whether the tear is the result of the "twisting" injury Petitioner described at the hearing, or the lifting injury Petitioner reported to Dr. Crawford both of which occurred on February 19, 2015 and resulted in Petitioner experiencing pain and walking with a limp or was it the incident that occurred on March 1, 2015 in Petitioner's kitchen when she turned and started walking from the sink to the bathroom and heard and felt the pop in her knee while at the same time experiencing so much pain she cried out and needed assistance to get to the couch.

Dr. Garelick, the Respondent's Section 12 examiner noted that causation was the real issue. Dr. Garelick believed the "pop" at home was the "inciting incident that caused this condition." Dr. Garelick noted that if the injury had really occurred on February 19, 2015, Petitioner could not have continued to work until February 26, 2015. His opinion was supported by the significant amount of disability manifested by the Petitioner at the time of the Section 12 examination. Specifically he noted that at the time of the examination the Petitioner could hardly walk. If the accident had actually occurred on February 19, 2015, Petitioner would have been in so much pain that she could not have continued to work from February 20 through February 26, as she did. Dr. Garelick also determined that Petitioner was magnifying her symptoms at the

time of his medical examination. He wrote that that factor was considered by him in reaching his opinion. He described the symptom magnification as (1) Petitioner crying during the physical exam; (2) the fact that she was still using crutches at the time of the examination which was three months after the injury; and (3) and the significant guarding on the physical examination which is not consistent with a meniscus tear. Dr. Garelick explained that patients with meniscal tears certainly have pain after the initial injury, but the pain more or less resolves to allow them to participate fully with the examination process within a few weeks. He also wrote that the range of motion for the knee returns to normal after a time, even though there is still pain. Finally gait does not require the use of crutches with "touchdown weight bearing." His opinion was supported by his examination of the Petitioner and his review of the medical records and test results as well.

For the above stated reasons, the Arbitrator finds Dr. Garelick's conclusions more credible than Dr. Crawford with respect to whether Petitioner's current condition of ill-being and her need for surgical intervention is causally related to the injury she sustained on February 19, 2015. The Arbitrator finds that Petitioner's current state of ill-being is not causally related to her work injury.

With regard to (1) whether the medical services that were provided to Petitioner were reasonable and necessary and whether Respondent paid all appropriate charges for reasonable and necessary medical treatment; (2) the amount due for temporary total disability; (3) whether Petitioner is entitled to prospective medical care: and (4) whether Petitioner is entitled to attorney's fees and penalties; the Arbitrator makes the following conclusions of law:

(1) The Petitioner failed to prove that her current condition of ill-being is causally connected to the injuries that she sustained when she twisted her knee at work on February 19, 2015. Petitioner testified that she was able to work the balance of her shift the day she twisted her knee and the days following, from February 20, 2015 through February 26, 2015. She testified that she experienced sufficient pain on February 27, 2015 to call off of work that day, however she did not seek medical treatment for two days after that. Petitioner did not seek medical treatment until her accident at home, wherein she turned from the sink and walking to the bathroom felt and heard the "pop" in her knee that caused her to be unable to walk without assistance and to seek medical treatment. Petitioner failed to prove any if the medical treatment was related to the injury that she suffered on February 19, 2015, therefore Respondent is not responsible for the medical treatment that Petitioner obtained for her knee.

(2) The Petitioner was able to work the rest of the day after she twisted her knee. She reported to work the hours that she was scheduled to work from February 20, 2015 through February 26, 2015. The Petitioner testified that she called in sick because of the pain in her knee on February 26, 2015, however she did not testify that she sought medical treatment that day or that she obtained an order from a medical treatment provider taking her off of work that day because of her knee injury. The Petitioner produced an order from her doctor taking her off of work after the injury on March 1, 2015, which is not a work related injury. No testimony was presented by Petitioner that she was scheduled to work on February 28 and was unable to do so.

Therefore Petitioner failed to prove that she is entitled to TTD for the time between February 27 and March 1, 2015.

(3) and (4) The Petitioner failed to prove a compensable accident therefore the above listed issues regarding prospective medical care and fees and penalties are moot.

ORDER OF THE ARBITRATOR

The Petitioner failed to prove that the injury she sustained on February 19, 2015 when she twisted her knee is causally connected to the current condition of ill-being with respect to her torn meniscus and the need for surgery. The injury she sustained on March 1, 2015 is the reason for her current condition and it is not related to her work injury ten days earlier. Therefore Petitioner failed to prove a compensable accident, benefits pursuant to Section 8 of the Act are denied.

Petitioner petition for fees and penalties is denied as well.

Deborah L. Simpson — Sept 29, 2015

Signature of 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 WILLIAMSON	)	☐ Reverse Choose reason	☐ Second Injury Fund (§8(e)18)
			☐ PTD/Fatal denied
		☐ Modify Choose direction	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Michael Brand,

Petitioner,

vs.

NO: 14 WC 19238

16IWCC0677

State of Illinois Department of Natural Resources,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, permanent 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 7, 2015, 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: OCT 2 6 2016
TJT:yl
o 10/18/16
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lambern

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BRAND, MICHAEL
Employee/Petitioner

Case# **14WC019238**

STATE OF ILLINOIS/DEPT OF NATURAL RESOURCES
Employer/Respondent

16IWCC0677

On 12/7/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.41% 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:

0969 THOMAS C RICH PC
6 EXECUTIVE DR
FAIRVIEW HTS, IL 62208

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

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

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

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

DEC 7 - 2015

16IWCC0677

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

Michael Brand
Employee/Petitioner

Case # **14 WC 19238**

v.

Consolidated cases: N/A

State of Illinois/Dept. of Natural Resources
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Michael Nowak**, Arbitrator of the Commission, in the city of **Herrin**, on **April 10, 2015.** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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 **March 4, 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 **$55,460.08**; the average weekly wage was **$1,066.54.**

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

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

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

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**.

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

ORDER

Respondent shall pay reasonable and necessary medical services of $63,812.02, as set forth in Petitioner's Exhibit 1, pursuant to Sections 8(a) and 8.2 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 $639.92/week for a further period of 53.75 weeks, as provided in Section **8(e)** of the Act, because the injuries sustained caused **25% loss 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

10/30/2015
Date

DEC 7 - 2015

FINDINGS OF FACT

Petitioner works as a Site Technician Class II at Pyramid State Park as an employee of the Illinois Department of Natural Resources. At the time of trial he had been employed there for nine years. The responsibilities of his employment include performing basic maintenance of park grounds, picking up fallen limbs, performing maintenance on vehicles, and patrolling trails in old coal mine grounds on hills, in valleys, and on or around rocks and slick mud slopes.

The Parties agree that Petitioner was involved in an accident that arose out of and in the course of his employment with Respondent on March 4, 2014, when he attempted to free his patrol vehicle which had become lodged in the snow and injured his left knee. He indicated he had to run a quarter of a mile over rough terrain to the road to get a ride to get a tractor. In the process of jumping a ditch his foot slipped and whenever it did he felt a pop in his knee. It immediately began to swell, and he had difficulty walking.

Respondent disputes that the accident resulted in an injury necessitating surgical reconstruction to the left knee anterior cruciate ligament (ACL), disputes liability for the surgery expenses related to same, and disputes the nature and extent of Petitioner's injury. The parties stipulated the treatment of Petitioner's left knee was reasonable and necessary.

Petitioner testified that he suffered no prior injuries to his left knee. Petitioner candidly testified that he suffered a prior fracture to the fibula of his lower leg four years prior, but this was healed and did not involve his knee. Petitioner sought treatment for his left knee the next day with his family physician, Dr. Priebe, who noted that Petitioner felt a sudden pop and a "tearing sensation to the inside part of the knee" after he jumped across a ditch. (PX3, 3/5/14). Petitioner reported swelling and pain with weight bearing despite the use of an Ace wrap and immobilizer and had not been able to move his left knee much since the incident. *Id.* Physical examination showed tenderness over the medial aspect of the knee joint with swelling. *Id.* Petitioner was given 800mg Ibuprofen, taken off work and referred for x-rays. (PX3, 3/5/14).

X-rays showed evidence of Petitioner's old fibula injury but were negative for fracture of the knee. (PX4). When Petitioner did not improve with rest, immobilization and anti-inflammatory medication, Dr. Priebe ordered an MRI. (PX3, 3/14/14). The MRI of 3/20/14 showed: 1) Pivot-shift type injury with kissing contusions of the lateral femoral condyle (anterior/inferior) and posterior lateral tibia; 2) complete ACL tear (rupture) from its femoral attachment; 3) moderate sized joint effusion; 4) small popliteal cyst; and 5) fluid layering adjacent to the medial head of the gastrocnemius. (PX5). Dr. Priebe referred Petitioner to Dr. Wood from the Orthopaedic Institute of Southern Illinois. (PX3, 3/24/14 Referral Form).

Dr. Wood saw Petitioner on three occasions, once in March, April, and May. (PX6). Petitioner continued to have complaints on May 22, 2014. (PX6, 5/22/14). Dr. Wood noted that Petitioner sustained an ACL tear of the left knee with detachment of the femoral attachment site. (PX6, 5/22/14). However, he did not recommend surgery because of supposed arthritis demonstrated on Petitioner's radiographs. *Id.* However, Petitioner testified that, to his knowledge, he did not suffer from arthritis. (T.27). According to the radiologist, Petitioner's x-rays make no mention of arthritis. The radiologist noted, "joint spaces are fairly well maintained." (PX4, 3/5/14). The only findings referenced were acute findings of joint effusion. *Id.* Petitioner's MRI findings note, "The patellafemoral and femorotibial joints have maintained alignment with preservation of the articular cartilage."

(PX5). Outside of acute findings, all of aspects of Petitioner's knee demonstrated "normal signal characteristics," and no mention of degeneration is included in the impression. (PX5). Notwithstanding these findings, however Dr. Wood stated that Petitioner was a "49-year-old gentleman with an ACL tear that is work related." (PX6, 5/22/14). Dr. Wood continued to recommend therapy and restricted duty. *Id.*

Petitioner came under the care of Dr. Nathan Mall on June 2, 2014. (PX8, 6/2/14). Dr. Mall took a consistent history of the injury, noted that Petitioner experienced no prior left knee problems or ACL injuries, and noted that neither Petitioner's x-rays nor his MRI demonstrated significant joint space narrowing, arthrosis or degeneration. He noted that Petitioner's MRI demonstrated a clear ACL tear. He indicated Petitioner suffered an ACL tear when he jumped across the stream, felt a pop and had immediate swelling in his knee. He further indicated this is a classic history for an ACL rupture, in which a maneuver causes a large pop in the knee which is followed by a significant amount of swelling in the knee joint. Dr. Mall felt the actual ACL tear that occurred, and the resulting treatment consisting of an ACL reconstruction is causally connected to the work related injury on 03/04/2013. *Id.*

Dr. Mall explained that ACL is used for cutting, pivoting and twisting of the knee, and that individuals with ACL injuries will have difficulty performing these maneuvers. He also pointed out that People who have ACL tears which go unrepaired have much higher incidence of repeat surgeries or surgeries for meniscal and cartilage injuries than do those who have the ACL reconstructed. The later patients had minimal residual problems with the meniscus or the cartilage requiring future arthroscopy. Dr. Mall had actually participated in a study of the comparison. He indicated that "[t]he conclusion of both our study and the other previously published study was that, ACL reconstruction in people over age forty should be undertaken if the patient needs to perform cutting, pivoting, twisting-type of activities such as Mr. Brand" performed while working. *Id.*

On his follow up visit of June 30, 2014, Dr. Mall's physical examination of Petitioner's left knee showed a 2B Lachman and positive pivot shift test with medial joint line tenderness and effusion. (PX8, 6/30/14). The right knee examination was entirely normal. *Id.* Dr. Mall continued to believe that Petitioner would require left knee ACL reconstruction to be able to return to work in a full duty capacity. *Id.*

On July 29, 2014, Dr. Mall performed ACL reconstruction using hamstring allograft. (PX9). Pivot-shift maneuver under anesthesia demonstrated grade II pivot shift of the knee. *Id.* There were no degenerative findings noted intraoperatively; Petitioner's patella, lateral femoral condyle, lateral tibial plateau and medial femoral condyle were all in good condition. *Id.* Only Petitioner's ACL, which was detached from its usual place in the lateral femoral condyle, required care during the surgery. *Id.* Following surgery and therapy, Petitioner's condition markedly improved and he was released to full duty work on February 9, 2015. (PX8, 8/12/14 – 2/9/15).

Petitioner testified that the strength in his knee was much improved following surgery. (T.15, 16). Petitioner testified that despite the improvement from surgery, he still experiences soreness in his knee associated with activity. (T.16). His complaints are consistent with the records of Dr. Mall, which document some complaints of pain following surgery despite improvement in stability. (PX8, 8/12/14 – 2/9/15). Petitioner testified that his employment causes soreness in his knee because he walks on uneven terrain every day. (T.17). He also testified that he has difficulty descending stairs, squatting to perform maintenance on vehicles, and

returning to a standing position. (T.17). He continues to wear a knee brace every day that he goes to work and uses ice and prescription Ibuprofen to manage his symptoms. (T.18, 19, 24). He testified that his hobby of gardening and his ability to perform home maintenance has been adversely affected, and that he will be unable to donate blood as he customarily does for at least a year because of his allograft. (T.19-21).

CONCLUSIONS OF LAW

Issue (C): **Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?**
Issue (F): **Is Petitioner's current condition of ill-being causally related to the injury?**
Issue (J): **Has Respondent paid all appropriate charges for all reasonable and necessary medical services?**

The stipulation sheet indicates Respondent disputed accident and causation "as to the need for surgery/reconstruction to the knee" as well as the bills related to the surgery. (AX1). The Arbitrator clarified the basis of Respondent's dispute on the record. Upon review of the evidence in the record, it would appear to be an issue of the reasonableness and necessity of Petitioner's care and treatment. However, Respondent expressly stipulated to the reasonableness and necessity of the treatment, in the event that the Arbitrator made a finding of causal connection. (T.4, 5).

The record leaves no question as to whether Petitioner's ACL injury was the result of his accidental injury on March 4, 2014. Petitioner had no prior injuries or problems with his left knee. Immediately after the incident, Petitioner consistently reported that he felt a pop and immediate pain. The records of Petitioner's family physician note that Petitioner felt a sudden pop and a "tearing sensation to the inside part of the knee" after he jumped across a ditch. (PX3, 3/5/14). Petitioner's MRI clearly shows a torn ACL, which is agreed upon by every physician in the record. (PX5). While Dr. Wood disagreed on the need for surgery, he clearly stated in his note that Petitioner was a "49-year-old gentleman with an ACL tear that is work related." (PX6, 5/22/14). Dr. Mall also concluded that Petitioner's tear was related to his accidental work injury. (PX8, 6/2/14). Respondent presented no evidence to refute the evidence in the record or the opinions of Petitioner's treating physicians.

Although Respondent stipulated to the reasonableness and necessity of Petitioner's treatment in the event of a finding of causal connection, the Arbitrator specifically finds that the ACL reconstruction was both reasonable and necessary to treat the ACL tear Petitioner sustained in the accident. Dr. Wood's opinion that Petitioner did not require surgery is not soundly based on the evidence. He declined to offer surgery to Petitioner based on some arthritic changes. However, Petitioner has minimal to no degenerative findings on his radiographs, and nothing whatsoever was mentioned of such findings in the operative report. Hence, Petitioner's testimony that he did not suffer from arthritis is credible and supported by the record. Further, Dr. Mall's opinion that Petitioner did require surgery and his explanation of the potential consequences of leaving the ACL tear untreated was well reasoned and credible. The Arbitrator finds the opinions of Dr. Mall much more persuasive.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner has met his burden of establishing that he sustained an accident which arose out of and in the course of his employment on

3/4/141 which resulted in injuries, including a torn ACL. Petitioner further established that his condition of ill-being was caused by the accident and that the treatment provided, including the ACL surgery was reasonable and necessary in light of the injuries.

Respondent shall therefore pay medical expenses of $63,812.02, as outlined in Petitioner's group exhibit 1 pursuant to the fee schedule. Respondent shall have credit for the amounts paid through its group carrier but shall indemnify and hold Petitioner harmless from any claims pertaining to the payment of medical expenses for which it is receiving this credit, pursuant to §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 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 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 class II site technician at the time of the accident and that he was able to return to work in his prior capacity as a despite said injury. The Arbitrator notes, however that Petitioner has difficulty kneeling, squatting, and walking on uneven surfaces, all of which are required by his employment. Because of the nature of Petitioner's injury, namely a tear of the ACL, a part of the knee crucial to pivoting and twisting, and intense nature of Petitioner's employment, which places a high demand on Petitioner's knees, the Arbitrator therefore gives *greater* weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 49 years old at the time of the accident. Because Petitioner has a number of working year to yet cope with his disability, 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 there is no evidence of reduced earning capacity 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 that Petitioner testified that despite the improvement from surgery, he still experiences soreness in his knee associated with activity. His complaints are consistent with the records of Dr. Mall, which document some complaints of pain following surgery despite improvement in stability. (PX8, 8/12/14 – 2/9/15). Petitioner testified that his employment causes soreness in his knee because he walks on uneven terrain every day. He also testified that he has difficulty descending stairs, squatting to perform maintenance on vehicles, and returning to a standing position. He continues to wear a knee brace every day that

he goes to work and uses ice and prescription Ibuprofen to manage his symptoms. He testified that his hobby of gardening and his ability to perform home maintenance has been adversely affected, and that he will be unable to donate blood as he customarily does for at least a year because of his allograft. Based upon Petitioner's credible testimony evidencing disability, which is supported by the medical records, the Arbitrator therefore gives *greater* weight to this factor.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability which resulted in the 25% loss of use of his left leg pursuant to §8(e) of the Act.

STATE OF ILLINOIS)		
) SS.	☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
COUNTY OF LA SALLE)	☐ 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

STEPHANIE L. THAYER,

Petitioner,

vs. NO: 13 WC 29751

KREIDER SERVICES, INC.,

16IWCC0678

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

The Commission finds that Petitioner's right knee arthroscopic surgery was reasonable, necessary, and causally related to her work injury. Petitioner was a Direct Service Provider (DSP) caring for clients. It is undisputed that on July 2, 2013, one of her clients kicked her in the knee. The Arbitrator found that Petitioner's right knee condition was causally related to her work injury through October 30, 2013, the date of the Section 12 examination with Respondent's Dr. Johnson. We note that, at that time, Dr. Johnson and Petitioner's initial treating orthopedic surgeon, Dr. Hernandez, both concluded that she did not need arthroscopic surgery because an MRI was essentially normal other than mild edema and because the physical examination did not show anything significant. However, due to Petitioner's continued complaints, Dr. Hernandez continued her off work on October 2, 2013, pending a referral to Dr. Glasgow for a second opinion. By the time approval was given for this referral, several months had gone by. In the meantime, Petitioner did return to work in January 2014 based on the opinion of Dr. Johnson. However, because Respondent only offered her full time work on second or third shift, Petitioner took a position as a part-time substitute due to child care issues.

When Petitioner saw Dr. Glasgow on March 19, 2014, she was still complaining of chronic 3-4/10 pain that got worse over the course of the day and the week with intermittent sharp, stabbing, pinching sensations in the anteromedial aspect of the knee. On examination, Dr. Glasgow noted that when palpating the medial plica, Petitioner got a sharp stabbing pain. His diagnosis was pathologic medial and longitudinal plica secondary to a direct blow. Since Petitioner had plateaued after eight to nine months at only 75% improvement with conservative treatment, Dr. Glasgow recommended a diagnostic arthroscopy, which would include excision of a pathologic medial and longitudinal plica. He allowed Petitioner to continue working full duty in the meantime.

Petitioner underwent the surgery on April 4, 2014. On April 7, 2014, Dr. Glasgow noted that Petitioner no longer had the anteromedial pain and tenderness. Physical therapy records indicate that Petitioner was "feeling great." On April 23, 2014, Dr. Glasgow wrote that Petitioner "feels as though we got the problem" and that she was at least 85% improved from her preoperative status. She was returned to work full duty on April 28, 2014. After a couple follow up visits, Petitioner was released from care on September 22, 2014.

Dr. Glasgow testified that about 5% of his approximately 250 annual knee surgeries are for plica and peripatellar fat problems in the absence of any ligament tears, etc. He opined that the blow to Petitioner's knee might have caused some acute edema and then it stiffened and her knee was starting to get pinched or clicking. He said there were some mechanical symptoms associated with it that didn't exist before Petitioner's injury. Dr. Glasgow testified that an essentially normal MRI is actually a good thing in terms of narrowing down the diagnosis. He testified that he found a significant amount of peripatellar fat and medial plica during surgery, which is what he was hoping to find. He felt that Petitioner was not 100% after the surgery but that Petitioner's 80% improvement shows that his diagnosis and surgery was appropriate. Dr. Glasgow testified that his examination findings were different than Dr. Johnson's and that one cannot see a pathological plica on an MRI. Regarding the peripatellar fat, although no other doctor or the radiologist mentioned it on the MRI, he testified that he did see it on the films himself.

Interestingly, although Dr. Johnson testified that Petitioner did not require surgery as of his examination on October 30, 2013, he did admit that the surgery would be appropriate in certain cases: 1) tenderness solely over the medial plica with consistent symptoms; 2) previous good response to cortisone injection that wasn't long lasting; and 3) symptoms have continued for at least 6 months. Dr. Johnson testified that Petitioner had diffuse pain over many areas; not just over the medial plica. However, he admitted that the records showed that Petitioner did have temporary relief from a cortisone injection. And, at the time he saw Petitioner, she had not been having symptoms for at least 6 months. Although he reviewed Dr. Glasgow's operative report and arthroscopic images and those did not change his opinion, his diagnosis was right knee contusion and continued right knee pain. We find that this indicates that he agreed that Petitioner was actually continuing to have problems.

The Commission finds that Dr. Glasgow's recommendation for surgery was reasonable and necessary. He believed that he had identified the source of Petitioner's continued complaints and, according to the records and Petitioner's testimony, the surgery appears to have given Petitioner significant relief of the right knee symptoms, which did not exist prior to her undisputed accident.

Based on the above, we find that the medical bills contained in Px2.1 through Px2.13 are reasonable, necessary, and causally related to Petitioner's work injury. These bills are awarded subject to the fee schedule in Section 8.2 of the Act with Respondent receiving credit for all payments already made. We reject Respondent's argument that it should only be required to pay the amount that was paid to Dr. Glasgow by the Illinois Department of Healthcare and Family Services because to do otherwise would give an employer an incentive to deny payment for medical expenses until after a petitioner is forced to obtain medical benefits through governmental, need-based means.

We affirm the Arbitrator's award of temporary total disability (TTD) benefits for 17-1/7 weeks from July 3, 2013 through October 30, 2013. We find that Petitioner is not entitled to TTD benefits from October 31, 2013 through April 3, 2014, because she was able to and did return to work during this period. At the time of her first appointment with Dr. Glasgow on March 19, 2014, he allowed her to continue to work full duty even though he was recommending surgery. As for the issue of temporary partial disability, we find that Petitioner's return to part-time work was her own decision, due to personal child care issues, and that she failed to prove that this was due to her physical capabilities. We do, however, find that Petitioner is entitled to an additional 3-4/7 weeks of TTD benefits for the period from April 4, 2014 through April 28, 2014, when Petitioner was taken off work due to her surgery. Petitioner is entitled to a total of 20-5/7 weeks in temporary total disability benefits with Respondent receiving a credit of $6,198.00 for benefits already paid.

On the issue of permanency, we mostly agree with the Arbitrator's analysis of the five factors in Section 8.1b of the Act. However, Petitioner sustained more than just a contusion to her right knee. This contusion caused a pathological plica, which required surgical excision along with peripatellar fat. Petitioner testified that she has not completely improved and the records indicate that the surgery only resolved 80% of her preoperative complaints. Petitioner still complained of occasional pain and swelling and takes over-the-counter Advil at least once a week depending on her activity level. The Commission finds that Petitioner has sustained the loss of use of 10% of the right leg.

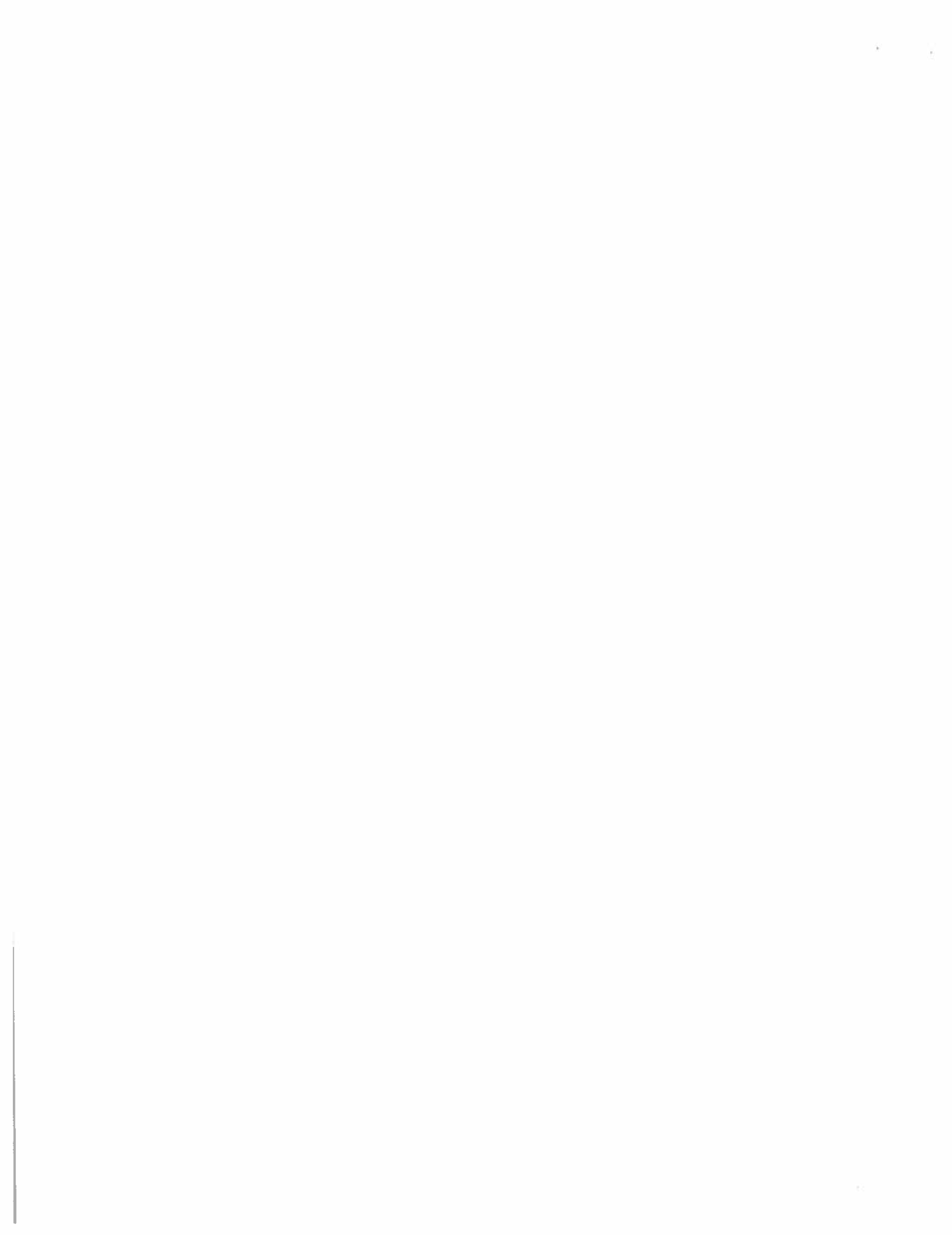
IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $258.24 per week for a period of 20-5/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $253.00 per week for a period of 21.5 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the 10% loss of use of the right leg.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the medical expenses contained in Px2.1 through Px2.13 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 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.



16IWCC0678

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $28,000.00. 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: OCT 2 6 2016

Charles J. DeVriendt

Ruth W. White

Joshua D. Luskin

SE/
O: 10/4/16
49

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

THAYER, STEPHANIE L
Employee/Petitioner

Case# **13WC029751**

KREIDER SERVICES INC
Employer/Respondent

16IWCC0678

On 6/19/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.10% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0021 REESE & REESE
TODD S REESE
979 N MAIN ST
ROCKFORD, IL 61103

0208 GALLIANI DOELL & COZZI LTD
ROBERT J COZZI
20 N CLARK ST SUITE 825
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF **LA SALLE**

- [ ] 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

Stephanie L. Thayer
Employee/Petitioner

v.

Kreider Services, Inc.
Employer/Respondent

Case # **13** WC **29751**

Consolidated cases: ---

16IWCC0678

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gerald Granada**, Arbitrator of the Commission, in the city of **Ottawa**, on **May 28, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] What temporary benefits are in dispute?
[x] TPD [ ] Maintenance [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 **July 2, 2013**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**17,818.39**; the average weekly wage was $**387.36.**

On the date of accident, Petitioner was **34** 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 $**6,198** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**6,198**.

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 $258.24/week for 17 1/7 weeks commencing July 3,2013 thru October 30, 2013 as provided in Section 8(b) of the Act.

No additional medical bills are awarded.

Respondent shall pay permanent partial disability benefits of $253/week for 10.75 weeks, because the injury caused 5% loss of use of the right leg as provided in Section 8(e) of the Act.

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

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

Signature of Arbitrator

6/18/15
Date

JUN 19 2015

FINDINGS OF FACT

The petitioner testified that she was employed by the respondent as a Direct Support Person (DSP) for a year. Her job duties consisted of caring for developmentally delayed adults.

On July 2, 2015, an adult resident grew combative on a transport bus and kicked her in her right knee. She completed an incident report but did not seek immediate medical attention that day. Her knee later became swollen and she could not put weight on it. She reported to work the following morning and was sent to Dr. Deets at KSB Hospital.

The records of KSB Hospital (Pet. Ex. 1.1) reflect that she presented on July 3, 2013 with complaints of right knee pain. The physical examination revealed tenderness; soft tissue swelling; and restriction of motion. She was diagnosed with a contusion of the right knee, given crutches, and instructed to perform sit down work only. (Pet. Ex. 1.1) Her employer could not accommodate her restriction.

When she returned on July 8, 2013, she continued to complain of pain. The physical examination showed no swelling or discoloration, only tenderness and restriction of motion. She was sent for physical therapy. On July 19, 2013, she was seen again by Dr. Deets and reported that there was no improvement. He suspected internal derangement and ordered an MRI of the right knee. The study was performed on July 24, 2013 and revealed only "mild edema/degenerative change of the anterior horn of the lateral meniscus; otherwise, unremarkable MRI of the right knee." (Pet. Ex. 1.2) When the petitioner returned to Dr. Deets with the MRI results, he referred her to an orthopedic surgeon, Dr. Thomas Hernandez. (Pet. Ex. 1.1)

The petitioner was first examined by Dr. Hernandez on August 7, 2013. The physical examination of the right knee revealed minimal, if any, effusion; range of motion of 0 – 120 degrees; patella stable and tracking nicely; no joint line tenderness; and stable ligaments in all planes. He reviewed the MRI which showed no evidence of any meniscal pathology; intact ligaments; and no evidence of chondromalacia of the anterior aspect of the patella. He diagnosed residual symptoms of patellofemoral syndrome due to prolonged non-weight bearing and deconditioning. He specifically instructed her to "get rid of the crutches" and return to weight bearing. She should undergo aggressive physical therapy. He specifically indicated that he would not recommend arthroscopic intervention. (Pet. Ex. 1.3)

When the petitioner returned to Dr. Hernandez on September 4, 2013, she reported that there was no relief from therapy. The physical examination of the right knee revealed no effusion; minimal medial joint line tenderness; stable patella with minimal pain on patella grind; and stable ligaments. Dr. Hernandez diagnosed right anterior knee pain with an essentially normal MRI. He administered cortisone injections. He again told her that he did not think any arthroscopic intervention would offer her any benefit. (Pet. Ex. 1.3)

The petitioner returned to Dr. Hernandez on October 2, 2013. She continued to complain of pain. The physical examination showed only minimal tenderness and pain with patella grind. He "once again had a long discussion with the petitioner explaining that arthroscopic intervention in the face of a normal MRI" was unlikely to provide any benefit. He indicated that she was welcome to obtain a second opinion. (Pet. Ex. 1.3) She requested a referral to Dr. Glasgow who had treated her brother-in-law.

In the meantime, the petitioner underwent an independent medical examination with Dr. Brent Johnson on October 30, 2013. She received a letter in mid-December 2013 inviting her to return back to work. She

returned back to work as a DSP for the respondent on January 9, 2014. Although she performed all of her normal job duties, she worked as a "fill-in substitute" DSP because the full time positions that were offered to her conflicted with her childcare obligations.

The petitioner first saw Dr. Glasgow on March 19, 2014. The physical examination revealed negative Lachman; posterior Drawer; varus and valgus instability tests; thickening of the anterior aspect of the knee which was bursal in origin; and medial joint line tenderness. He diagnosed pathological medial and longitudinal plica. He recommended surgery at this first visit. (Pet. Ex. 1.5)

Surgery was performed on April 4, 2014 at Rochelle Hospital. The post-operative diagnosis was "pathological medial longitudinal plica with peripatellar fat impingement medially." She underwent a short course of physical therapy and was released to return to full duty work as of April 28, 2013.

The petitioner returned to full duty work as a DSP for the respondent but again worked only on a substitute basis due to scheduling conflicts with her childcare. She was also attending school at the time. She was last seen by Dr. Glasgow on September 22, 2014. She continued to complain of pain and Dr. Glasgow noted, "I thought she could do better." He placed her at maximum medical improvement and indicated she could continue full duty work. (Pet. Ex. 1.5)

At the present time, she continues to notice pain in the knee. She notices pain when going on long hikes although she still is able to play kickball, football and baseball with her son. She will take an Advil approximately once per week for knee pain.

Jodi Murdock testified that she was a Human Resource Generalist from late 2013 to the present for the respondent. Her job duties included hiring, handling worker's compensation FMLA issues and handling return-to-work issues. The respondent operates 25 group homes for adults developmentally delayed individuals in Lee and Whiteside counties. It has approximately 358 employees and 200 of them are DSPs.

When an individual returns to work after being off for 12 weeks or more, three different positions are offered to the returning employee. The petitioner was sent a letter on December 18, 2013 inviting her to return to full duty work. (Resp. Ex. 7) She was offered three different positions and the petitioner chose a position as a substitute DSP even though there were positions available as a full time DSP. Throughout the entire year of 2013 and 2014, full time DSP positions were always available. Likewise, when the petitioner returned back to work following her surgery in April of 2014, there were full time positions available but she chose to come back as a substitute. Her employment was eventually terminated in late January of 2015 because she did not work the required number of hours in the prior three months. (Resp. Ex. 8)

Dr. Glasgow testified that he is a board-certified orthopedic surgeon who first examined the petitioner on March 19, 2014. (Pet. Ex. 7, pgs. 4-6) She provided a history of being kicked in the right knee at work. He performed a physical examination which was negative with the exception of the following findings: thickened bursa on the anterior of the knee; medial joint line tenderness and stabbing pain with palpation of the medial plica. (Pet. Ex. 7, pgs. 6-9) The plica is a synovial fold inside the knee that serves no purpose or function. (Pet. Ex. 7, pgs. 10-11) He felt that both the bursa and the plica in her right knee were damaged. (Pet. Ex. 7, pg. 13) He reviewed the MRI which was normal for the intra-articular portion of the knee but showed edema in the pre-patellar bursa. (Pet. Ex. 7, pg. 17) He believed that the condition of her right knee was related to the kick she sustained in July of 2013. (Pet. Ex. 7, pg. 20) He recommended a diagnostic arthroscopy and a surgical arthroscopy as indicated which would probably include the incision of the medial plica. (Pet. Ex. 7, pg. 22)

He performed the procedure on April 4, 2014. He encountered a significant amount of peripatellar fat and medial plica which were excised. (Pet Ex. 7, pg. 30) At the first post-operative visit, he sent her for physical therapy. He re-examined her on April 23, 2014 and he released her to return to work as of April 28, 2014. (Pet. Ex. 7, pgs. 34-35) He next saw her on June 23, 2014 and her knee was a little bit puffy but he was pleased with the progress. (Pet. Ex. 7, pgs. 36-37) His final evaluation was on September 22, 2014. She reported she was only 80% improved. He placed her at MMI and released her from his care. (Pet. Ex. 7, pg. 38)

On cross-examination, he stated he did not review any medical records from the physicians who had treated the petitioner up until the point in time where he first evaluated her. (Pet. Ex. 7, pgs. 54-55) It might have been helpful to review those materials before rendering treatment and the diagnosis. (Pet. Ex. 7, pg. 55) He conceded that the radiologist who reviewed the MRI did not find a pathological plica (Pet. Ex. 7, pg. 56) nor is there any mention of bursa being abnormal. (Pet. Ex. 7, pgs. 56-57) He took photos during the arthroscopy which revealed the pathology which he addressed in the surgery. (Pet. Ex. 7, pg. 59) During the surgery, he excised the distal third of the medial plica and a considerable amount of peripatellar fat. (Pet. Ex. 7, pgs. 62-67) He did not send it to the Pathology Department. The by-laws of Rochelle Hospital where the procedure was taken does not require him to send tissue removed during surgery to the Pathology Department. (Pet. Ex. 7, pgs. 63-64)

Over the past three years, 95% of the surgeries that he performs on the knee are related to damage to the meniscus, ACL or articular cartilage. There were no other abnormalities found in the knee other than the plica and the peripatellar fat. Actually, the abnormal plica was minimal and the peripatellar fat was more impressive. (Pet. Ex. 7, pgs. 67-68) He conceded that damage to the plica and the peripatellar fat can be caused by everyday wear and tear of walking and everyday living. (Pet. Ex. 7, pgs. 67-68) He could visualize a copious amount of peripatellar fat on the MRI but it was not mentioned in the MRI report. (Pet. Ex. 7, pg. 71) Neither Dr. Hernandez nor Dr. Johnson noted the peripatellar fat in their reviews of the MRI. (Pet. Ex. 7, pg. 71)

Dr. Brent C. Johnson is a board-certified orthopedic surgeon who testified on behalf of the Respondent via evidence deposition on April 8, 2015. (Resp. Ex. 2, pg. 3) Dr. Johnson conducted an independent medical examination of Petitioner on October 30, 2013. In that examination, petitioner provided a history of being kicked in the right knee at work and undergoing conservative treatment. (Resp. Ex. 2, pgs. 9-11) He performed a physical examination which revealed a slight decrease in the range of motion and tenderness. All other findings were negative. (Resp. Ex. 2, pgs. 11-12) Although she complained of popping in her knee, instability, weakness, and grinding of the knee none of these complaints could be produced on physical examination. (Resp. Ex. 2, pg. 13) He took x-rays of the right knee and also reviewed x-rays from previous visits, both of which were normal. He also reviewed the MRI films which were normal. (Resp. Ex. 2, pg. 14) He then reviewed all of the medical records of treatment to date. (Resp. Ex. 2, pgs. 15-17)

Based on the history, radiographs, MRI, the physical examination and his review of the medical records, Dr. Johnson diagnosed a contusion with continued right knee pain. Dr. Johnson opined that the petitioner did not require arthroscopic surgery or surgery of any type for her knee (Resp. Ex. 2, pg. 18) because the physical examination and the MRI films did not identify any pathology. He felt she was at MMI and could return to full duty work. (Resp. Ex. 2, pgs. 19-20) Dr. Johnson also received the Petitioner's operative report for review. There was nothing contained in the operative report which would cause him to change his opinion regarding the necessity of the surgery. (Resp. Ex. 2, pg. 20) He thereafter received the intra-operative photographs that were taken at the time of the arthroscopic procedure. He did not see anything in the photographs which would cause him to change his opinion. The photographs did not show that the plica or the peripatellar fat were inflamed. (Resp. Ex. 2, pg. 23)

On cross-examination, Dr. Johnson stated that he only examined the petitioner on one occasion that being on October 30, 2013. He believes she did sustain an injury of her right knee as a result of the work accident of July 2, 2013 which consisted of a contusion to the right knee. (Resp. Ex. 2, pg. 23) All of the medical treatment that the petitioner received up until the day that he examined her on October 30, 2013 was reasonable and necessary. (Resp. Ex. 2, pg. 28)

CONCLUSIONS OF LAW

1. With respect to the issue of causation, the Arbitrator finds that the Petitioner has met her burden of proof. Specifically, the Arbitrator finds that the Petitioner sustained a contusion to her right knee as a result of her undisputed work accident on July 2, 2013. In support of this finding, the Arbitrator relies on the medical evidence presented at trial. The petitioner was diagnosed with a right knee contusion and anterior knee pain by Dr. Deets, Dr. Thomas Hernandez and Dr. Brent Johnson. Two of these physicians are board-certified orthopedic surgeons. Although Dr. Glasgow asserts that the petitioner also had a pathological medial plica and peripatellar fat, this opinion is not shared by the other three physicians who treated the petitioner. Furthermore, this diagnosis is not supported by the MRI films. The radiologist Dr. Schwalm, Dr. Hernandez and Dr. Johnson, all reviewed the MRI films and found no abnormalities of the medial plica or the peripatellar fat. In addition, Dr. Glasgow claims that the intra-operative photographs show inflamed and pathological medial plica and peripatellar fat. Dr. Johnson, however, viewed the intra-operative photographs and asserted that no such findings were present. Based on all these facts, the Arbitrator concludes that the Petitioner's knee contusion arose out of and in the course of her employment with respondent on July 2, 2013. Furthermore, the Arbitrator finds that the Petitioner's subsequent knee surgery is not causally related to the accident in question.

2. Based on the above findings with respect to the question of causation, the Arbitrator finds that the Petitioner's medical expenses stemming from the Petitioner's knee contusion were reasonable and necessary to address that condition and awards those expenses to the Petitioner with a credit to Respondent for any such medical expenses it has already paid. However, the Petitioner's claim for expenses related to Petitioner's surgery performed by Dr. Glasgow and any treatment stemming from that surgery are denied.

The petitioner offered into evidence numerous medical bills consisting of Exhibits 2.1 – 2.13. The respondent offered into evidence its medical payment screen (Resp. Ex. 1) which reflects payment of these bills at the fee schedule amount of medical bills 2.1 – 2.6. The respondent did not pay for the medical treatment which began with the treatment of Dr. Glasgow from March 19, 2014 through September 22, 2014 with the exception of the first visit of Dr. Glasgow on March 19, 2014 for which the respondent agreed to and did pay.

The issue with respect to medical bills 2.7 through 2.13 is also one of medical necessity. Dr. Glasgow contends that the petitioner had a pathological medial plica and peripatellar fat thus making arthroscopic surgery necessary. The petitioner's original treating orthopedic physician, Dr. Hernandez, asserted at each visit that surgery was not necessary. His opinion was corroborated by orthopedic surgeon, Dr. Brent Johnson, who also opined that arthroscopic surgery was not necessary. The Arbitrator finds the opinions of Drs. Hernandez and Johnson to be more persuasive for the following reasons. Dr. Johnson's opinions were based on the complete review of all available records, the MRI films, the operative report and the intra-operative photographs. Dr. Glasgow indicated that he did not review any of the records of the prior treatment. In addition, the opinions of Drs. Hernandez and Johnson are supported by interpretation of the MRI rendered by the radiologist, Dr. Cheryl A. Schwalm. These three doctors identified no abnormalities with respect to the medial plica or the peripatellar fat in their reviews of the MRI films. For these reasons, the medical bills 2.7 through 2.13 are denied as they were for treatment that was not medically necessary.

3. With respect to the issue of TTD, the Arbitrator finds that the petitioner was temporarily totally disabled from July 3, 2013 through and including October 30, 2013, a period of 17 1/7 weeks. It is undisputed that the petitioner was kept off of work by her treating physicians through the date of the evaluation with Dr. Brent Johnson, October 30, 2013. Based on his review of the normal MRI, records of treatment and his physical examination, Dr. Johnson opined that the petitioner was capable of returning to her normal job duties. No doctor examined the petitioner thereafter and indicated that she was either totally disabled from working or restricted in any capacity until surgery. Given the above findings with respect to causation and medical expenses, the Petitioner's claim for either TTD or temporary partial disability stemming from Petitioner's surgery is denied.

With respect to the petitioner's claim for temporary partial disability benefits between January 8, 2014 and April 4, 2014, the Arbitrator notes that the petitioner was performing her full duty work as a DSP, albeit on a part-time basis. The respondent's Human Resource representative, Jodi Murdock, indicates that full time work was offered to the petitioner and available at all relevant times. The petitioner testified that she decided to not take the full time position because of childcare issues. Since the petitioner had been offered full duty work on a full time basis between January 8, 2014 and April 4, 2014, and petitioner declined the same for personal reasons, her claim for temporary partial disability benefits is denied.

4. Pursuant to Section 8.1b of the Act, for accidental injuries occurring after September 1, 2011, permanent partial disability shall be established using five enumerated criteria, with no single factor being the sole determinant of disability. Per 820 ILCS 305/8.1b(b), the criteria to be considered are as follows: (i) the reported level of impairment pursuant to subsection (a) [AMA "Guides to the Evaluation of Permanent Impairment"]; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records.

Applying this standard to this claim, the Arbitrator first notes that there was no reported level of impairment offered into evidence and therefore the Arbitrator places no weight on this factor. Petitioner's occupation was a Direct Service Provider caring for disabled adults, a position she was able to return to with no restrictions – a factor on which the Arbitrator places great weight. Petitioner was 34 years old at the time of the accident – a factor on which the Arbitrator places some weight. There was no evidence of the Petitioner's future earning capacity and therefore the Arbitrator places no weight on this factor. There was evidence of disability corroborated by the medical records showing the Petitioner sustained a contusion to her right knee for which she continues to experience swelling, pain and difficulty in performing recreational activities with her kids.

Based on all these factors, the Arbitrator finds that the Petitioner has sustained a 5% loss of use of her right leg as a result of her July 2, 2013 accident.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

16IWCC0679

Lori Hoffman-Tellef,
Petitioner,

vs.

NO: 15WC 6017

CCSD #15,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 2, 2016 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: OCT 27 2016
KWL/vf
O-10/25/16
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

16IWCC0679

HOFFMAN-TELLEF, LORI
Employee/Petitioner

Case# **15WC006017**

CCSD #15
Employer/Respondent

On 2/2/2016, 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 0.46% 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:

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

2337 INMAN & FITZGIBBONS LTD
TERRENCE DONOHUE
33 N DEARBORN ST SUITE 1825
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

16IWCC067

LORI HOFFMAN-TELLEF
Employee/Petitioner

v.

CCSD #15
Employer/Respondent

Case # 15 WC 006017

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 **MARIA S. BOCANEGRA**, Arbitrator of the Commission, in the city of **CHICAGO**, on **DECEMBER 1, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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 **January 14, 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 **$33,178.08**; the average weekly wage was **$638.04**.

On the date of accident, Petitioner was **48** 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 **$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 under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of **$425.36/week** for **12 weeks**, commencing **January 19, 2015** through **April 13, 2015**, as provided in Section 8(b) of the Act. Respondent shall pay Petitioner the temporary total disability benefits that have accrued from **January 19, 2015** through **April 13, 2015**, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall pay Petitioner permanent partial disability benefits of **$382.82/week** for **10.25 weeks**, because the injuries sustained caused the **5%** loss of use of the **right hand**, as provided in Section **8(e)** of the Act.

Respondent shall pay directly to Petitioner the reasonable and necessary medical services of **$5,555.00**, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit for medical benefits that have been paid and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.
STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

1-29-2016
Date

FEB 2 - 2016

FINDINGS OF FACT

Lori Hoffman-Tellef ("Petitioner") testified that she was employed as a driver for CCSD #15 for approximately 17 years and was so employed as such on January 14, 2015. Her duties included pre-trips, which meant making sure everything is right, being at stops, taking kids to school and in the afternoon, those duties were reversed. Pre-trips, she testified, involved arriving before route times, going into the buses to start them, checking air pressure, tires, lights and doing a complete walk around.

Petitioner testified she worked for Respondent on January 14, 2015. That morning, she began her shift around 6:30am, and it was still dark out. While walking back into the buss, she said she tripped up the steps and hit her right hand on the dashboard. By then, she had already completed her pre-trip, completed her paperwork and turned it in. She walked back to the bus, located in the yard. She stated there were no light directly over the bus and the interior lights inside the bus were not on. She described the steps as follows: from the ground to the first step, the distance was about mid-shin; the second step was slightly shorter than the first and the third step was equal in height to the second step.

At the time she fell, she testified she had in her hands a 1-1.5 inch route book in her left hand, her purse over her left shoulder and a soda drink in her right hand. She testified she is allowed to have a drink on the routes. She said she caught her right foot on the edge or lip of the second step and fell forward. She thinks she wore boots that day, she didn't recall if it was snowing out and did not recall whether the steps were wet. She did not recall any defect, paper or debris. She did not recall whether she was raising her right foot to reach the second step or to bypass the second step and go directly to the third step or whether she had already completed the second step on her way to the third step. Petitioner further testified that she had traversed those steps once already that day and that when she fell, that was the second time she had traversed the steps. In total, she traversed the bus steps generally three times per day as they did not have a pre-trip in the afternoon. She stated she usually gets up each step by placing one then the other foot onto the first step and then once both feet are on the first step, she begins the next step in the same manner.

Petitioner reported her injury to her supervisor, Thomas Bramley. In his incident investigation report, Bramley wrote Petitioner "slipped on school bus stairs while entering." Under actions taken to prevent recurrence, he wrote that "DRIVER MUST USE 3 POINT SYSTEM AT ALL TIMES WHEN ENTERING AND EXITING SCHOOL BUS." Rx2. Similarly, the employer's first report of injury indicated Petitioner "fell while walking up the stairs." Petitioner completed an employee injury report and wrote that she "fell up the stairs of the bus." Rx1. She reported she injured her right hand. On cross, she stated she did not recall grabbing the rail as her hands were full.

Later on January 14, 2015, Petitioner presented to Alexian Brothers Medical Center complaining of pain in her right hand, with sharp shooting pain radiating to her wrist. Px2. Petitioner denied other pain or injury. Petitioner related that she fell up the stairs in her bus and slammed her fingers into the stairs and that nothing else hurt. On examination, Petitioner exhibited tenderness over the third, fourth, and fifth digits of her right hand, as well as tenderness over the dorsal aspect of the middle of the hand and tenderness over the distal metacarpals. Minimal swelling was observed; there was no visible deformity. Petitioner was able to flex and extend all of her digits with reproducible pain. Early ecchymosis of the proximal phalanx of the right 5th finger was observed. An x-ray was taken of the Petitioner's right hand, which disclosed no acute fractures. She was prescribed Motrin and diagnosed with right hand contusion. Petitioner was cleared to full duty work and ordered to return as needed.

On January 19, 2015, Petitioner sought treatment with Dr. Michael Melnick at PCP Acute Care. Px3. The history noted was the she had slipped on a bus and hurt her right hand and she hit the dash board while at work. Pain over her 5th MCP joint as well as shooting pain in her wrist and forearm were noted. On examination, Dr. Melnick noted that Petitioner was tender to palpation over the third, fourth, and fifth MTP joints, with pain around Petitioner's right wrist, mostly on the ulnar side. Dr. Melnick noted in Petitioner's history that she had undergone bilateral carpal tunnel repair in the past. Dr. Melnick assessed Petitioner with finger pain and hand pain and opined that she was unable to drive a school bus at that time. He recommended a wrist splint and referred Petitioner to an orthopedic surgeon.

On January 28, 2015, Petitioner presented to Dr. Josephine Mo at Orthopedic Surgery Specialists for an initial consultation. She referred Petitioner for 4 weeks of physical therapy and kept her off of work. Px1.

On February 3, 2015, IMPG sent Petitioner a letter stating Petitioner was ineligible for workers' compensation benefits. Rx4.

Petitioner began physical therapy on February 13, 2015. Px4. At her initial evaluation, she reported pain at 3-4/10 and at 4-9/10 pain with use. She reported shooting pains into the ulnar aspect of her wrist and forearm, with numbness and tingling in that same area. She reported that she was having trouble using knives and using the toilet, and that she could not put on or remove her own bra, open jars or use a vacuum cleaner. Petitioner related her history of injury as tripping when going up the stairs in a school bus at work. She was holding a can of soda in her right hand, which she "punched" into the dashboard. Exam showed edema in Petitioner's right thumb, with decreased range of motion in her thumb and wrist as well as sensory and strength deficits (particularly in her ability to grip and pinch) in her right hand and wrist.

On March 9, 2015, therapists note decreased edema at the right thumb, increased right wrist range of motion and thumb range of motion. Px1, Px4. Increased right grip and pinch strength were noted. Pain was reported at the right ring finger and small finger in the web/dorsal of the hand. Petitioner reported decreased function putting car in gear and opening jars. Additional therapy was recommended.

On March 11, 2015, Petitioner returned to Dr. Mo for follow-up of the right hand. Px1, Px3. Petitioner reported that she had improved with physical therapy but complained of intermittent pain between the right ring and small fingers. She rated her pain at 6 out of 10. Twisting motions triggered discomfort and Petitioner expressed concern about turning the steering wheel or changing gears as a bus driver. On examination, radial artery pulse was normal, capillary refill in the digits was good. Mild tenderness to palpation in the web space between the right finger and small MCP joints was noted. Petitioner generally had good light touch sensation and good range of motion in the digits. Assessment was right hand sprain. Additional therapy was recommended and Petitioner was off of work.

On April 6, 2015, physical therapists noted Petitioner was independent with activities of daily living and still had popping and pain with opening a jar along with decreased right grip strength compared to the left. Additional therapy was recommended. Px1, Px4.

On April 8, 2015, Petitioner returned to Dr. Mo for follow up of the right hand. Px1, Px3. She still had occasional popping sensation in the right hand but had otherwise regained strength and overall use of the hand. She complained of joint pain, joint swelling and injuries to her joints. Examination of the right hand noted normal radial artery pulse with good color/turgor/capillary refill in the digits. Mild tenderness to palpation in

the web space between the right finger and small fingers was noted. Good range of motion of the digits was noted. Assessment was right hand sprain. The doctor discharged Petitioner and released her to return to work full duty the following Monday. On May 20, 2015 Petitioner returned to Dr. Melnick complaining primarily of sore throat, congestion, and ear pain. Active problem list included finger and hand pain. No specific treatment is given for the hand or fingers. Px3.

At trial, Petitioner testified she notices everything is pretty much back, that she gets twinges of pain between the middle base of the hand and between the small and ring fingers. She stated she is right hand dominant and that she gets pains but that they are not as strong as before. The parties disputed liability for unpaid medical bills but no specific bills were listed in Ax1. The Arbitrator notes the following balances found in Petitioner's medical records:

Advocate Good Shepard Hospital	Charged $4,775.00	Balance $0.00	Px4-5
Alexian Brothers Med. Grp.	Charged $611.00	Balance $611.00	Px2
Advocate Med. Grp. (Melnick)	Charged $353.00	Balance $0.00	Px3
Orthopedic Surgery Specialists	Charged $508.00	Balance $425.00	Px1

Testimony of Thomas Bramley

Thomas Bramley ("Bramley") testified on behalf of Respondent. He is the director of transport for Respondent for the 7.5 years. His duties include ensuring the complete and safe transport of all students, handling employment of drivers, handling office staff and budgets. He also reviews work comp injuries that occur. Bramley stated he is Petitioner supervisor and became aware of an accident occurring with Petitioner on January 14, 2015. He had an opportunity to investigate that claim and that as part of the investigation; he prepared a supervisor's report, which he identified as Rx2. He also identified Illinois Form 45 as what he filled out in relation to the claim. Rx3. Bramley identified Rx1 as a document given to employees to complete on their own.

He testified Petitioner reported what happened to him, that she had slipped while getting on the steps of the bus and that maybe she hit the right hand. He testified Petitioner was consistent with what she verbally told him and the paperwork she filled out. He said she was truthful in saying that her hands were full at the time. Bramley investigated the steps after it was reported to make sure there was no loose material or anything on the steps. He said he did not notice anything unusual about them. He thought there were 3 or 4 steps in the bus. He did not visually notice anything slippery or broken. Bramley stated that Petitioner traversing the steps three times a day is fairly consistent with using the steps. He testified that the 3 point system used by Respondent recommends that of 2 feet and 2 hands, at least three at any point in time should be in contact with the bus at all times. He agreed this may not always be followed by drivers.

Respondent also introduced a video depicting bus steps and use of the 3 point system. The video was not taken on the same date of the accident and was done during daylight. Rx5. The video consisted of five separate mini videos depicting a woman ascending and descending 4 steps of a yellow bus. In the first video, the woman (not Petitioner) ascends and descends the bus with a bag and binder in one hand, holding the railing with the other. The second video, the woman ascends and descends the bus with a bag and binder in one hand and a coffee mug in the other hand, without holding onto railings. In the third video, the woman ascends and descends with only a binder in one hand and the other hand is on the railing. In the fourth video, the woman ascends and descends with nothing in either hand, holding the railing with one hand. In the fifth and final video depicts various visual angles of the bus and its steps.

CONCLUSIONS OF LAW

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

At trial, the parties disputed whether Petitioner's accident arose out of and in the course of her employment with Respondent. Ax1. Here, there is no doubt Petitioner was in the course of her employment when she fell up the stairs of her work bus. Petitioner testified she began her shift that morning and completed her pre-trip inspection and was on her way back into her assigned bus when the incident occurred. The central issue is whether Petitioner's accident ***arose out of*** her employment.

An injury sustained by an employee *arises out* of the employment if it can be shown that the injury had its origin in some risk connected with, or incidental to, the employment. The injury arises out of one's employment if, at that time of the injury, the employee was performing acts she was instructed to perform by her employer, acts which she has a common law or statutory duty to perform while performing those duties for her employer or acts which the employee might reasonably be expected to perform incident to her assigned duties. *Howell Tractor & Equip. Co. v. Indus. Comm'n*, 78 Ill. 2d 567, 573, 403 N.E.2d 215 (1980). A risk is incidental to the employment where it belongs to or is connected with what an employee has to do in fulfilling her duties.

There are three general types of risks to which an employee may be exposed: (1) risks that are distinctly associated with the employment; (2) risks that are personal to the employee; and (3) neutral risks that do not have any particular employment or personal characteristics. In the context of falls, employment risks include tripping on a defect at employer's premises or falling on uneven or slippery ground at the work site. Because the general public is not exposed to such employment risks, such risks universally arise out of employment. *Ill. Consol. Tel. Co. v. Indus. Comm'n*, 314 Ill. App. 3d 347, 352, 347 Ill.Dec. 333 (Justice Rakowski, concurring), citing 1 A. Larson & L. Larson, Larson's Workers' Compensation Law § 4.01, at 4-2 (1999).

Examples of personal risks include falls due to a bad knee or an episode of dizziness. Because such a fall is due to a personal defect or weakness, such falls, commonly known as idiopathic falls, usually do not arise out of the employment. *Id.* However, injuries caused by an idiopathic fall arise out of one's employment where work place conditions significantly contribute to the injury by increasing the risk of falling or the effects of a fall. The added risk may be due to some physical circumstance of the immediate vicinity or due to tools, implements, or apparatus the employee is required to use in her duties.

Neutral risks have no particular employment or personal characteristics. In the context of falls, neutral risks include falls on level ground or while traversing stairs. Because the general public and employees alike are equally exposed to the risks of walking and traversing stairs, injuries resulting from these acts generally do not arise out of employment. *Id.*, See also *Village of Villa Park v. Ill. Workers' Comp. Comm'n*, 3 N.E.3d 885, 890, 378 Ill.Dec. 320 (2d Dist. 2013). However, as with personal risks, there is an exception where employment conditions create a risk to which the general public is not exposed. The increased risk may be qualitative, such as the dangerous nature of the stairs or quantitative, such as where the employee is exposed to a common risk more frequently than the general public. *Id.* Falls arising from a "neutral" origin or risk have been characterized as "unexplained falls." *Ill. Consol. Tel. Co.*, 314 Ill. App. 3d at 353-354, *Elliot v. Indus. Comm'n*, 153 Ill. App. 3d 238, 242, 106 Ill.Dec. 271 (1st Dist. 1987).

In the instant case, there is no evidence that Petitioner's fall was due to a personal risk or that it was otherwise idiopathic in nature. Petitioner testified that she tripped on the steps leading up the bus and could not recall if the steps or her shoes were wet. She did not recall any defect, paper or debris. She testified that at the time of the fall, she had her purse on her shoulder, a can of soda in one hand and her required binder in the other hand. She did not have her hands on the railing. This portion of Petitioner's testimony is consistent with and corroborated by Thomas Bramley's testimony. She recalled there was no lighting but did not specifically identify this as the cause. Rather, she said her foot caught the lip or edge of one of the steps. The evidence most points to Petitioner's fall as unexplained. Thus, the question is whether Petitioner presented enough evidence to show that her employment conditions created a risk to which she was exposed to a greater degree than the general public, whether qualitative and/or quantitative.

The Arbitrator concludes that Petitioner has proven by a preponderance of the evidence that her unexplained fall on the employer's premises arose out of the employment as she was exposed to a risk to a greater degree than the general public. The demands of her job required to complete a pre-trip, which involved inspecting the bus, completing paperwork, turning paperwork in and elating the bus with a required binder via the only steps to get on to the bus and into the driver's seat. She stated that on that morning, there was no lighting over the bus and the interior lights were not on. She described the first step as mid-shin height and the other steps slightly shorter in height. The Arbitrator also observed the video submitted by Respondent and notes the unusually high first step and other steps to get onto the bus. Rx5. *Caterpillar Tractor Co. v. Indus. Comm'n*, 129 Ill.2d 52 (1989). Both Petitioner and Bramley identified the bus steps as different than the steps at each of their homes. Qualitatively, Petitioner's employment conditions were such that it created a risk to which she was exposed to a greater degree than the general public.

Petitioner stated that at the time she fell, she had in her hands a 1-1.5 inch route book in one hand, her purse over her left shoulder and a soda drink in her right hand. It was unrebutted that she is allowed to have a drink on the routes. She stated and it was unrebutted that the route book is required. See also Rx5. Evidence also demonstrated the requirement of having drivers use the three-point system whereby two feet and one had are required to be touching the bus while ascending or descending the stairs at all times. Rx2, Rx5. Bramley acknowledged that not all drivers followed this system. The Arbitrator views carrying the can of soda and a purse as acts of personal comfort and the carrying of the route book as required by her employment. Based on Petitioner's and Bramley's testimony, the Arbitrator sees nothing unusual, unreasonable or unexpected in the manner in which Petitioner ascended the bus steps that morning. *Ill. Consol. Tel. Co. v. Indus. Comm'n*, 314 Ill. App. 3d 347 (5th Dist. 2000).

Finally, both Petitioner and Bramley testified that she would have likely traversed these particular bus steps three times per day; twice in the morning and once in the afternoon. Thus, quantitatively, Petitioner was exposed to the risk of falling on these particular bus steps to a greater degree than the general public. The Arbitrator notes that there was no direct testimony that the general public had equal access to the bus or its steps, or that the general public were open and invited guests to the bus or that the general public was required to be on those steps on a regular basis to the same degree and frequency as Petitioner. Indirectly, at most the evidence established that the only public persons getting on the bus were members of the school district which Petitioner may have driven to and from a school. In this way, the Arbitrator finds *Baldwin* distinguishable. 409 Ill. App. 3d 472, 949 N.E.2d 1151 (4th Dist. 2011). There, the court held that the claimant failed to show that the unexplained fall was caused by exposure to risks greater than that faced by the general public.[1] The

[1] *Baldwin* involved two separate falls at work. The Arbitrator will focus on only on the first fall, however, as it was addressed in the context of an unexplained fall, whereas the second fall was addressed in the context of an idiopathic fall.

claimant testified she did not know why she fell, she could not identify what caused her to slip and fall, she stated she had nothing in her hands at the time and was not in any hurry. Here, Petitioner was clear that her foot caught the lip or edge of the step causing her to fall. Petitioner also stated that her hands were full with a purse, a can of soda and a route binder. The court concluded that the claimant in *Baldwin* failed to establish any evidence that she was exposed to a risk greater than that faced by the general public. For the reasons already stated previously, that is not the case here.

The instant case is most analogous to *Knox County YMCA v. Indus. Comm'n*, where the appellate court upheld a finding of accident where the claimant fell down stairs while carrying a purse and a can of soda resulting in an increased risk preventing her from grabbing onto the railings. 311 Ill. App. 3d 880, 885 (3d Dist. 2000). Here, Petitioner was unable to hold onto the bus railings, which were not lit, with both hands because her hands were full with a required route book and permitted items of personal comfort. Therefore, for the foregoing reasons, the Arbitrator finds that Petitioner suffered an accident arising out of and in the course of her employment with Respondent.

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

Having found in favor of Petitioner on the issue of accident, the Arbitrator resolves the issue of causal connection between the accident and Petitioner's right hand injury in favor of Petitioner. Here, the evidence showed that when Petitioner fell, she struck her right hand against the dashboard. She testified to and reported an immediate onset of right hand pain. Her testimony was corroborated by Bramley and the accident reports. Further, Petitioner's medical records identify the onset date of her right hand symptoms as January 14, 2015. There was no evidence that Petitioner had any right hand injuries, symptoms or problems prior to or immediately prior to the work accident. Therefore, under a chain of events theory, the Arbitrator concludes Petitioner's right hand injury is causally related to her work accident occurring January 14, 2015.

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?

At trial, Respondent disputed liability for unpaid medical bills. Ax1. The parties agreed, however, that if the case was found compensable, Respondent is to receive credit for its Section 8(j) group insurance payments. Having found in favor of Petitioner on the issue of accident and causation, the Arbitrator finds that the treatment rendered in connection with Petitioner right hand injury is related to the work accident and was reasonable and necessary. The Arbitrator notes that Petitioner did not list specific bills as unpaid in Ax1. Petitioner did testify, however, that not all bills were paid and that some were paid by group insurance. She further submitted the following bills in Petitioner's exhibits:

Advocate Good Shepard Hospital	Charged $4,775.00	Balance $0.00	Px4-5
Alexian Brothers Med. Grp.	Charged $611.00	Balance $611.00	Px2
Advocate Med. Grp. (Melnick)	Charged $353.00	Balance $0.00	Px3
Orthopedic Surgery Specialists	Charged $508.00	Balance $425.00	Px1

The Arbitrator notes that the $184.00 charge for date of service June 25, 2015 from Advocate Medical Group (Dr. Melnick) is not only is past the date of MMI but also the actual medical note is not found anywhere in the record. Px3. Therefore, the Arbitrator declines to award this charge as part of Petitioner's award of medical bills. Thus, Respondent shall pay directly to Petitioner the reasonable and necessary medical services of **$5,555.00**, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit for medical

between the right index finger and small fingers. Finger pain and hand pain remained active problems as of Petitioner's last visit to Dr. Melnick more than one month later. In light of the foregoing, the Arbitrator therefore gives the *greatest* weight to this factor. Based on the above factors and the record taken as a whole, the Arbitrator finds that Respondent shall pay Petitioner permanent partial disability benefits of **$382.82/week** for **10.25 weeks**, because the injuries sustained caused the **5%** loss of use of the **right hand**, as provided in Section **8(e)** of the Act.

Signature of Arbitrator

1-29-2016
Date

STATE OF ILLINOIS	)	☒ Affirm and adopt	☐ 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	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Lisa Lowe,
Petitioner,

16IWCC0680

vs.

NO: 12 WC 13391

State of Illinois DOC Stateville,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 5, 2015 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: OCT 27 2016
KWL/vf
O-10/25/16
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

16IWCC0680

LOWE, LISA
Employee/Petitioner

Case# **12WC013391**

STATE OF ILLINOIS DEPT OF CORRECTIONS
Employer/Respondent

On 11/5/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.28% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0924 BLOCK, KLUKAS & MANZELLA PC
MICHAEL BLOCK
19 W JEFFERSON ST
JOLIET, IL 60432

5661 ASSISTANT ATTORNEY GENERAL
MALLORY ZIMET
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

1350 CENTRAL MANAGEMENT SYSTEMS
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

NOV 5 2015

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

16IWCC0680

LISA LOWE
Employee/Petitioner

Case # 12 WC 13391

v.

Consolidated cases: ____

STATE OF ILLINOIS DEPARTMENT OF CORRECTIONS
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 **Gerald Granada**, Arbitrator of the Commission, in the city of **New Lenox**, on **October 14, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of 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 [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 **4/1/12**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$86,366.80**; the average weekly wage was **$1,660.90**.

On the date of accident, Petitioner was **45** 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 **$43,342.93** for TTD, $ for TPD, $ for maintenance, and $ for other benefits, for a total credit of **$43,342.93**.

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

ORDER

The Respondent shall pay the Petitioner temporary total disability benefits of $1,107.27/week for 39 2/7 weeks ($43,499.89), commencing from 4/2/12 through 1/2/13, as provided in Section 8(b) of the Act. Respondent is entitled to a credit of $43,342.93.

Respondent shall pay the Petitioner permanent partial disability benefits of $695.78/week for 37.5 weeks ($695.78/week x 37.5 weeks = $26,091.75), as provided in Section 8(d)(2) of the Act, because the physical injuries sustained caused 7.5% loss of use of person 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.

Signature of Arbitrator

11/6/15
Date

NOV 5 - 2015

FINDINGS OF FACT

Lisa Lowe (the "Petitioner") seeks relief from the Respondent-Employer, the State of Illinois, Stateville Correctional Center (the "Respondent"), for the Petitioner's alleged work-related accident on April 1, 2012, pursuant to the Illinois Workers' Compensation Act (the "Act"). On October 14, 2015, a hearing on the disputed issues was held in New Lenox, Illinois. The disputed issues are: causation, medical expenses, temporary total disability, and nature and extent. [Arb. Ex. 1]. The parties stipulated that on April 1, 2012, the date of the alleged work-related accident, the Petitioner was 45 years old and married with one dependent child. [Arb. Ex. 1].

The Petitioner testified she worked for the State of Illinois at Stateville Correctional Center as a Nurse Supervisor. She testified that prior to the accident in question, she was working in that capacity for less than a year. She is no longer employed by the State of Illinois and currently resides out of state.

On October 4, 2011, prior to the work related accident, Petitioner fell and injured her back and neck. She reported to Ingalls Occupational Health on October 7, 2011 and reported pain to her back and neck. [Resp. Ex. 2]. She had limited range of motion in the lumbar spine. [Resp. Ex. 2]. On October 12, 2011, she returned to Ingalls. [Resp. Ex. 2]. Her primary problem was pain located in the neck and lower back. [Resp. Ex. 2]. Petitioner missed about a week of work for this injury.

Petitioner testified that on April 1, 2012, the date of the alleged accident, she slipped and fell on a wet floor while performing her duties as a nurse supervisor. [See also, Pet. Ex. 11]. She hit her head and body during the fall. An inmate noticed her fall and ran to help her. However, he also slipped on the same water and slid into Petitioner. Petitioner testified that she was knocked unconscious after the inmate struck her.

After the accident, Petitioner presented to St. Joseph Medical Center. [Pet. Ex. 1 at 9]. A CT of her head without contrast was normal. [Pet. Ex. 1 at 28]. A CT of her cervical spine showed no acute osseous abnormality. [Pet. Ex. 1 at 26]. Minimal spondylotic change is identified at C5-C6 without associated degenerative disc disease. [Pet. Ex. 1 at 26]. An X-ray of her lumbar spine showed minimal facet hypertrophic; otherwise it was unremarkable. [Pet. Ex. 1 at 30]. The hospital records indicate that she did not lose consciousness. [Pet. Ex. 1 at 32]. She denied any tingling or numbness in her extremities. [Pet. Ex. 1 at 32].

That same day, Petitioner met with Dr. Watson of Health Benefits Pain Management Services. [Pet. Ex. 3 at 2]. She reported that she hit her head three times. [Pet. Ex. 3 at 2]. Dr. Watson referred her to a neurology specialist and an MRI for her cervical and lumbar spine. [Pet. Ex. 3 at 3]. She was instructed to refrain from work. [Pet. Ex. 3 at 3].

On April 16, 2012 Petitioner's MRI of the cervical spine revealed straightening of the cervical spine, may be due to myospasm; at C5-C6, mild bilateral foraminal stenosis due to mild predominantly left central disc fragment extrusion pointing caudally; at C4-C5, subtle focal central disc bulge, that indents the thecal sac. [Pet. Ex. 5 at 6].

An MRI of the lumber spine revealed transitional vertebra at lumbosacral junction; at L5-S1 level, mild bilateral forminal stenosis due to mild predominantly central disc bulge, hypertrophy of facet joints and ligament flava; at L4-L5 level, subtle disc bulge that abuts the thecal sac. [Pet. Ex. 5 at 4].

Petitioner returned to Dr. Watson on May 9, 2012. [Pet. Ex. 3 at 8]. He recommended Petitioner meet with Dr. Kelly, a neurologist, and to start physical therapy. [Pet. Ex. 3 at 8]. They discussed how she would benefit from epidural steroid injections if her pain does not improve. [Pet. Ex. 3 at 8].

Petitioner began physical therapy at Maximum Rehab on May 22, 2012. [Pet. Ex. 6]. On July 3, 2012, she transferred but continued physical therapy at ATI. [Pet. Ex. 7].

Petitioner returned to Dr. Watson on June 6, 2012. [Pet. Ex. 3 at 14]. Petitioner had attended six sessions of physical therapy with success. [Pet. Ex. 3 at 14]. Petitioner stated that she does not wish to undergo the nerve block at this time. [Pet. Ex. 3 at 14]. Accordingly, Dr. Watson recommended she continue with physical therapy. [Pet. Ex. 3 at 14].

On June 27, 2012, Petitioner presented to Dr. Kelly. [Pet. Ex. 3 at 16]. Dr. Kelly noted that the physical therapy was helping quite considerably. [Pet. Ex. 3 at 16]. Dr. Kelly recommended an epidural steroid injection, but Petitioner opted to wait to have this done just before she would go back to work to try to maximize the duration of benefits during her time of working. [Pet. Ex. 3 at 16].

Petitioner returned to Dr. Kelly on August 29, 2012. [Pet. Ex. 3 at 23]. Dr. Kelly noted that Petitioner opted not to pursue the epidural steroid injections. [Pet. Ex 3 at 23]. Instead the patient would like to continue to just pursue the physical therapy for now until December 2012 and then have the injections performed before returning to work at that time. [Pet. Ex. 3 at 23]. Dr. Kelly informed Petitioner that there was no need to wait. [Pet. Ex. 3 at 23]. Petitioner reported that she was not hesitant to receive the injection, but would like to postpone it until just before she returns to work in December. [Pet. Ex. 3 at 23]. Dr. Kelly informed Petitioner that she would thus be at MMI but Petitioner was not happy with this. [Pet. Ex. 3 at 23]. Dr. Kelly noted that Petitioner wanted to wait to return to work until December, but putting off the appropriate interventional treatment until December 2012 is just delaying the process inappropriately. [Pet. Ex. 3 at 23]. Dr. Kelly noted that she was giving a number of excuses that Dr. Kelly told her were not medically appropriate. [Pet. Ex. 3 at 23]. Petitioner did not schedule a follow-up with Dr. Kelly. [Pet. Ex. 3 at 25].

On October 4, 2012, Petitioner underwent an FCE which placed her functioning at the light capacity. [Pet. Ex. 8]. Petitioner began work hardening.

On November 27, 2012, Petitioner underwent an IME with Dr. Daniel Troy. [Resp. Ex. 1]. Dr. Troy diagnosed Petitioner with a left shoulder strain, lumbosacral strain, and cervical strain. [Resp. Ex. 1]. He believed her condition had long resolved. [Resp. Ex. 1]. Dr. Troy based his opinion on Petitioner's August 29, 2012 visit with Dr. Kelly in which it was revealed that Petitioner was purposely extended her care to remain off of work. [Resp. Ex. 1. See also, Pet. Ex. 3 at 23]. Dr. Troy found her treatment excessive. [Resp. Ex. 1]. He recommended finishing the work hardening and then report to work full duty. [Resp. Ex. 1].

On January 2, 2013, Petitioner returned to Dr. Watson. [Pet. Ex. 3 at 35]. Petitioner reported to Dr. Watson that her headaches have resolved. [Pet. Ex. 3 at 35]. Dr. Watson noted that Petitioner completed work hardening and she is able to lift 50 pounds. [Pet. Ex. 3 at 35]. This allowed the Petitioner to return to work in the medium physical demand level. [Pet. Ex. 3 at 35]. Dr. Watson found Petitioner to be at MMI and to return to work. [Pet. Ex. 3 at 35]. Petitioner did not return to work at this time. Instead, Petitioner returned to Dr. Watson on January 30, 2013. [Pet. Ex. 3 at 37]. Petitioner complained of knee pain, left arm pain, and left hand numbness. [Pet. Ex. 3 at 37]. Dr. Watson reiterated that she should return to work. [Pet. Ex. 3 at 37].

Petitioner again returned to Dr. Watson on February 27, 2013. [Pet. Ex. 3 at 39]. Petitioner told Dr. Watson that she never returned to work due to a fear of passing out. [Pet. Ex. 3 at 39]. She complained of continued headaches and pain to her left knee and left arm. [Pet. Ex. 3 at 39]. Dr. Watson referred her to a neurologist. [Pet. Ex. 3at 39]. Petitioner returned to Dr. Watson on March 27, 2013. [Pet. Ex. 3 at 39]. She had not yet seen the neurologist. [Pet. Ex. 3 at 39].

Petitioner presented to Dr. Marquess Wilson on April 4, 2013. [Pet. Ex. 1 at 38]. He gave her a prescription for physical therapy and Zanaflex. [Pet. Ex. 1 at 39]. Petitioner was to follow-up in 3 weeks. [Pet. Ex. 1 at 39]. Petitioner returned to Dr. Wilson on May 6, 2013. [Pet. Ex. 1 at 41]. Petitioner reported that she no longer is experiencing headaches, she denied numbness and tingling in her extremities, and she currently had no complaints. [Pet. Ex. 1 at 41].

On May 8, 2013, Petitioner returned to Dr. Watson. [Pet. Ex. 3 at 43]. Dr. Watson instructed her to return to work on May 13, 2013. [Pet. Ex. 3 at 43].

On September 6, 2014, Petitioner underwent an exam with Dr. Coe, at the request of her attorney. [Pet. Ex. 12]. Petitioner denied a history of significant injuries to her back or neck. [Pet. Ex. 12]. On July 9, 2015, the parties took the evidence deposition of Dr. Coe. [Pet. Ex. 14]. Dr. Coe did not review any medical records concerning Petitioner's pre-existing injury. [Pet. Ex. 14 at 70]. Dr. Coe explained that when he asked Petitioner if she suffered any previous injuries, he explained that this did not just involve bumps and bruises, which is typical for someone her age. [Pet. Ex. 14 at 71]. He clearly explained to her that he was referring to anything that required medical treatment. [Pet. Ex. 14 at 71]. Petitioner continued to deny a history of pain that required medical treatment. [Pet. Ex. 14 at 71]. Dr. Coe opined that the Petitioner suffered a contusion and strain type injuries in the accident of April 1, 2012 with a head injury and post concussion syndrome, a neck injury with C5-6 disc protrusion, herniation and some aggravation of the pre-existing cervical degenerative changes causing chronic neck pain and then some aggravation of degenerative changes in her lumbar spine-L4 – S1 – with now chronic lumbar pain of multiple origins, disc and facet joints as well as soft tissue muscular pain [Pet. Ex. 14. at 39].

Petitioner testified that she returned to work full duty with the Respondent from May 12, 2013 through July 20, 2013. In July, 2013, she moved to North Carolina to work for the federal government at the VA, where she was making the same amount of money as her job with the Respondent. In August, 2015, Petitioner began a new job in Los Angeles, as a labor and delivery nurse. At that time, she began noticing numbness in her fingers and arms, along with the experience of headaches. She then sought treatment at Cedars-Sinai, where she received treatment from Dr. Levesque who noted Petitioenr had chronic neck pain and low back pain without sciatica. [Pet. Ex. 20] Dr. Levesque ordered an MRI, which indicated Petitioner had degenerative changes in her cervical spine, mild to moderate spinal canal stenosis at C5-6, small left paracentral disc herniatation at C3-4 without cord compression, and mild degenerative changes at L5-S1.

The Petitioner broke down in tears as she testified that she could no longer work two jobs following her accident on April 1, 2012. Petitioner testified that she has to be careful in her current job and does not do house chores. She has pain with sitting for long periods of time and takes over the counter medication for her pain. She still complains of constant lower back pain.

CONCLUSIONS OF LAW

1. With regard to the issue of causation as to her neck and back condition, the Arbitrator finds that the Petitioner has met her burden of proof. In support of this finding, the Arbitrator relies on both the Petitioner's

testimony and the medical evidence. While Respondent disputes this issue based on the fact that the Petitioner sustained a prior injury on October 4, 2011 resulting in pain to her upper and lower back - there was relatively little medical treatment following that incident, after which the Petitioner continued to work fully duty until April 1, 2012. With regard to the Petitioner's complaints to her hands and arms, and her complaints of headaches for which she is most recently seeking treatment in Los Angeles, the Arbitrator finds these conditions are not causally related. In support of this finding, the Arbitrator relies on the medical records showing the Petitioner had reached MMI in May, 2013.

2. With regard to the issue of medical expenses, the Arbitrator finds that the Petitioner's medical treatment through January 2, 2013 was reasonable and necessary to alleviate Petitioner's work related conditions. The records from Dr. Watson show that as early as January, 2013, Petitioner was placed at MMI and instructed to return to work. However, Petitioner did not return to work and went back to the doctor complaining of headaches, knee pain, left arm pain, and left hand numbness. Petitioner continued to see Dr. Wilson and Dr. Watson, who later released her full duty as of May 13, 2013. In reviewing the medical records, the Arbitrator is persuaded by Respondent's IME, Dr. Troy that the Petitioner continued to unnecessarily prolong her treatment to remain off work. Therefore, the Petitioner's medical treatment following her release on January 2, 2013 do not appear to be reasonable and necessary. Accordingly, the Arbitrator awards Petitioner all related medical expenses through January 2, 2013 subject to the fee schedule, with Respondent receiving credit for any and all related medical expenses it has paid to thus far.

3. Regarding the issue of TTD, the Arbitrator finds that the Petitioner was temporarily totally disabled from April 2, 2012 through January 2, 2013. Under section 19(d), the Commission may, in its discretion, reduce an award in whole or in part if it finds that a claimant is doing things to retard his or her recovery. A claimant's refusal to undergo medical treatment must be reasonable. Keystone Steel & Wire Company v. IWCC, 72 Ill.2d 474 (1978). In this case, Petitioner purposefully prolonged her treatment, as documented by Dr. Kelly's records. On August 29, 2012, Petitioner indicated to Dr. Kelly that she was interested in a series of epidural steroid injections but preferred to wait until her return to work. Petitioner explicitly told Dr. Kelly that she was not hesitant to undergo the injections. It is clear that under section 19(d), Petitioner purposely retarded her recovery to stay off of work. She had no real treatment after she was released from work hardening. In fact, an FCE indicated, and Dr. Watson confirmed, that she could return to work as of January 2, 2013. This date is also corroborated by Respondent's doctor, who stated she could return to work after she completed her work hardening. Petitioner is trying to confuse the evidence to indicate why she did not return to work when instructed to by both her own physician and Respondent's physician. Petitioner's statement at trial that Respondent did not want her back is in complete contrast to her statement to her doctor that she did not return to work because she was afraid of "passing out." Both her treating doctor and Respondent's doctor told Petitioner to go back to work. She chose not to return. Therefore, Petitioner is entitled to temporary total disability until the date of her release to work, which was January 2, 2013. Accordingly, the Respondent shall pay the Petitioner temporary total disability benefits of $1,107.27/week for 39 2/7 weeks ($43,499.89), commencing from 4/2/12 through 1/2/13, as provided in Section 8(b) of the Act. Respondent will be given a credit of $43,342.93.

4. Pursuant to Section 8.1b of the Act, for accidental injuries occurring after September 1, 2011, permanent partial disability shall be established using five enumerated criteria, with no single factor being the sole determinant of disability. Per 820 ILCS 305/8.1b(b), the criteria to be considered are as follows: (i) the reported level of impairment pursuant to subsection (a) [AMA "Guides to the Evaluation of Permanent Impairment"]; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. Applying this standard to this claim, the Arbitrator notes the following...

(i) Level of Impairment – there was no reported level of impairment offered into evidence and therefore the Arbitrator places no weight on this factor.

(ii) Occupation - . Petitioner was employed as a nurse supervisor, she returned to work shortly after the accident in that capacity, and has continued to work as a nurse since the injury; the Arbitrator places great weight on this factor.

(iii) Age – Petitioner was was 45 years old at the time of the accident and the Arbitrator places some weight on this factor.

(iv) Future Earning Capacity – there was no credible evidence presented at the hearing proving the Petitioner's future earning capacity has been affected by her accident, other than the Petitioner's tearful description of her inability to work a second job, since the medical evidence show that the Petitioner was able to return to her previous job with no medical restrictions and has since been able to obtain employment in other parts of the country as a nurse. The Arbitrator places significant weight on this factor.

(v) Evidence of Disability – there was evidence of Petitioner's disability corroborated by the medical evidence showing that as a result of the Petitioner's April 1, 2012 work accident, she sustained cervical and lumbar strains and underwent physical therapy. Petitioner did not undergo any other treatment other than physical therapy as she refused epidural steroid injections. She returned to work full duty. Petitioner's complaints of hand, arm, and finger numbness are not corroborated by the medical records. Petitioner continues to complain of back pain for which she takes over the counter pain medication and does home exercises.

Based on all these factors, the Arbitrator finds that the Petitioner has sustained 7.5% loss of use to the person as a whole, pursuant to Section 8(d)(2) of the Illinois Workers' Compensation Act.

STATE OF ILLINOIS	)	[X] Affirm and adopt	[ ] 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	[X] None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Alma Chacon,

Petitioner,

16IWCC0681

vs.

NO: 13 WC 42428

Labor Network,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 3, 2015 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 $24,500.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: OCT 27 2016
KWL/vf
O-8/30/16
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

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

16IWCC0681

CHACON, ALMA
Employee/Petitioner

Case# **13WC042428**

LABOR NETWORK
Employer/Respondent

On 11/3/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.28% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5015 ESR LAW GROUP LLC
EDWARD S RUEDA
33 N LASALLE ST SUITE 3350
CHICAGO, IL 60602

5001 GAIDO & FINTZEN
LUKE BEHNKE
30 N LASALLE ST SUITE 3010
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF KANE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

16IWCC0681

ALMA CHACON
Employee/Petitioner

Case # 13 WC 042428

v.

Consolidated cases: N/A

LABOR NETWORK
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **JESSICA HEGARTY,**, Arbitrator of the Commission, in the city of **Elgin**, on **7/14/2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **12/16/2013**, 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 $**3,354**; the average weekly wage was $**304.96** .

On the date of accident, Petitioner was **36** years of age, ***single*** with **3** dependent children.

Respondent ***hasnot*** 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 $**588.93** under Section 8(j) of the Act.

ORDER

Respondent is found to be liable and is ordered to pay for Petitioner's unpaid medical bills contained in Petitioner' Ex. 5 pursuant to Sections 8(a) and 8.2 of the Act.

Petitioner is awarded TTD from 12/16/13 through 7/14/15, representing 82.1 weeks, a sum of $24,971.43 as provided by Section 8(b) of the Act.

Petitioner is awarded prospective medical treatment including the surgery recommended by Dr. Dixon.

As stated in the Addendum to the Arbitrator's decision, Petitioner did not exceed the limits of "chain of referral".

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

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

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

[signature]

Signature of Arbitrator

10/16/15
Date

NOV 3 - 2015

BEFORE THE ILLINOIS
WORKERS' COMPENSATION COMMISSION

ALMA CHACON,	)	**16IWCC0681**
Petitioner,	)	
vs.	)	No. **13 WC 042428**
	)	
LABOR NETWORK	)	
	)	
Respondent.	)	

This matter proceeded to hearing on July 14, 2015 before Arbitrator Jessica Hegarty in Elgin, Illinois.

Respondent disputes the following issues:

1. Whether an accident occurred that arose out of and in the course of employment;
2. Whether Petitioner provided notice of her accident to Respondent;
3. Whether there is a causal connection between Petitioner's accident and her current state of ill being;
4. Whether Petitioner had three dependent children at the time of the alleged ACCIDENT;
5. Whether Respondent is liable for unpaid medical bills;
6. Whether Petitioner is entitled to prospective medical treatment consisting of a L4-L5 and L5-S1 lumbar micro lumbar discectomy as proposed by Geoffrey Dixon, M.D.;
7. Whether Petitioner is entitled to TTD; and
8. Whether Petitioner exceeded the limits of the "chain of referral".

FINDINGS OF FACT:

Petitioner, Alma Chacon, testified, she is the mother of three dependents: Jesse Cruz (18), Lupita Cruz (15) and Julio Cruz (13). (TX. p. 28). She had been employed by the Respondent for approximately one year as a "bread-assembler" prior to the date of the alleged accident. According to her testimony, on December 16, 2013, she slipped on some garlic powder, strewn on the floor near her work station, and fell striking her back. (TX. pp.12, 17). (TX p. 11). Petitioner testified that she immediately reported her work injury to her supervisor, who is described as a woman wearing a "red helmet". (TX. p. 12). Regarding her injuries, Petitioner testified she felt the immediate onset of pain in her lumbar spine down her left leg, and was unable to complete her work shift. (TX. p.13).

Petitioner testified she was in her usual state of good health before the date of injury and asymptomatic for lumbar spine and left leg. (TX. p. 12).

On December 17 2013, Petitioner presented to Alexian Brothers Medical Group who noted a history of a slip and fall at work the day before. (PX1). Petitioner reported slipping on some breadcrumbs and falling onto her left side and left hip with complaints of left lower back, hip and upper leg pain. (Id.). Petitioner was diagnosed with a left hip contusion and left posterior chest wall contusion and released to light duty work. (Id.).

Petitioner next presented to Diversey Medical Center, Elgin Clinic, on December 21, 2013 where Nancy Miyoshi, D.C. noted a history of Petitioner falling onto her left side striking her hip, left buttock and low back while at work on December 16, 2013. (PX2). Petitioner's complaints of low back pain radiating into her left hip with palpation were noted. (Id.) Petitioner further reported pain with lumbar deflexion, left lumbar lateral flexion and left lumbar rotation. (Id.). It was further noted that she was limping and antalgic to the left. (Id.)

On December 23, 2013, Petitioner followed-up at the Diversey Medical Center where Gerardo Guzman, M.D. noted complaints of left hip pain radiating into the leg. (Id.). On exam, the doctor noted Petitioner "has limited turning and moving" and was limping. (Id.). Petitioner was assessed with a bruise contusion from a fall. (Id.) Physical therapy was recommended. (Id.) Petitioner's work status was listed as "undetermined at this point." (Id.).

On December 26, 2013, Diversey Medical Center records note that Petitioner requested to be seen by Dr. Guzman rather than start physical therapy due to persistent and increasing pain. (Id.). Dr. Guzman noted Petitioner was walking with one crutch at her right side. (Id.). On exam, the doctor noted "some spasm and point tenderness along the paravertebral area, mainly on the left. It is worse when she walks." (Id.) Petitioner was prescribed Flexeril and told to begin therapy in a few days. (Id.)

On December 28, 2013, Petitioner presented to Aref Senno, M.D. at Diversey Medical Center where she reported experiencing pain, tenderness and swelling on her thigh. (Id.). Dr. Senno noted that her "neck and thoracic spine are the most painful as well as the lumbar spine." (Id.). On exam, the doctor noted Petitioner's "neck has severe muscle spasms on the paraspinous muscles in the cervical, thoracic and lumbar regions." (Id.). The doctor further noted "tenderness of the lumbar spine and spasms of the muscles with restriction of the movement of the lumbar back." (Id.). The doctor recommended a lumbar MRI, instructed Petitioner to obtain crutches due to difficulty with ambulation and told to her to follow up in one week. (Id.).

On January 4, 2014, Dr. Senno noted Petitioner's complaints of persistent low back pain with radiation into the left leg. (Id.) Petitioner was noted to be using crutches. (Id.) On exam, "significant muscle spasms in the paraspinious muscle

region in the lumbar area" were noted. (Id.) The doctor commented that he was awaiting authorization for a lumbar MRI "that is highly advised". (Id.) Petitioner was advised to rest, walk with assistance only as needed, continue with Flexeril and Motrin, and to remain off of work. (Id.).

A lumbar MRI was performed on January 14, 2014, that was interpreted by the radiologist as revealing:

1. *At L4-L5: a 3-4 mm posterior broad-based disk protrusion with generalized spinal stenosis and bilateral neuroforaminal narrowing;*
2. *At L5-S1: a 5-6 mm posterior and left sided disk herniation with left sided spinal stenosis and bilateral neuroforaminal narrowing.*

Petitioner next presented to Sajjad Murtaza, MD, at Illinois Orthopedic Network on January 31, 2014 who noted complaints of left lower back pain radiating into the buttock. (PX. 3). Petitioner reported her pain as "constant, sharp and severe in nature" and at a 7 on a 10 point scale. (Id.). Dr. Murtaza noted "she endorses numbness, tingling, and weakness in the left lower extremity as well." (Id.). The doctor further noted that Petitioner continued to use a friend's crutch to ambulate. (Id.). On exam, Petitioner was "only able to flex the lumbar spine approximately 20 degrees without significant pain. Extension is at approximately 10-20 degrees. Both movements cause significant pain." (Id.) A positive straight leg raise test of the left lower extremity as well as Petitioner's "grossly antalgic" gait were evident on the neurological exam. (Id.)

Dr. Murtaza reviewed the January 31, 2014 lumbar MRI noting the findings correlated with Petitioner's current physical symptoms. The doctor recommended holding off on physical therapy, dispensed Tramadol and Flexeril for pain and Mobic for inflammation, kept Petitioner off of work and recommended an epidural steroid injection at L4-L5, L5-S1 which was administered on February 20, 2014. (Id.)

On March 7, 2014, Petitioner followed up with Dr. Murtaza reporting significant improvement in her symptoms. (Id.).

At the request of Respondent, Petitioner presented to a §12 examiner, Dr. Jay. L. Levin, M.D. on May 22, 2014. (RX. 3). Petitioner's complaints of pain in the lumbar spine with radiation down the left lower extremity were noted. (Id). Dr. Levin reviewed the January 14, 2014 lumbar MRI noting:

> *[T]here are degenerative disk changes at L4-L5 and L5-S1. T2 axial images are non-diagnostic, and I cannot ascertain anything but long-standing degenerative changes at L4-L5 and L5-S1.* (Id.).

Dr. Levin further commented that the "official interpretation of radiologist George Kuritza, M.D. is described on page 2, but his findings cannot be diagnosed by the images currently in my possession." (Id.). Dr. Levin

prescribed a new lumbar MRI of "diagnostic quality" indicating his opinion would be forthcoming after review. (Id.).

A second steroid injection was administered to Petitioner's lumbar back on May 15, 2015, after Petitioner's pain complaints returned. (PX. 3.)

On June 4, 2014 Petitioner returned to Dr. Murtaza reporting that the prior injection did not afford significant pain relief. (Id.). Her complaints of radiating pain from the lower lumbar spine to the posterolateral aspect of the lower extremity down to her left foot were noted. (Id.). The doctor commented that he wished to progress Petitioner back to light duty. (Id.). Petitioner commented that she did not believe there was light duty available at her job "that can help with her pain". (Id.). Petitioner articulated that she did not wish to proceed with more injections due to the negative side effects including an increase in blood sugar. (Id.). It is noted throughout Petitioner's treating medical records that she is diabetic. The doctor recommended a surgical consultation and placed Petitioner on Norco. (Id.).

On June 13, 2014, neurosurgeon Geoffrey Dixon, M.D. noted Petitioner's complaints of lumbar spine pain descending down the left lower extremity. (Id.) Dr. Dixon noted that MRI evaluation was not available for review. (Id.). He recommended an EMG of both lower extremities and kept her off of work. (Id.).

An EMG exam of Petitioner's left lower extremities was performed on July 9, 2014. Rizwan Arayan M.D., authored a report in which his impressions were noted as revealing:

> *[E]lectrodiagnostic evidence of a left L5, S1 lumbar spine radiculopathy. This is demonstrated by the abnormal needle EMG findings in left L5, S1 innervated muscles. Of note, reinnervation potentials are present. There is no electrodiagnostic evidence of a distal left lower extremity peripheral neuropathy at this time.* (Id.).

On August 8, 2014, Petitioner followed up with Dr. Dixon who commented that:

> *MRI evaluation of the lumbar spine demonstrates significant disk herniations at L4-5 and even greater at L5-S1. There is significant compression of the nerve within the lateral recess and foramen at both L5 and S1. EMG suggests left L5 and S1 acute radiculopathy with deinervation." (Id.)*

The doctor recommended surgical intervention consisting of an L4-5 and L5-S1 microlumbar discectomy. (Id.).

On August 29, 2014, Dr. Dixon authored a letter to Dr. Murtaza stating that Petitioner's pain has been "refractory to multiple interventions including physical therapy and multiple epidural injections. Given the size of the disk herniations,

and the increased T2 signal within the annular tear I believe to a reasonable degree of medical certainty that her work related injury of 3/8/2014 is the proximate cause of her pain and that the care and treatment she has received until now has been both reasonable and necessary." (Id.).

On September 2, 2014, Petitioner again presented to Dr. Levin for an Independent Medical Examination. (RX 4). Dr. Levin diagnosed a contusion of the lumbar spine/left hip area consistent with the original diagnosis at Alexian Brothers. He believed the contusion was causally related to the alleged December 16, 2013 accident. He did not believe Petitioner sustained any injury to the cervical spine from that alleged accident. He opined that lumbar/hip contusions require between zero and 10 days off work, and 6 to 8 physical therapy visits. Specifically regarding Petitioner's contusion, he believed Petitioner did not need to miss any time from work. She had already reached maximum medical improvement by September 2, 2014, did not require additional medical care, including back surgery, and could return to work in a full duty capacity. (Id.).

On September 23, 2014, Dr. Levin authored a record review report in relation to the July 9, 2014 EMG findings of Dr. Arayan. (RX 5). He opined that the deficits at the nerve roots measured in that study should have produced findings at L2 – L4, not at L5 – S1. Because Petitioner's subjective complaints of pain were not located at L2 – L4 and the June 9, 2014 MRI of the lumbar spine was normal at L1 – L4, but showed minor degenerative changes at L5 – S1, the EMG was of no clinical significance in Dr. Levin's opinion. (Id.).

On April 6, 2015, Petitioner again presented to Dr. Levin for an Independent Medical Examination. (RX 6). She was again diagnosed with a contusion of the lumbar spine/left hip and it was believed she was at MMI for the lumbar spine. Dr. Levin did not believe there was any objective necessity for further care for the back, including back surgery.

On April 13, 2015, Dr. Levin authored an AMA impairment rating, where – based upon his April 6, 2015 assessment – he believed Petitioner's permanent impairment rating with respect to the lumbar spine is 1% of the whole person. (RX 7).

On June 1, 2015, Dr. Dixon authored a follow-up note and IME response. (PX. 3). Dr. Dixon noted he had last evaluated Petitioner on August 29, 2014. (Id.). On exam, the doctor found significant decrease in strength due to severe pain and a positive straight-leg raise on the left side. (Id.). Dr. Dixon reviewed the three reports authored by Dr. Levin dated May 22, 2014, December 2, 2014 and April 6, 2015:

> *In these documents Dr. Levin suggests a number of ascertains that I find to be inaccurate. In the initial document of 5/22/2014 he states that the MRI of the lumbar spine demonstrates degenerative changes only; however, the axial images are nondiagnostic at that time. He states that the patient may have chronic lumbar changes, however, that her*

symptoms at that time would be related to a left hip contusion and a lumbar strain. He then reevaluates her on 09/02/2014 with a new MRI dated 06/09/2014. He interprets this MRI as again having degenerative changes that he corresponds to "chronicity." However, this seems to overlook that the date of this study is at least 6 months distant from the patient's injury, therefore, some element of chronicity would be expected. He further goes on to include a paper to suggest that if there are no findings that are of an acute nature that MRI findings regardless of their severity should not be related to a specific instance. Again, this is a completely __argument as he states that the MRI that was most closely related to the injury was nondiagnostic. Finally, Dr. Levin does not feel it is necessary to comment on the implication of the increased T2 signal within the annular tear that he himself notes in his evaluation and makes no comment in any of the three documents of the EMG findings which are again completely consistent with herniated disk with nerve root compression at the L4-5 level and the L5-S1 level on the left side. (Id.).

On behalf of Respondent, Nely Diaz, attested that Labor Network was able to, and did, accommodate Petitioner's restricted duty recommendations from December 17, 2013 to the present. (RX 1). Ms. Diaz attested that after Petitioner was released to full duty work in September 2014 by Dr. Levin, Labor Network had an employment position available to Petitioner paying her the same wage she earned prior to the alleged December 16, 2013 accident. (RX 1; RX 2).

At hearing Petitioner testified she was in constant pain of the lower back radiating down her left lower extremity (TX. pp. 15-16). Petitioner states she wishes to continue treating with Dr. Dixon and undergo his recommended lumbar spine surgery. (Id. p. 16).

CONCLUSIONS OF LAW

With respect to issues (C)(D) and (F), respectively: (C) Accident (D) what was the date of the accident, and (F) Is Petitioner's current condition of ill-being causally related to the injury?

Petitioner testified at the hearing that she suffered only one work accident (TX. p. 35), and this accident occurred on December 16, 2013. (TX. p. 33). Petitioner further testified that on the date of accident, she immediately reported the accident to her supervisor. (TX. p. 12).

At hearing, Petitioner provided unrebutted testimony that (1) she was in good health and asymptomatic regarding lumbar spine and left leg pain prior to the date of accident (TX. p.12); (2) she sustained a back injury on December 16, 2013 (TX. p. 11).

The Arbitrator finds Petitioner's subjective complaints are supported by the preponderance of clinical and objective medical evidence. First, Petitioner's treating physicians, including Neurosurgeon, Dr. Dixon, attribute Petitioner's current condition of ill-being to her December 16, 2013 work injury. (PX 3, 8/29/2014). Second, Dr. Dixon's causation opinion and prospective surgery recommendation are supported by clinical and diagnostic evidence contained in the record:

1. The January 14 2014 MRI showing a L4-5 3-4mm broad based disc herniation with impaction and L5-S1 5-6mm left sided disc herniation with impaction levels. (PX2, Dr. George G. Kuritza, M.D., Radiologist 1/14/2014 Rpt. Pg. 2)
2. The June 9, 2014 lumbar spine MRI interpreted by Dr. Dixon as showing disk herniations at L4-5 and even greater at L5-Sl. (PX 3).
3. The July 9, 2014 EMG suggesting left L5 and S1 acute radiculopathy with deinervation. (PX3, 8/8/2011 Rpt.)

The Arbitrator takes particular notice that Petitioner is consistent in the pattern of her complaints of lumbar spine pain radiating down the left leg; all diagnostics show pathologies and radicular pain consistent with Petitioner's complaints.

The Arbitrator finds Respondent's §12 examiner Dr. Levin discredited on the question of causation. The Arbitrator notes Dr. Levin fails to acknowledge that, contrary to his initial "contusion" diagnosis (RX), Petitioner, in fact, *does* present with substantial objective evidence of a lumbar spine injury and correlating radiculopathy in the form of two MRIs and an EMG. The Arbitrator notes that the MRI ordered by Dr. Levin was not included in any of his reports, nor was it offered into evidence. As noted by Dr. Dixon, the diagnostic exams all positively correlate with her subjective complaints of low back pain radiating down the left leg. The medical record also demonstrates that over Petitioner's more than nine-month clinical record, she has exhausted all conservative measures. The Arbitrator notes Petitioner used a cane to ambulate at the July 14, 2015 hearing and needed to stand for a significant portion of the hearing due to her condition. The totality of the facts including Petitioner's demeanor, testimony and medical record are enough to demonstrate to the fact finder that Petitioner has incurred an injury far more serious than a simple lumbar spine contusion.

In sum, Petitioner's medical records, including diagnostic evidence as well as the documented consistency in her pain complaints, discredits Dr. Levin's opinions. Accordingly, Arbitrator finds Petitioner's physicians' opinions more credible than Respondent's §12 examiner.

The Arbitrator concludes Petitioner has shown by a preponderance of medical evidence that her current state of ill-being is causally related to the December 16, 2013 work place accident.

With respect to issue (J) whether the medical services that were provided to Petitioner are reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?

For reasons stated in issue (F) above, Arbitrator concludes the medical services provided to Petitioner and contained in Petitioner's Exhibit 5 are reasonable and necessary. Arbitrator further finds that Respondent is responsible for any outstanding charges for Petitioner's reasonable, related and necessary medical treatment.

With respect to issue (K) Is Petitioner entitled to any prospective medical care?

The Arbitrator concludes Petitioner is entitled to prospective medical care as recommended by her treating neurosurgeon Dr. Dixon. The Arbitrator concludes Dr. Dixon's recommended course of prospective treatment, based on the overwhelming objective medical evidence in the record, is reasonable, necessary and related to alleviate Petitioner's current state of ill-being.

Accordingly, Arbitrator finds by a preponderance of the medical evidence that Petitioner's subjective complaints are supported by the objective medical evidence, and therefore Petitioner's proposed medical treatment including L4-5 and LS-S1 microlumbar discectomy is reasonable, necessary and related to alleviate Petitioner's current state of ill-being.

With respect to issue (L) whether Petitioner is entitled to temporary total disability benefits?

Petitioner claims she is entitled to temporary total disability benefits for the 82 – 1/7 week period between December 17, 2013 and July 14, 2015. As a preliminary matter, the Arbitrator finds that Petitioner is not at MMI for her lumbar spine and left leg injuries caused by the December 16, 2013 work place accident. Petitioner's treating physician has not declared her condition to have stabilized, and Petitioner testified she is still symptomatic and remains off work due to her physician's restrictions. For reasons discussed above regarding issues (F) and (K), the Arbitrator finds the opinions and recommendations of Petitioner's treating physicians are credible and supported by the preponderance of medical evidence.

With respect to Respondent's dispute that Petitioner had three dependent children at the time of her accident, (Arb. 1). Petitioner testified that she had three children named Jesse Cruz (18), Lupita Cruz (15) and Julio Cruz (13). The Arbitrator notes the December 28, 2013 chart by Dr. Senna where he noted Petitioner "has had three births". (PX2) Respondent's Section 12 examiner, Dr. Levin, noted on May 22, 2014, that Petitioner reported a surgical history including 3 Cesarean sections. The Arbitrator finds that Petitioner has

established the fact that she had three dependent children on the relevant accident date.

Petitioner's AWW was stipulated to at trial as $304.96 on the date of injury with a TTD rate of $304.96

In addition, Arbitrator finds Respondent unreasonably suspended Petitioner's TTD benefits on the basis of Petitioner arriving "late" to one of her scheduled appointments with Respondent's §12 examiner. Section 12 of the Act provides, when an injured worker *refuses* to attend a §12 examination compensation payments (i.e. TTD) may be temporarily suspend "...until such examination shall have taken place..." 820 ILCS 305/12. (*see* R.D. Masonry, Inc. v. Industrial Commission, 349 Ill.App.3d 752, 812 N.E.2d 382, 285 Ill.Dec. 562 (1st Dist. 2004). Pursuant to R.D. Masonry to withhold TTD payments, Respondent must show Petitioner *refused* to attend the IME appointment, not just that Petitioner arrived late. Respondent has failed to offer any evidence that Petitioner refused to attend any of her scheduled IME appointments. Accordingly, Arbitrator finds that Respondent unreasonably withheld Petitioner's TTD benefits, because arriving "late" for an IME appointment is not a lawful basis for suspension of §8(b) benefits.

In sum, Arbitrator finds Respondent owes Petitioner TTD arrearages from December 16, 2013 through July 14, 2015, the date of hearing, or 80.5 weeks at a TTD rate of $304.96 or $25,050.29.

With respect to issue (O) "chain of referrals".

At hearing Petitioner testified Respondent referred her to their medical clinic Alexian Brothers on December 17, 2013. (TX. p. 13). Alexian Brothers Medical Records from December 17, 2013 include a note addressed to the Respondent, thanking Respondent for "this opportunity to have evaluated your employee for her work-related injury. (PX1).

Petitioner's next treated at Diversey Medical Center. She testified a "friend" referred her there. (TX. p. 21).

Thereafter, Petitioner presented to ION Orthopedics through referral from "the doctor" (TX. pp. 14-15), or a friend (TX. p. 21).

Lastly, on June 4, 2014, Dr. Murtaza noted that he was referring Petitioner for a surgical consultation. (PX 3). Petitioner then presents to Dr. Dixon (ION). (Id.). Dr. Dixon's June 13, 2014 initial evaluation gives thanks to ION for allowing him to see their patient. (PX 3).

Based on Petitioner's testimony at hearing and review of the record related to "chain of referrals", Arbitrator finds Petitioner has remained within her allowable two physician lines of referral.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

CHARLES C. STAPLES,

Petitioner,

16IWCC0682

vs. NO: 05 WC 10814

KANKAKEE SCHOOL DISTRICT #111,

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 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.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $423.77 per week for a period of 296 weeks for the period of February 15, 2005 through October 18, 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 $381.39 per week for a period of 200 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused permanent partial disability to the extent of 40% loss of use of the person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay reasonable, related and necessary medical services as identified in Petitioner's Exhibits 14-25 subject to the Fee Schedule and as provided in §8(a) and §8.2 of the Act.

16IWCC0682

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: OCT 27 2016
KLW:bsd
O: 8/30/16
42

Kevin Lamborn

Thomas Tyrrell

Michael Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

16IWCC0682

STAPLES, CHARLES C
Employee/Petitioner

Case# **05WC010814**

KANKAKEE SCHOOL DISTRICT #111
Employer/Respondent

On 10/6/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

3269 SPIROS LAW PC
SANDRA K LOEB
2807 N VERMILION ST SUITE 3
DANVILLE, IL 61832

0507 RUSIN & MACIOROWSKI LTD
DANIEL R EGAN
10 S RIVERSIDE PLZ SUITE 1530
CHICAGO, IL 60606

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

16IWCC0682

Charles C. Staples
Employee/Petitioner

v.

Kankakee School Dist. #111
Employer/Respondent

Case # **05** WC **10814**

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 **Kankakee**, on **September 15, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the 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 21, 2004**, Respondent *was* operating under and subject 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 $**33,053.80**; the average weekly wage was $**635.65**.

On the date of accident, Petitioner was **47** years of age, *single* with **0** dependent children.

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

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

Respondent shall be given a credit of $**37,584.89** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**37,584.89**.

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 $423.77/week for 296 1/7 weeks, commencing 2/15/05 through 10/18/10, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of $**37,584.89** for TTD, $**0** for TPD, and $**0** for maintenance benefits, for a total credit of $**37,584.89**.

Respondent shall pay any outstanding, related, reasonable and necessary medical services reflected in Petitioner's exhibits14-25, subject to the Fee Schedule and as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $381.39/week for 200 weeks, because the injuries sustained caused the 40% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

Signature of Arbitrator

10/2/15
Date

OCT 6 - 2015

FINDINGS OF FACT

Petitioner began working for the Respondent as a custodian in 1987 and was the head custodian at the time of his June 21, 2004 work accident. His usual job duties consisted of opening the school building, cleaning 10 classrooms, setting up and taking down 12 cafeteria tables, moving school furniture, taking out the garbage, snow removal and lawn care. Petitioner testified that he had no problems associated with his lower back or legs prior to June 21, 2004. On June 21, 2004, he spent 3-4 hours unloading semi-trucks containing computer tables, counsel tables and boxes of books when he began to feel his back get tight and eventually felt a sharp pain down his buttocks and legs. He testified that he reported the injury to Nancy, the school secretary on the same day, but continued to work full duty through the pain he continued to experience thereafter until he finally sought medical care on September 21, 2004. Respondent stipulated that Petitioner sustained a work injury that arose out of and in the course of his employment on June 21, 2004 and that it received timely notice of the same.

On September 21, 2004, Petitioner was seen by Dr. Ellis at OAK Orthopedics with what Dr. Ellis recorded as a two week history of back pain. Though Dr. Ellis's records reflect that Petitioner denied any "specific injury of trauma." associated the onset of his condition, Petitioner did relate the condition to his "regular job as a maintenance custodian that requires a lot of heavy lifting." Petitioner presented to Dr. Ellis on that day with complaints of intermittent back pain, paraspinal muscle spasms and numbness and tingling that radiates down into his left foot. Dr. Ellis suspected a herniated disk pulposus at L5-S1. He ordered an MRI and returned Petitioner to work with restrictions.

An MRI of Petitioner's lumbar spine was undertaken at OAK Orthopedics on October 10, 2004 that, according to the radiologist, revealed an "L5-S1 small central protrusion" with "contact of bilateral S1 and right S1 nerve roots without displacement" and an "L4-5 disc bulge with a left foraminal protrusion" with mild right and moderate left foraminal stenosis. The Petitioner was subsequently referred to Dr. Thomas who diagnosed "left S1 radicular symptomology" and performed two epidural steroid injections at the L5-S1 level. After conservative treatment failed to relieve Petitioner's symptoms, Petitioner was referred to a neurosurgeon, Dr. Michael Malek.

Dr. Malek testified by evidence deposition that he began treating Petitioner on February 9, 2005 at which time Petitioner provided a history of back pain that began on June 21, 2004 while unloading heavy boxes at work. Dr. Malek testified that that the June 21, 2004 work accident caused a pre-existing , degenerative, silent and asymptomatic condition of Petitioner's lumbar spine commensurate with his age to become symptomatic, likely associated with the disc herniation, beyond the natural progression of the disease. Dr. Malek ordered lumbar discography and an EMG/nerve conduction study that were not approved until after Petitioner was examined by Respondent's Section 12 examiner, Dr. Jay Levin.

On March 2, 2005, Petitioner was examined by Repspondent's Section 12 examiner, Dr. Jay Levin. Dr. Levin, an orthopedic spine surgeon, reviewed Petitioner's previous MRI studies and recommended that a CT/mylogram be done in conjuction with EMG/Nerve conduction studies. Dr. Levin later reviewed the results of those studies and testified that the the CT/myelogram revealed a central L5-S1 herniated nucleus pulposus and opined that the same appeared to be the "pain mediator." He furthermore admitted on cross-examination that the herniated disc might or could have been anatomically caused by the June 21, 2004 workplace accident. He concurred with Dr. Malek that a lumbar discogram should be done in consideration for decompression/ fusion or anterior spine arthroplasty pending the results.

On June 20, 2005, Petitioner underwent a lumbar discogram performed by Dr. Malek and post discogram CAT

16IWCC0682

scan at Provena St. Mary's Medical Center. Dr. Malek testified that the results of those studies did not correlate with the clinical symptomology and the findings on the MRI scan. Dr. Malek recommended that those studies be repeated by a third party in order to rule out that possibility that the study was a false negative. Respondent's section 12 examiner, Dr. Levin reviewed the results of the June 20, 2005 studies and opined in a report dated August 31, 2005 that the Petitioner was not a surgical candidate, had reached maximum medical improvement, and should undergo a functional capacity evaluation. Petitioner attempted to undergo a functional capacity evaluation thereafter on October 27, 2005 that could not be completed due to Petitioner's elevated blood pressure.

On December 1, 2005, Petitioner was re-evaluated by Dr. Levin at Respondent's request. At this visit, Dr. Levin was afforded with some video surveillance of Petitioner that was admitted into evidence as well as a job description of a "Day Head Custodian that was not admitted into evidence. Dr. Levin opined that based on Petitioner's diagnosis being limited to degenerative disc disease and Petitioner's job description, Petitioner could return to full duty work as of December 1, 2005. At Dr. Levin's evidence deposition, he denied that the video surveillance provided a basis for his opinions.

Petitioner's temporary total disability benefits were discontinued soon after his December 1, 2005 Section 12 examination. Petitioner had received TTD benefits from February 14, 2005 up until that time while his treating physicians had placed restrictions on his ability to work. A letter dated February 11, 2005 from the Respondent's Assistant Superintendent for Personnel was admitted into evidence that indicated that the school district would not accommodate Petitioner's work restrictions after February 14, 2005. The letter also instructed Petitioner to remain off work until he could return to unrestricted duty.

Petitioner testified and the medical records reveal that the Petitioner continued to seek medical care with Dr. Malek after his TTD benefits were discontinued. Dr. Malek testified and his records reveal that he was of the opinion that Petitioner's condition continued to require work restrictions and he continued to recommend that Petitioner undergo a repeat discogram. Petitioner testified that his pain continued to get worse and that he did not return to work during this period.

On May 25, 2006, Counsel for both parties agreed to have Petitioner examined by a third surgeon, Dr. Charles Slack. Dr. Slack testified via evidence deposition that he diagnosed a "small central disc herniation at the L5-S1 level" and that Petitioner's symptoms were consistent with the same as well as irritability of the left L5 nerve root. He, however, did not consider Mr. Staples to be a surgical candidate as of the time of his evaluation and that he recommended that Petitioner undergo a functional capacity evaluation.

On July 7, 2006, Petitioner underwent a Functional Capacity evaluation that was considered to be a valid study and placed him at the sedentary level. Dr. Stack reviewed that same and opined that Petitioner could not return to his full duty occupation. Dr. Slack recommended physical therapy, a work conditioning and a work hardening program.

Petitioner was reexamined by Dr. Slack on October 23, 2006 after Petitioner had completed the recommended therapy program and underwent a subsequent functional capacity evaluation on October 6, 2006 that placed him at the medium level. Dr. Slack opined that Petitioner could return to his full duty employment with Respondent as of October 23, 2006 based on the job description he was provided that categorized Petitioner's employment as within the medium level.

Petitioner testified that he returned to his employer after being provided with Dr. Slack's release to return to

16IWCC0682

work, but that he was not offered any work. Petitioner also testified that his regular work as a custodian routinely required lifting in excess of 50 pounds that would exceed the medium level of employment. Petitioner testified that he was not provided with any assistance in locating new employment by Respondent.

Petitioner's medical records reveal that he continued to receive medical care from Dr. Malek with visits occurring approximately every 90 days though May 14, 2007. On June 18, 2005, Petitioner was examined by his second choice of physician, Dr. Ronald Michael. At that visit, Dr. Michael took a history of the June 21, 2004 work accident, reviewed Petitioner's MRI study and discogram, and diagnosed a herniated nucleus pulposus at L5-S1 and a protruding disk at L4-5. He recommended a repeat discogram since he considered the previous one to be outdated. Petitioner continued to treat with Dr. Michael on a regular basis through May 7, 2008. A repeat discogram was performed on September 27, 2008 that confirmed discogenic pathology at L4-L5 and L5-S1, but also equivocal findings at L3-L4 . Dr. Michael recommended that Petitioner undergo a "plasma disk decompression surgery."

On October 8, 2008, Petitioner returned to Dr. Malek for follow-up care. Dr. Malek reviewed Dr. Michael's records and ordered a repeat MRI and an EMG/nerve conduction study that were undertaken at Riverside Medical Center on October 23, 2008. Dr. Malek testified that the October 23, 2008 MRI was consistent with the previous MRI study, showing significant pathology at L4-5 and L5-S1, and that the new EMG/nerve conduction velocity showed evidence of lumbar radiculopathy at L4-5 and L5-S1, whereas the previous one did not. Dr. Malek subsequently recommended a third discogram that he performed on August 3, 2009 at Provena St. Mary's Medical Center. According to Dr. Malek, this study confirmed that L4-5 and L5-S1 were the pain generators without contribution from L3-4. Dr. Malek subsequently performed a two-level fusion at those levels on November 3, 2009 at Provena St. Mary's Medical Center. Among Dr. Malek's surgical findings were "those of significant irritability of the left L5 nerve root." Dr. Malek testified that the need for the lumbar fusion surgery was caused by the June 21, 2004 work accident.

After Petitioner's surgery and completion of care with Dr. Malek and at the request of both parties, Dr. Slack performed a records review on December 4, 2011. Upon review of the medical records and diagnostic studies post-dating his 2006 examinations, Dr. Slack opined that the additional medical records indicated that there had been a "progressive worsening of the patient's clinical picture with development of a positive EMG and a positive discogram at the L4-5 and L5-S1 levels." He also opined that the treatment provided subsequent to his 2006 examination, including the surgery, was reasonable and necessary to treat Petitioner's ongoing back and leg pain. He furthermore opined that Petitioner was unable to return to his former employment with Respondent after his surgery.

On December 19, 2012, Dr. Levin was once again asked by Respondent to conduct a Section 12 examination. After re-examining the patient and reviewing the medical records that had post-dated his previous examination in 2005, Dr. Levin testified that his prior opinions remained largely unchanged from the report he authored on December 9, 2005. He testified that the petitioner had reached maximum medical improvement from his work accident as of December 9, 2005, that he required no work restrictions as of that time, and that the medical treatment rendered subsequent to December 9, 2005 was neither reasonable nor necessary as it related to the work accident.

Petitioner testified that he still complains of lower back pain and experiences tingling in his feet. His left side is weaker and he uses a cane for balance. His low back is stiff and he cannot sit or stand for long periods of time. He has pain with walking distances greater than one block and has given up gardening or coaching youth basketball because of his lack of leg strength.

CONCLUSIONS OF LAW

1. With regard to the issue of causation, 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, unrebutted testimony and the medical evidence. In this case, the treating surgeon, Dr. Malek and Respondent's examiner, Dr. Levin, agree that Mr. Staples suffered a low back injury as a result of the June 21, 2004 accident. Though the first medical records from OAK do not contain a history of the June 21, 2004 workplace accident, the Arbitrator finds significant that Respondent's examiner, Dr. Levin, reviewed the same medical record and still opined that Petitioner's condition was causally related to the June 21, 2004 work accident. The main dispute between the experts in this case is whether or not the Petitioner reached maximum medical improvement at some point prior to his November 3, 2009 fusion surgery. Based on the Petitioner's testimony and the medical records admitted into evidence, the Arbitrator finds that Petitioner aggravated an underlying asymptomatic degenerative disc disease in his low back as result of his workplace accident and that his symptoms have not abated, despite a lengthy and protracted course of medical treatment, including the fusion surgery performed by Dr. Malek. The Arbitrator finds further persuasive the testimony of Dr. Malek, and of Dr. Slack on the issue of the necessity of the surgery as it relates to the workplace accident. Accordingly, the Arbitrator concludess that the Petitioner's current condition of ill-being is as a result of his June 21, 2004 workplace accident.

2. With regard to the issue of medical expenses, based on the findings above, Petitioner's medical treatment has been reasonable and necessary to cure the effects of the June 24, 2004 work place accident and Respondent is ordered to pay the same. Respondent shall have credit for any amounts previously paid.

3. On the issue of TTD, the Arbitrator finds that the Petitioner was temporarily and totally disabled from February 15, 2005 through October 18, 2010. In support of this finding, the Arbitrator relies on the Petitioner's credible testimony and the medical evidence. Respondent bases its denial of TTD on Dr. Slack's October 23, 2006 opinion that Petitioner could return to full duty work. Dr. Slack later testified that his opinion based on his understanding that Petitioner's occupation was at the medium level. However, the Arbitrator finds the Petitioner's testimony credible that his job duties often required lifting in excess of 50 pounds and in excess of the medium level. Also, the Arbitrator finds it significant the Respondent failed to offer Petitioner any work at anytime after October 23, 2006 though it had previously indicated in its February 11,2005 letter that his job would be available when he could return to unrestricted work. Finally, the Arbitrator finds that Petitioner's condition did not stabilize until October 18, 2010. Respondent is therefore ordered to pay Petitioner the sum of $423.77/week for a period of 296 1/7 weeks, that being the period of temporary incapacity between February 15, 2005 and October 18, 2010. Respondent shall have credit for any amounts it has already paid to the Petitioner in the form of TTD or disability benefits.

4. Regarding the issue of nature and extent, the Arbitrator finds that the Petitioner has sustained injuries that have resulted in 40% loss of use of the person as a whole. As a result of Petitioner's June 21, 2004 accident, Petitioner sustained injuries requiring him to undergo a protracted course of conservative care, followed by a two-level fusion at L4-5 and L5-S1. Petitioner continues to have residual complaints following the surgery and has not returned to work. His treating physician, Dr. Malek, and Dr. Slack agree that his post-operative condition requires work restrictions that would prevent him from returning to his former occupation. Accordingly, Respondent is therefore ordered to pay Petitioner the sum of $381.39/week for a further period of 200 weeks in accordance with 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 LAKE	)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
			☐ PTD/Fatal denied
		☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Andy McGinnis,

Petitioner,

16IWCC0683

vs.

NO. 07 WC 32105

R & D Theil,

Respondent.

DECISION AND OPINION ON REMAND

This matter comes before the Commission on remand from the Appellate Court of Illinois, Second District, directing the Commission to recalculate Petitioner's average weekly wage and proper amount of TTD, TPD, and PTD benefits and attorney fees and penalties. The prior Decision of the Commission filed on January 10, 2013 is modified as stated below in accordance with the Commission's recalculation.

We find that the average weekly wage is $1,406.18. This is based on $61,067.68 annual earnings divided by 43.428 weeks, of earnings during the 52 weeks preceding the date of accident.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 5, 2012 and the Commission Decision on January 10, 2013 is modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $937.45 per week for a period of 127 and 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 two-thirds of the difference between the Petitioner's average weekly wage of $1,406.18 and gross amount which he earned in the performance of modified duties for Respondent from July 19, 2007 through December 6, 2007 and from September 16, 2008 through October 14, 2009, that being the period of temporary partial incapacity for work under §8(a) of the Act, and the amounts of

temporary partial disability compensation are found to be $6,484.91 for the earlier period and $19,247.49 for the second period making a sum of $25,732.40 in all.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $937.45 per week for life, as provided in §8(f) of the Act, for the reason that the injuries sustained caused Petitioner's permanent and total disability.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $9,064.34 for medical expenses under §8(a) and §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner $10,000.00 in penalties, as provided in §19(l) of the Act, the sum of $2,510.38 in penalties as provided by §19(k) of the Act and the sum of $502.08 in attorneys' fees as provided in §16 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any; on the finding that the award has been reduced on review by the Commission, Circuit Court and Appellate Court no interest is due.

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. Respondent shall have credit for its payments totaling $165,400.34: $100,996.68 for temporary total disability benefits, $20,711.64 for temporary partial disability benefits, $31,497.80 for maintenance benefits and $12,194.22 for other benefits; paid through Arbitration on November 11, 2011, and $165,196.12 paid after November 10, 2011 through October 26, 2015, and $937.45 per week since October 26, 2015 and $68,220.94 has been paid to resolve underpayments.

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: OCT 2 8 2016
RWW/plv
o-10/6/16
46

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

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 Choose reason	☐ Second Injury Fund (§8(e)18)
		☐ PTD/Fatal denied
	☒ Modify: Up	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

LAUREN BAUER,

Petitioner,

16IWCC0684

vs.

NO: 15 WC 5352

MADISON POLICE DEPARTMENT,

Respondent.

DECISION AND OPINION ON REVIEW

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

Findings of Fact and Conclusions of Law

1. Petitioner testified on February 2, 2015 she was employed by Respondent's police department as a patrolman and had been for about 16 months. On that date she was involved in pursuing suspects along with other police departments. The pursuant went into Missouri. She put her car in position to block the suspects' car. Their car struck her squad car. As her car was struck, she "ducked to the left in the event they opened fire." The suspects fled and she pursued them on foot. She was feeling "all adrenalin;" she "couldn't feel anything except at the point of impact thinking wow that was really hard." She did not feel anything until her "adrenalin dumped." She lost sight of the suspects and was driven back to the accident scene by St. Louis policemen.

2. As they were searching the area for evidence, she "started to feel pain and stiffness" in her back/neck. Petitioner saw the incident report and had no issue with it. Petitioner abandoned the search and called her supervisor who told her she had to take an ambulance to Barnes Hospital to be evaluated. The next day she saw Dr. Eavenson, to whom a lot of officers went. Her lawyer did not send her to him. After an MRI, Dr. Eavenson referred her to Dr. Gornet, whom she saw on February 24, 2015. He prescribed physical therapy, chiropractic treatment, and injections. She got temporary relief from the second of three injections. Prior to the injections, she felt "absolutely terrible" with "constant pain and stiffness." She "always has pain in the very bottom portion" of her back into her hips and lower back.

3. Petitioner remembered a Section 12 examination with Dr. Stiehl and filling out a pain questionnaire. She answered based on how her condition affected her ability to perform various functions and not based on her level of pain. She explained the "10" on whether her condition caused her to see doctors more frequently to mean that she virtually never saw a doctor prior to the accident. Her "12" on the question on recreational activities referred to her inability to work out in the gym, which she previously did avidly. She has not been able to lift weight at all since the accident. She tried to run, but had to stop because the jarring in her neck caused a lot of pain. She did not believe she could function as a police officer at the time of arbitration.

4. Petitioner also testified that currently, her most severe pain is in her neck, shoulders, and head; she also has pain in her lower back and hips. She also has pain and numbness in her arms, which comes and goes. She could go days without any symptoms in her arms but it has gotten worse. She was not taking any pain medication based on Dr. Gornet's advice. She never had problems with these parts of her body prior to the accident, and it was getting worse month to month. She understood that Dr. Gornet wanted to perform a 3-level cervical procedure; she wants it because "it's something that needs to be done."

5. On cross examination, Petitioner explained that the answer "6" to the effect on her ability to travel meant that she had trouble driving long distances. She can only stand still or sit for up to "30 to 45 minutes max." She can't lift her arms over shoulder level without pain. Bending, stooping, and squatting cause pain. She had constant pain in her neck and head. She always had a "headache usually almost to a migraine status." She has constant pain in her shoulders and sometimes it is sharp. She has dull pain in her lower back and hips. She could only rotate her head to the right at about 45 degrees, according to the estimate of the Arbitrator. To the left she could probably rotate about 80 degrees. Looking up and down causes her pain.

6. Petitioner also testified that in 2012 she practiced catching footballs "with girls," it was not an organized team. She did normal weightlifting like bench presses, squats, and lunges. Since the accident she tried lifting 5-lb dumbbells, but did not have the muscle strength and it pulled on her neck. She eliminated lifting with her legs altogether. She is able to socialize but "might just stay home: if her head hurts too bad." Petitioner had chiropractic treatment several years previously. It was "just normal adjustments" for her mid-back. She never had medical treatment for her back or neck prior to the accident.

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7. Petitioner opened a LinkedIn account but didn't have access to it. She has two Facebook accounts. She originally made the second Facebook account because she did not want her former stepdaughter to see her "adult version." She was shown a Facebook entry which indicated she was self-employed. She did not know when she posted that, but it was probably when she was "doing in-home child care prior to being a police officer."

8. She identified a picture of herself and another woman, which was taken at a cousin's birthday. It was always on her page, but she recently made it her profile picture. Her "adult account" is in the name "Lavren Baver." She was shown a picture taken in October of that year of her at a pumpkin patch at which she was walking while her boyfriend picked up pumpkins chosen by her children. There was also a picture of her in Florida leaning over with her arm in a fake alligator's mouth. She was there to visit her boyfriend's "ailing parents." She did go to the beach while in Florida.

9. On redirect examination, Petitioner testified the drive to the Section 12 examination was 70 miles. After the drive she had more stiffness in her neck and low back. She can only drive about 30 to 45 minutes before getting stiffness. The picture of her preparing to throw a football was taken in June 2012. The last time played was in September 2012. She has not been on the LinkedIn account since the accident. The picture of her with her friend was about a year ago or more. She posted pictures lifting weights prior to the accident but not after the accident.

10. On re-cross examination, Petitioner testified she flew to Florida; she thought the flight was about 1 hour 40 minutes. It took 18 to 20 minutes to get to the St. Louis airport. It took about 30 minute to get from the airport to the place they stayed in Florida. They did drive around in Florida; they went to restaurants and she shopped at an outlet mall.

11. The medical records reveal that on February 2, 2015, Petitioner presented to the Emergency Department at Barnes Hospital complaining of neck/back pain. The pain diagram seems to concentrate on the shoulder and chest. Paraspinal tenderness was noted. Chest x-rays were normal. There was no report of numbness or weakness. The nurse's assessment is difficult to read but it appears Petitioner reported an unbelted head-on motor vehicle accident at relatively slow speed. The initial diagnosis was pneumothorax musculoskeletal strain, cervical fracture was considered unlikely. Petitioner was provided pain medication and discharged.

12. The St. Louis Police Department report was dated February 3, 2015. It received notice of a pursuit of a robbery suspect. Petitioner was assisting police from Granite City and Venice. She traveled to intercept the suspect car. "The suspects (*sic*) vehicle began to slow when it approached" her. Petitioner also slowed her car because she thought the suspect's car was going to stop and the suspect may be armed. She began to duck down. The suspect's car "accelerated and struck the front corner of the passenger side of" Petitioner's car. The occupants left the car and fled on foot. Petitioner pursued on foot but lost sight of the suspects. Medics responded to the scene but the arrestees refused treatment. Petitioner "began to feel stiffness in her body" and was taken to Barnes.

13. Also on February 3, 2014, Petitioner presented to Dr. Eavenson, a chiropractor, for "examination and evaluation of injury sustain during the course of her usual duties as a police officer." She was in high-speed pursuit of murder suspects. She was not wearing a seatbelt so she could get out of the car quickly. Petitioner left the pursuit to block the speeding suspect. "The car hit the accelerator causing a head on collision." Immediately prior to impact she tilted her entire torso to the left. She did not hit her head or have any loss of consciousness. She has had neck and back pain since more on the left.

14. On examination, Dr. Eavenson noted palpable spasm throughout the spine, reduced cervical range of motion and pain with all movements, and pain at C5-6 on compression "positive distraction/negative Spurling's." There was less restricted range of motion in the lumbar spine, normal reflexes, slight sensory loss over the upper arm, and negative straight leg raises bilaterally. Dr. Eavenson diagnosed cervical and lumbar disc protrusion and thoracic strain. He prescribed physical therapy and MRI and restricted her to 5-lb lifting.

15. A lumbar MRI taken on February 5, 2015 was normal. A cervical MRI taken that day showed broad-based disc protrusions C3-C7 and evidence of central annular tears with central canal stenosis at those levels. The stenosis was minimal at C3-4 and C6-7 and mild/moderate at C5-6, with minimal effacement of the ventral surface of the spinal cord at that level.

16. Thereafter, Petitioner continued to treat with Dr. Eaverson and Mr. Voss, an associated physical therapist, through October 5, 2015. There were over 100 separate daily entries noting treatment. She continued to complain of low back pain and neck pain throughout. The neck pain seemed pretty constant and the low back pain varied a little more. On the last date Dr. Eavenson reported no change in her neck pain 6/10 but did note low back pain was only 3/10 on that day. Mr. Voss reported no low back pain and that the neck pain was the same. It appears that Dr. Eavenson kept Petitioner off work for the duration.

17. On February 24, 2015 Petitioner presented to Dr. Gornet on referral from Dr. Eavenson. Petitioner's pain diagram indicated 8/10 pain. Pain was worse at the neck but also extended to the back of the head, shoulders, upper back, and lower back. She noted her problems began on February 2, 2015 when she was working as a police officer. She was involved in a high speed pursuit when the other car apparently turned and rammed her car head on. The airbags did not employ. She leaned over to the left because the suspect was armed and she was concerned about being shot. Petitioner had constant symptoms, but her sensation and strength were normal. Dr. Gornet prescribed three more weeks of treatment with Dr. Eavenson and injections if that treatment did not resolve her condition.

18. On March 16, 2015, Petitioner returned to Dr. Gornet and still complained of pain to the base of her neck, headache, and pain between her shoulder blades. Her exam was still "non-focal 5/5." Dr. Gornet noted her symptoms were worse at C3-4 and C5-6. If injections failed he would consider disc replacement at C3-4, C5-6, and possible C6-7. Dr. Gornet noted "she will need a CT myelogram" and kept her off work.

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19. On March 30, 2015, April 13, 2015, and April 27, 2015, Dr. Boutwell administered injections at C3-4, C5-6, and C6-7 for varying diagnoses.

20. On May 18, 2015, Dr. Gornet noted that the injections had diminished Petitioner's headache somewhat, but she still had daily headaches which affected her quality of life. Dr. Gornet noted he had recommended a CT myelogram and disc replacement at C3-4, C5-6, and C6-7. He also indicated she had a small protrusion at C4-5 but he did not think it needed treatment at that time. Petitioner wanted to proceed.

21. On May 19, 2015, Dr. Stiehl authored a report after an examination at Respondent's direction under Section 12 of the Act. Dr. Stiehl indicated that Petitioner was being evaluated for a significant motor vehicle accident on February 2, 2015. Her car "was crashed into by a suspect in a violent criminal chase" in which Petitioner's car was blocking the car that collided with hers. She went to an Emergency Room complaining of neck and low back pain. She did not complain of numbness or tingling in any extremity. "Virtually all other evaluation proved to be normal."

22. The next day she began treatment with a chiropractor. Dr. Stiehl noted an MRI "reportedly showed some broad disc protrusions at C3-4 through C6-7. They suggest the possibility of an annular tear. No foraminal stenosis was seen at any level." Petitioner then saw Dr. Gornet on February 24, 2015 complaining of neck pain radiating into the trapezius muscles of both shoulder and maybe the left arm. He continued conservative treatment and noted the possibility for the need of injections.

23. Petitioner reported she was not currently working. She needed to be released to full duty to be able to perform as a "street officer." She had been in physical therapy for "the better part of the last three months." Petitioner filled out an AMA Physical Disability Questionnaire ("PDQ") and scored 98, which was "consistent with pain with minimal activities."

24. On examination, Dr. Stiehl noted unrestricted cervical range of motion. Extension was 40 degrees, flexion was 45 degrees, and rotation was 65 degrees right and left. Spurling and cephalocaudal compression were negative for significant foraminal portal pain. She also did not exhibit any other symptoms in the foraminal portals of the neck. She had full range of motion in the shoulder but had modest discomfort in the trapezius muscles. Strength and reflexes were normal. The lumbar exam was normal.

25. Dr. Stiehl then answered interrogatories. Dr. Stiehl diagnosed a minor whiplash injury with absolutely no evidence of neurological impairment. There were no objective findings to support Petitioner's significant subjective complaints. Her PDQ score of 98 was "not consistent with the paucity of findings." Dr. Stiehl did not recommend injections because there was absolutely no evidence of neurological impairment and he did not find any structural damage. In addition, disc replacement was clearly not indicated because he found no abnormalities. Petitioner had reached maximum medical improvement for the whiplash injury she sustained and needed no additional treatment or diagnostic studies. She could return to work as a police officer without restrictions.

26. Dr. Gornet testified by deposition on September 10, 2015. He is a board certified orthopedic surgeon. He initially saw Petitioner on February 24, 2015, and she was complaining of pain in the neck, in both shoulders, both trapezius, and left upper arm, as well as headaches. Dr. Gornet related her history of the motor vehicle accident as in his treatment note. Cervical films showed no significant degeneration (loss of disc height), but there were "obvious disc herniation at C3-4, a smaller one at C4-5, and more significant at C5-6 and even C6-7." There were annular tears and C3-4 and C5-6 and there was spinal cord deformity and compression at C5-6. Petitioner's complaints were consistent with her pathology and her pathology was consistent with "a high-speed or head on collision."

27. Dr. Gornet continued Dr. Eavenson's conservative treatment. She was still having pain so he referred her to Dr. Boutwell for injections. She returned to Dr. Gornet on May 18, 2015. The injections had diminished her headaches somewhat, but she still had symptoms including headaches. He told Petitioner they "would move forward with a CT myelogram" and he recommended 3-level disc replacement.

28. Dr. Gornet reviewed the report of Dr. Stiehl. Dr. Gornet noted that Dr. Stiehl indicated he was evaluating Petitioner after a significant motor vehicle, but then concluded she suffered a minor whiplash injury. "So either it is a significant accident or it is not a significant accident." He found Dr. Stiehl's statements inconsistent. Dr. Gornet agreed with Dr. Stiehl that Petitioner did not exhibit significant neurological compression. But that did not mean that she did not have a structural problem that needed treatment. He disagreed that Petitioner was at maximum medical improvement, but he believed he could get Petitioner back to full duty work after the recommended surgery.

29. Dr. Gornet noted that the term "whiplash" was coined in the 1950s and which referred to persistent neck pain and headaches. However, now CT myelograms are available and showed that whiplash injuries are disc injuries, "no different than a torn cartilage in your knee, a torn rotator cuff, and they cause pain." Those conditions cause pain in the absence of nerve compression. He thought Dr. Stiehl's reliance on the lack of nerve compression to be "foolish" and "outdated." It was "consistent with Dr. Stiehl not performing spine surgery, never performing disc replacement, and never treating these patients in this fashion."

30. On cross examination, Dr. Gornet agreed that at the time he had only seen Petitioner on three occasions and only examined her on the initial visit. Petitioner had subjective evidence of pain radiating into the trapezius, but that cannot be measured objectively. Petitioner did not have severe spinal cord compression, but her disc at C5-6 abutted up against the spinal cord. Petitioner's symptoms were related to the disc injury. When she applies mechanical load it causes pain in the nerve fibers of the structure itself. A disc protrusion is generally a small disc herniation, but the size of the herniation does not necessarily affect its relation to a neurological condition. An annular tear is a tear in the ring of the disc. The only cause for an annular tear was "when the force on a disc exceeds what it can handle."

31. Dr. Gornet was aware that Petitioner was a smoker (1pack per day), and smoking is associated with disc herniation. He agreed that Petitioner had mostly discogenic pain, which is different than myelopathy or radiculopathy *per se*. He was treating her structural problem. He did not really know the symptoms of "minor whiplash." Petitioner had daily headaches that affected the quality of her life and was unable to work full duty. Dr. Gornet would consider that "major."

32. Dr. Gornet did not necessarily expect the injections to have produced more relief if those discs were the source of her symptoms. Injections sometimes completely alleviate symptoms and sometimes, "in this situation it seemed to be a sort of mix. It did help her but not enough to really push her over the edge to the point that she could go back and do her job full duty and all the other things."

33. Dr. Gornet agreed that Dr. Eavenson referred Petitioner to him and he referred her back to Dr. Eavenson for chiropractic care and physical therapy. That treatment helped "on a temporary basis. Unfortunately, it wasn't enough to again push her back in to work, and so we shifted into the injection realm." He planned to refer Petitioner back to Dr. Eavenson for postop rehabilitation. While he was not currently planning on replacing C4-5, he would look at the disc critically at the time of surgery. He was not recommending treatment of Petitioner lumbar spine at that time.

34. Dr. Stiehl testified by deposition on October 1 2015 that he is a board certified orthopedic surgeon. He was a "traumatologist" for years in Milwaukee. Then he practiced adult reconstructive surgery for 25 years, where he basically performed joint replacement surgery. He was now practicing general orthopedic medicine in a rural town in southern Illinois.

35. He evaluated Petitioner on May 13, 2015, reviewed records, and issued a report at the request of the employer. She was a police officer who was involved in a motor vehicle accident on February 2, 2015. He concluded that Petitioner suffered a minor whiplash injury, which is a cervical strain, in the motor vehicle accident and there was no evidence of a neurological component to her condition. He did not believe the objective findings supported her subjective complaints. She subjectively tested as being severely disabled in the AMA pain disability questionnaire, perhaps to the extent of being wheelchair bound.

36. Dr. Stiehl noted that it was his understanding that the indication for ESIs is chronic neurological radiculopathy, which Petitioner did not exhibit, either in the medical records or in his examination. In fact, he found no abnormalities in his examination. Regarding "structural damage," Dr. Stiehl carefully reviewed the MRI and did not find any structural changes that he "could directly attribute to this" motor vehicle accident. He also concluded she was at maximum medical improvement and needed no additional treatment or diagnostic exams. He saw no reason why she could not return to work without restrictions.

37. Finally, Dr. Stiehl testified that while Dr. Gornet was a very qualified and well trained spine surgeon, Dr. Stiehl, as an expert in orthopedic surgery, did not find any indication for the 3-level disc replacement surgery he recommended. In 20 years he had only seen a handful of patients with 3-level fusion and none of them was 28 years old.

38. On cross, Dr. Stiehl testified that independent medical examinations have risen to nearly 50% of his current practice and at least 95% of them are on behalf of employers. He had not performed spine surgery for many years, since about 1982. He thought disc replacements had been used for only about 10 to 12 years. However, multiple disc replacement surgery started more recently.

39. Dr. Stiehl agreed that some orthopedic surgeons prescribe injections for both diagnostic and therapeutic purposes; he would not prescribe ESIs unless there was some neurological aspect to a patient's condition. However, he would not criticize another surgeon for prescribing ESIs for diagnostic purposes. He often prescribed ESIs and then referred a patient to a spinal surgeon if the ESI did not provide relief. He supposed he agreed that different doctors may have different definitions of what constitutes a neurological condition.

40. Dr. Stiehl did not know whether PDQs are meant to be used only with patients at maximum medical improvement. He uses them at various stages of treatment. They provide him with a lot of useful information in order to ask additional questions.

41. Dr. Stiehl agreed that an annular tear can progress into a herniated disc and that process could be caused without another injury but through the activities of everyday living. Rather than identifying general numbness and tingling in arms to evidence a disc herniation, he would look to symptoms in specific dermatomes, which really shows radiculopathy. Patients with a cervical disc herniation could have headache and certainly could have trapezius symptoms from a cervical strain.

42. Various photographs were submitted into evidence. In an undated LinkedIn posting, Petitioner is seen in a type of sport-bra holding a football in anticipation of making a pass. In undated photographs from Petitioner's Facebook page, she seemed healthy and was smiling a lot. The most relevant picture is the one with a fake alligator. She is sitting on it with her knee about at shoulder level. Photographs of her squad car after the collision are dark and a little difficult to discern. Petitioner's car was hit on the passenger-side front fender. There is some damage to the very front of the fender, the headlight area, and the lower part of the right bumper. The damage does not seem extensive. The suspects' car seems to have sustained more damage than the police car.

The Arbitrator found that Petitioner proved the motor vehicle accident caused a current condition of ill-being of her cervical spine resulting in some headaches and range of motion issues. She noted the sequence of events, the lack of evidence of any other accident/injury, and the coincidence of her complaints. However, the Arbitrator noted that it was less clear whether the MRI findings were caused by the motor vehicle accident or whether surgery was indicated.

The Arbitrator found the opinions of both Dr. Stiehl and Dr. Gornet unpersuasive. She noted that Dr. Stiehl's conclusions were based "on an incorrect perception of Petitioner's pain complaints from the start." She also questioned his reliance on the PDQ, the answers on which Petitioner provided a reasonable explanation. In addition she pointed out that his specialty was not related to spinal surgery and the predominance of independent medical examination work in his current practice.

Regarding Dr. Gornet, the Arbitrator noted that he was under the misimpression that Petitioner was involved in a head-on collision which seemed to be inaccurate according to the photographs of the vehicles and the Emergency Department report. She also seemed very concerned that Dr. Gornet recommended extensive 3-level cervical surgery based on only a single examination and little more than subjective complaints.

The Arbitrator also noted the photographs seemed to contradict Petitioner's subjective complaints of ongoing and debilitating impairment/disability. Those included both the photos of the cars involved in the motor vehicle accident and those of her activities. The Arbitrator also found that Petitioner did not prove she suffered a condition of ill-being of her lumbar spine in the motor vehicle accident because there was never any objective evidence of any condition of ill-being and she basically received no treatment for her lumbar spine.

The Arbitrator found that all medical expenses incurred were necessary and reasonable to treat her condition of ill-being and awarded it. However, she denied Petitioner's request for prospective treatment because she was not convinced her condition warranted the surgery recommended by Dr. Gornet. On the issue of temporary total disability, the Arbitrator "somewhat reluctantly" awarded 37&2/7 weeks through the date of arbitration. She was reluctant because she thought Petitioner would have been able to work for Respondent in some capacity. However, she noted that Petitioner did report to Dr. Diehl that she could only return to work if she was cleared to work full duty. In addition, there is no indication that Respondent attempted to find work for Petitioner which her doctor may have found acceptable.

Respondent argues the Arbitrator erred in finding Petitioner proved a causal connection to a current condition of ill-being of her cervical spine. It stresses Petitioner's lack of credibility and that the Arbitrator clearly had issues with Petitioner's recitation of the severity of her symptoms. Respondent basically argues that the Arbitrator erred in awarding medical expenses and temporary total disability past the date of the report of Dr. Stiehl. Respondent also asks the Commission to affirm the Arbitrator's decision regarding Petitioner not proving causation to a condition of ill-being of a lumbar condition. Petitioner does not address the issue of a condition of ill-being of her lumbar spine. In its brief Petitioner only argues that the Arbitrator erred in not awarding prospective treatment recommended by Dr. Gornet. She notes that he was the only spinal surgeon to provide recommendations for treatment.

The Commission notes that although the Arbitrator may have had some misgivings about the severity of Petitioner condition of ill-being, she actually viewed her testimony and found her sufficiently credible to find she proved she had a current condition of ill-being of her cervical spine. The Commission sees no reason to disturb that finding. There is some corroboration of her condition in the protrusions and likely annular tears seen in the cervical MRIs.

Therefore, the Commission affirms the Decision of the Arbitrator concerning causation and her award of current medical expenses and temporary total disability. The Commission also affirms the Decision of the Arbitrator that Petitioner failed to prove causation to a current condition of ill-being of her lumbar spine. However, the Commission modifies the Decision of the Arbitrator regarding possible prospective treatment. At this time, the Commission is not prepared to finally conclude whether Petitioner is actually at maximum medical improvement without the need for additional treatment, or whether the invasive surgery of a 3-level cervical replacement is actually warranted. These are the only options currently proposed by the parties.

The Commission does not find either of these options to be acceptable. The Commission concludes that additional information is needed for a decision to be rendered about whether prospective treatment should be ordered, and if so, what such treatment should entail. The Commission notes that in his treatment notes Dr. Gornet recommended a CT myelogram both on March 16, 2015 and in his final treatment note of May 18, 2015. There is no indication in the record before us that such a test, or any other diagnostic tests, has been administered subsequently.

Accordingly, the Commission remands the matter to the Arbitrator for further proceedings consistent with this Decision. The Commission recommends that the parties obtain a 3rd opinion either from a neurologic surgeon or an orthopedic surgeon specializing in spine surgery. Hopefully, the parties can mutually agree on a particular physician. Upon such agreement, the Respondent shall authorize and pay for any diagnostic tests regarding Petitioner's cervical spine recommended by that doctor as well as any subsequent recommendations for treatment. If the parties cannot mutually agree on a particular doctor to provide a 3rd opinion, the Commission has the authority to designate one pursuant to Section 19(c)(1) of the Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 22, 2015 is hereby modified as outlined above and otherwise 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.

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

DATED: OCT 2 8 2016

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

RWW/dw
O-10/4/16
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

16IWCC0684

BAUER, LAUREN
Employee/Petitioner

Case# **15WC005352**

CITY OF MADISON
Employer/Respondent

On 12/22/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.51% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4463 GALANTI LAW OFFICE
DAVID M GALANTI
PO BOX 99
E ALTON, IL 62024

0180 EVANS & DIXON LLC
MARILYN C PHILLIPS
211 N BROADWAY SUITE 2500
ST LOUIS, MO 63102

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Lauren Bauer
Employee/Petitioner

v.

City of Madison
Employer/Respondent

Case # **15** WC **005352**

Consolidated cases: **none**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Collinsville**, on **October 21, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

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

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

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

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

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

G. [ ] What were Petitioner's earnings?

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

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

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

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

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

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

N. [ ] Is Respondent due any credit?

O. [ ] Other ______

FINDINGS

On the date of accident, **2/2/15**, 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 $**53,190.31**; the average weekly wage was $**1,022.89**.

On the date of accident, Petitioner was **28** years of age, ***single*** with **2** dependent children.

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

Respondent shall be given a credit of $ * for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $ *. *Respondent provided Petitioner with full pay from 2/3/15 through 6/15/15.

Respondent is entitled to a general credit for any medical bills paid by its group medical plan for which credit is allowed under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of **$681.93/week** for **37 2/7 weeks**, commencing **2/3/15** through **10/21/15**, as provided in Section 8(b) of the Act. Respondent shall be given a credit for the full pay Petitioner received from Respondent February 3, 2015 through June 15, 2015.

Respondent shall pay the following medical bills subject to the Medical Fee Schedule: Barnes Jewish Hospital: $997.00; Multicare Specialists: $3,938.16; and STL City Ambulance: $729.00.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.

Prospective medical care is denied.

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

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

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

Nancy Lindsay
Signature of Arbitrator

December 17, 2015
Date

ICArbDec.19(b)

DEC 2 2 2015

Lauren Bauer v. City of Madison, 15 WC 005352 (19(b))

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Arbitrator Finds:

On February 2, 2015, Petitioner was 28 years of age and had been employed by Respondent as a patrol officer for about 16 months when she was involved in a motor vehicle accident. The incident was described in a police report identified as Respondent's Exhibit 3, which Petitioner testified was accurate.

According to the report, Petitioner was in her patrol car traveling west pursuing robbery suspects who were riding in a Pontiac Grand Prix. When she turned south she saw the suspects' car traveling north toward her vehicle. The Grand Prix began to slow as it approached Petitioner. Believing the suspects might stand try to shoot her, Petitioner slowed her vehicle and began to duck down. The suspects accelerated and struck the front corner of the passenger side of Petitioner's patrol vehicle with the front of their vehicle. Photos of the vehicles after impact are included in RX 3. The report does not state the estimated speed of either vehicle at the time of impact. RX3.

Petitioner was taken by ambulance to Barnes Jewish Hospital. According to EMS records, Petitioner was able to get herself out of the vehicle and was walking after the accident. She was not wearing a seat belt. Front motor vehicle damage was described as "moderate." At the hospital, Petitioner complained of neck, mid upper back, left side and back pain. She denied any loss of or headache. The Nursing ED Assessment Flowsheet states that the collision was at "relatively slow speed." (PX 1, p. 10) Petitioner was diagnosed with a neck and back strain and discharged home. (PX1, pp. 1 – 12, 13-18)

Petitioner saw Chiropractor Mark Eavenson and physical therapist Corey Voss on February 3, 2015 with complaints of pain in her neck, and her mid and low back, especially on the left. Petitioner gave a history of her accident adding that just before the impact she tilted her entire torso to the left and since then she had been experiencing neck and low back pain, more on the left side. Petitioner told Dr. Eavenson and Mr. Voss that she was in a head on collision. (PX 2, p. 254) Cervical range of motion was limited. On physical examination he found cervical, thoracic and lumbar spine muscle spasm. His assessment was cervical disc protrusion, thoracic strain, and lumbar disc protrusion. He provided therapy, took her off work and noted consideration of an MRI. (PX2)

Petitioner was re-examined by Chiropractor Eavenson the next day and she also underwent physical therapy with Mr. Voss. Her chief complaint was increased soreness as she had pain with all movements. Dr. Eavenson recommended an MRI of her cervical and lumbar spine. He felt she should remain off work and use moist heat at home on a frequent basis. (PX 2)

The cervical MRI performed on February 5, 2015 revealed: broad based central disc protrusions of C3-4 – C6-7 discs; evidence of a posterior central annular tear at the C3-4, C5-6, and C6-7 disc levels; minimal central canal stenosis at C3-4 and C6-7 disc levels with mild to moderate central canal stenosis at the C5-6 intervertebral disc level; minimal effacement of the ventral surface of the spinal cord at the C5-6 disc level; and no significant neural foraminal exit stenosis throughout the cervical spine. Petitioner's lumbar spine was normal. (PX3)

Petitioner was again re-examined by Dr. Eavenson and underwent therapy with Mr. Voss on February 5, 2015. No significant changes were noted. (PX 2)

Petitioner again presented to Dr. Eavenson and Mr. Voss on February 9, 2015. She tolerated therapy well without incident. Petitioner received chiropractic treatment to her entire spine. She was advised to continued physical therapy

and moist heat and to remain off work. (PX 2)

Petitioner signed her Application for Adjustment of Claim herein on February 10, 2015. (AX 2)

Petitioner was re-examined by Dr. Eavenson and attended physical therapy with Mr. Voss on February 10, 2015 reporting her lower back was really bothering her and that it started getting worse the night before. She also complained of frequent headaches. Dr. Eavenson noted, "[she states] my lower back is so freaking sore, neck is achy, mid back is a little sore" No changes in treatment were noted. (PX 2)

Dr. Eavenson noted that on February 11, 2105 Petitioner was not feeling well at all as she was stiff and sore all over. No treatment changes were noted. When seen by Mr. Voss she reported her low back was feeling somewhat better but still was still experiencing neck pain and headaches. She tolerated treatment well without incident. (PX 2)

As of February 12, 2015 Petitioner was reporting increased pain in her neck and low back and pain in her upper extremities with numbness in the right extremity. Dr. Eavenson noted, "Dr. Gornet told me tolday that he would try to get the in patient [sic] next week." Petitioner told Corey Voss that her headaches were really bothering her and her neck remained sore. (PX 2)

In their February 16, 2015 office notes both Corey Voss and Dr. Eavenson noted Petitioner's lower back was reportedly finally starting to get better but continued pain in her neck and upper back remained. Dr. Eavenson again noted that Dr. Gornet was still trying to get Petitioner in for an exam. No changes were noted in treatment recommendations. (PX 2) No changes were noted on February 17, 2015. (PX 2)

When seen by Dr. Eavenson on February 18, 2015 Petitioner reported that her head felt like it was going to explode. She was experiencing a headache but her lower back was better. She was scheduled to see Dr. Gornet the following week. Her visit the next day was similar. At her February 23, 2015 visit she was reporting increased pain along the left side of her neck, mid and low back. (PX 2)

Petitioner returned to Dr. Eavenson on February 24, 2015 reporting her neck was very sore and she was having more pain in her left lower back/SI joint. She was scheduled to see Dr. Gornet that evening. (PX 2, p. 223)

Petitioner presented to Dr. Matthew Gornet on February 24, 2015. Petitioner's main complaint was neck pain with headaches to the base of her neck, pain between her shoulder blades, bilateral trapezius pain to both shoulders, and left upper arm. Petitioner completed a pain drawing at the time of the exam. Petitioner reported being referred by Dr. Eavenson. Petitioner denied any distal arm pain, numbness or weakness. Dr. Gornet noted that on February 2, 2015, Petitioner "was in a high speed pursuit and apparently the car turned and rammed her car, striking her head on." The air bags did not deploy and she leaned to the left as she was concerned about being shot at the same time. She denied any prior neck problems of significance. Petitioner reported her symptoms were constant and worse with arm activity or fixed head positions. On physical examination he found decreased range of motion in all directions secondary to some visible spasm; 5/5 motor strength in all groups; trace deep tendon reflexes in the biceps, triceps and brachioradialis; and, normal sensation. (PX 4, 7)

According to the office note, Dr. Gornet felt Petitioner's lumbar MRI revealed well-hydrated disks at all levels; and, no evidence any significant disc injury. He further felt that her cervical MRI revealed obvious disc herniation at C3-4, a smaller one at C4-5, and more significant pathology at C5-6 and C6-7. At C3-4 and C5-6, there were obvious annular tears. The C5-6 lesion caused spinal cord deformity and compression. Dr. Gornet recommended three more weeks of treatment from Dr. Eavenson followed by steroid injections if she did not improve. He related her problems to the February 4, 2015 incident. He kept her off work through 3/16/15. Dr. Gornet placed Petitioner's low back "on hold" as she seemed to be improving. (PX 4)

As advised, Petitioner followed up with Dr. Eavenson and Mr. Voss on 2/26/15, 3/3/15, 3/4/15, 3/5/15, 3/9/15, 3/11/15,

and 3/12/15. (PX 2)

On March 12, 2015, Petitioner also met with Dr. Rodney Lupardus of Multicare Specialists for a new patient evaluation. Petitioner reported undergoing chiropractic care and physical therapy for neck pain and headaches after a work-related motor vehicle accident on February 2, 2014 in which she had a "head on" collision with a suspect during a pursuit. Petitioner described her headaches as mostly occipital with a constant aching sensation and occasional throbbing. Occasionally, she would also experience nausea when her headaches were very bad. Petitioner had been given Flexeril but it caused excessive sedation and Petitioner reported disliking having to take medication. Petitioner's social history included weight lifting. Petitioner reported a weight gain since the accident along with frequent daily headaches which seemed to be related to her neck pain. Petitioner also reported a history of peptic ulcer disease and chronic abdominal pain with related symptoms. Petitioner reported following a very healthy diet and exercising regularly. She also gave a history of arthritic symptoms in her upper extremities since the age of 16 which seemed to be getting worse with intermittent pain and stiffness in her hands, wrists and elbows. She denied any numbness, tingling, or weakness. She also reported difficulty falling asleep and staying asleep and had tried Ambien once in the last few years but it made her feel unusual and confused. Petitioner also related a past history of a syncopal episode related with dizziness and some positional vertigo symptoms over the last few weeks. Dr. Lupardus recommended general lab work and a follow-up with her gynecologist for her abdominal/pelvic pain. He also prescribed medication for pain, inflammation, headaches, and sleep issues. She was told to continue with her chiropractic treatment and physical therapy. (PX 2, pp. 208-210)

Petitioner then returned to Dr. Gornet's office with ongoing symptoms on March 16, 2015. Dr. Gornet felt Petitioner still had disc injuries at C3-4, C5-6 and C6-7 with her most significant symptoms at C3-4 and C5-6. He felt she needed a CT myelogram and she remained temporarily totally disabled. (PX 4)

Petitioner returned to see Dr. Eavenson and Mr. Voss on 3/17/15, 3/18/15, 3/19/15, 3/23/15, 3/24/15, and 3/26/15. (PX 2)

Petitioner underwent an epidural steroid injection at C3-4 performed by Dr. Boutwell on March 30, 2015 for a diagnosis of cervical radiculopathy and disc displacement. (PX 6)

Petitioner returned for chiropractic care and physical therapy on 3/31/15, 4/1/15, 4/2/15, 4/7/15, 4/8/15, and 4/9/15. (PX 2)

Petitioner underwent an epidural steroid injection at C5-6, again performed by Dr. Boutwell, on April 13, 2015. Petitioner's diagnosis was cervical cervicalgia. (PX 6)

Petitioner continued to receive chiropractic care and physical therapy on 4/14/15, 4/15/15, /16/15, 4/20/15, 4/21/15, and 4/23/15. (PX 2)

Petitioner had a third epidural steroid injection at C6-7 with Dr. Boutwell on April 27, 2015. Petitioner's diagnosis was bilateral cervical radiculopathy. (PX6)

Petitioner resumed chiropractic care and physical therapy on 4/28/15, 4/30/15, 5/4/15, 5/5/15, 5/6/15, 5/11/15, and 5/12/15. (PX 2)

Dr. Stiehl examined Petitioner at Respondent's request on May 13, 2015. RX1, Depo X2, 1. On physical examination of the cervical spine he found full range of motion, negative Spurling's test and cephalocaudal compression for significant foraminal portal pain; no symptoms over the foraminal portals of either side of the neck; modest discomfort in the trapezius muscles; full range of motion of both shoulders; normal sensation to pinwheel test in all dermatomes of both arms; 5/5 grip strength, elbow flexion/extension, shoulder internal/external rotation and abduction; and, symmetric and brisk deep tendon reflexes. Id. 4. Dr. Stiehl reviewed Petitioner's MRI and found neither a significant bulge nor a protrusion at multiple levels. (RX1, Depo. Ex. 2, 4)

On examination of Petitioner's lumbar spine Dr. Stiehl found: full range of motion; forward flexion past 100° with fingertips reaching the floor; unrestricted extension and side bending; 90° straight leg raising; no calf pain; intact sensation in lower extremity dermatomes; normal heel-toe walking; and, normal Trendelenburg's sign. (RX1, Depo X2, 4-5)

Dr. Stiehl diagnosed a minor whiplash injury with absolutely no evidence of neurological impairment. He noted no significant objective findings other than the typical chronic complaints of whiplash strain injury. Although Petitioner reported significant subjective complaints, she presented no objective physical findings. He determined she had reached maximum medical improvement and recommended no injections or surgery. He found she could work without restriction. (RX1, Depo X2, 5-6)

Petitioner underwent chiropractic treatment and physical therapy on May 18, 2015. (PX 2)

On May 18, 2015 Petitioner followed up with Dr. Gornet. According to his note, Petitioner's injections had diminished her headaches to some extent, but she continued to experience daily headaches affecting all aspects of her life and her quality of life. Accordingly, he recommended a CT-myelogram and disc replacement surgery at C3-4, C5-6 and C6-7. Dr. Gornet noted that Petitioner had a small protrusion centrally at C4-5 but he didn't believe it needed to be treated at this point in time. He stated that he believed he could "get her back to work full duty with no restrictions." Pending her anticipated full post-operative recovery, however, Dr. Gornet authorized Petitioner to remain off work through June 11, 2015. He again noted that Petitioner's accident was a head-on motor vehicle accident and that her injury was work-related. (PX4)

Petitioner returned to Dr. Eavenson and Mr. Voss on 5/19/15, 5/20/15, 5/26/15, 5/27/15, 5/28/15, 6/2/15, 6/3/15, 6/4/15, 6/8/15, 6/9/15, 6/10/15, 6/16/15, 6/17/15, 6/18/15, 6/22/15, 6/23/15, 6/25/15, 6/29/15, 6/30/15, 7/2/15, 7/6/15, 7/7/15, 7/13/15, 7/14/15, 7/15/15, 7/20/15, 7/21/15, 7/23/15, 7/27/15, 7/28/15, 8/3/15, 8/4/15, 8/6/15, 8/10/15, 8/11/15, 8/12/15, and 8/17/15. (PX 2)

Petitioner cancelled her scheduled appointment with Dr. Eavenson and Mr. Voss on August 18, 2015 as it was her daughter's last day before school and she wanted to spend time with her. (PX 2, p. 47)

Petitioner returned to see Mr. Voss and Dr. Eavenson on 8/19/15, 8/20/15, 8/24/15, 8/26/15, 8/27/15, 9/1/15, 9/2/15, 9/3/15, 9/8/15, and 9/9/15. (PX 2)

Dr. Matthew Gornet was deposed on September 10, 2015. Dr. Gornet is a board certified orthopedic surgeon. (PX5, 3) Dr. Gornet testified that her initial complaint was neck pain, headaches at the base of her neck, pain between her shoulder blades, both trapezius, shoulders, and her left upper arm. Petitioner believed her problem began "on or about" 2/2/15. It was his understanding that Petitioner had been involved in a high speed pursuit and that the suspects' car turned and "rammed" her car, striking her, which she felt was "head on." Petitioner recalled no prior problems of "significance" with her neck. Her physical examination showed no neurologic deficit, 5/5 strength, and normal sensation. (PX 5, 3-5) Dr. Gornet testified that Petitioner's cervical MRI showed herniations at C3-4, C4-5, C5-6 and C6-7; obvious tears at C3-4 and C5-6; and, the C5-6 lesion caused some spinal cord deformity and depression. (PX5, 5-6) He explained her films were "consistent with a structural injury to the cervical spine causing predominantly neck pain, headaches and pain into the shoulders with the absence of focal neurologic deficit. So essentially, [she] injured the structure without causing significant spinal cord compression." Dr. Gornet further testified that Petitioner's mechanism of injury "that being a high-speed or head-on collision," was consistent with the pathology revealed on the MRI films. (PX5, 6)

Dr. Gornet further testified that at the next visit with Petitioner on March 16, 2015 Petitioner reported she was still having pain and they talked about injections which were subsequently performed by Dr. Boutwell. (PX 5, p. 7) Thereafter, Petitioner returned to see him in May and reported diminished headaches but still having daily headaches that affected her quality of life. Dr. Gornet recommended a CT myelogram and disc replacement surgery at C3-4, C5-6 and C6-7. At that time he kept Petitioner off work and had not seen her again since then. (PX 5, p. 8) He further testified that

if her condition remained unchanged, he would continue to hold her off work. (PX 5, p. 9)

Dr. Gornet testified regarding Dr. Stiehl's examination report noting that it appeared they had a disagreement as to whether or not Petitioner had a significant accident and just whiplash. He agreed that Petitioner had no significant neurologic component to her injury but, nevertheless, she had a structural problem requiring treatment. He further disagreed that Petitioner was at maximum medical improvement as there is treatment available for Petitioner to get her back to work at full duty. (PX 5, pp. 9-11)

Dr. Gornet admitted that Petitioner's studies showed no focal neurologic deficit; that she demonstrated normal strength and normal sensation; and, that he did not believe she had severe spinal cord compression. He admitted that although C5-6 "abuts up and does deform the spinal cord to some extent," he did not believe that abutment caused "a clinical state that would demonstrate spinal cord compression." According to Dr. Gornet, Petitioner's symptoms were related to a disc injury, but not nerve compression. (PX5, 14-15) He admitted that C5-6 was the only level with "significant contact causing some cord deformation." (PX5, 18)

Dr. Gornet further acknowledged that he only examined Petitioner on one occasion and that was at the time of their first visit in March. Thereafter he never re-examined her because she did not complain of any new focal neurologic changes. (PX 5, p. 13) When asked if Petitioner had any cervical radiculopathy, he replied that one could state that she had evidence of that by the pain radiating into her trapezius which would be the normal radicular pattern for a disc herniation at the C3-4 level but it would be difficult to measure from a strength standpoint. He added that she had subjective evidence of cervical radiculopathy based on her pain complaints but it couldn't be measured objectively. (PX 5, p. 14)

Dr. Gornet also testified that the disc protrusions seen in Petitioner's MRI are considered the lowest level of disc herniation. (PX 5, p. 15) He further testified that he did not know the exact answer to whether or not annular tears only occur with acute injuries or can occur over time degeneratively. (PX 5, p. 16) He also went on to testify that he is treating Petitioner for discogenic pain and not myelopathy or radiculopathy. Petitioner has a structural problem resulting in pain from an injured disc. (PX 5, p. 18)

When asked about his plan to do a three level disc replacement on Petitioner, Dr. Gornet testified that he needs to scan her again as it has been eight months or so since the initial MRI and he wants to reassess the disc. He also feels Petitioner needs a CT myelogram as he has no current plans to replace the disc at C4-5 but he would not want to be right next to a disc and not treat it. (PX 5, p. 21)

Dr. Gornet also testified that Petitioner's primary complaint at the present is her neck. There may be some subtle suggestion of some disc pathology at L5-S1 but he has no plans to do any "major issues" on her low back at this time. (PX 5, p. 22)

Petitioner underwent chiropractic treatment and physical therapy on 9/10/15, 9/14/15, 9/16/15, 9/17/15, 9/21/15, 9/22/15, 9/23/15, and 10/1/15. (PX 2)

Dr. Stiehl was deposed on October 1, 2015. Dr. Stiehl testified he is a board certified orthopedic surgeon.(RX1, 5) He explained that Petitioner sustained a minor whiplash injury to her neck, which was a cervical strain, with no evidence of a neurological component, and that she had reached maximum medical improvement. He further testified that although Petitioner reported significant subjective complaints, she presented no objective physical findings. He testified that Petitioner required no injections because she showed no evidence of chronic radiculopathy. RX1, 11-12. He testified that in 20 years of practice he had only seen a handful of patients who had undergone a three level disc replacement, and could recall none of them being as young as Petitioner. (RX1, 12-13) He explained that he found no abnormalities on his examination or otherwise, and that Petitioner was able to return to work without restriction as a police officer. (RX1, 13-15)

Dr. Stiehl is a board certified orthopedic surgeon. H further testified that his particular specialty has been trauma-based and then adult reconstructive surgery primarily of the hip and knees. Half of his practice is devoted to independent examinations (with 95% of them being for employers). He has not performed any surgery and has not performed any spine surgery since 1982. He also acknowledged having only one examination with Petitioner. He also acknowledged that he had Petitioner complete a pain disability questionnaire which is generally associated with impairment ratings when an individual is at maximum medical improvement. He uses it as it supplements his having to ask lots of questions. Dr. Stiehl agreed that annular tears can progress to herniated discs. He further agreed that one can have headaches and pain into the shoulder blades and trapezius with disc herniations. (RX 1)

Dr. Gornet had another appointment with Petitioner on October 5, 2015. According to his notes, Petitioner remained temporarily totally disabled and he continued to believe her symptoms were related to her "head-on" motor vehicle accident. He further noted, "There was some confusion regarding her follow-up visit. This is in part related to our office and I believe that we have requested treatment and this has been delayed. Her treatment status is unchanged. Her work status is unchanged. I have given her an off work slip dating back to 9/16/15." Her exam was unchanged. (PX 2)

Petitioner underwent chiropractic care and physical therapy on October 5, 2015 reporting to Mr. Voss that her neck was not any worse but not any better. She denied any low back pain. He noted Petitioner was showing no signs of improvement either subjectively or objectively and was unable to tolerate exercises secondary to increased neck and lower back pain with activity. Chiropractor Brooks noted that Petitioner had a slight increase in neck pain over the weekend that he attributed to lack of therapy over the weekend. Petitioner described her neck pain as a "6/10" and reported that her low back wasn't nearly as bad (perhaps a "3/10"). Petitioner reported tightness throughout her mid back. (PX 2)

Petitioner's case proceeded to arbitration on October 21, 2015. The issues in dispute were causal connection, temporary total disability benefits, and prospective medical care. Petitioner was the sole witness testifying at the hearing. Chief Christopher Burns was present throughout the hearing as Respondent's representative. The parties stipulated that Petitioner received full salary through June 15, 2015 and that said amount should be credited against any award of temporary total disability benefits.

Petitioner testified that she was using her car as a "block" for the other vehicles that were in pursuit, and she did not know how fast the suspects' car was traveling when it struck her vehicle. Petitioner testified she felt no immediate pain, got out of her car and chased a suspect on foot. When she lost sight of him she was given a ride back to the crash scene. Thereafter, she began experiencing pain and stiffness in her back and neck and after consulting with her sergeant via cell phone she was taken by ambulance to Barnes Hospital for evaluation.

Petitioner testified that due to a rush of adrenalin, she felt no immediate pain, got out of her car and chased a suspect on foot. When she lost sight of him she was given a ride back to the crash scene. She began experiencing pain and stiffness in her back and neck and was taken by ambulance to Barnes Hospital for evaluation.

Petitioner testified that she began treating with Dr. Eavenson because other officers had gone to him for care. Dr. Eavenson ordered MRIs of her neck and low back which were performed on February 6, 2015. Petitioner testified Dr. Eavenson then referred her to Dr. Gornet who initially recommended that she continue with chiropractic care and physical therapy. She then underwent injections with Dr. Boutwell and the second one provided temporary relief. Petitioner testified that the relief lasted only two days and then she felt "absolutely terrible" with constant headaches, pain and stiffness. Petitioner also testified to ongoing pain in the very bottom portion of her back and into her hips.

Petitioner testified that she underwent an examination with Dr. Stiehl and that she filled out a questionnaire as part of the exam (RX 2 – Pain Disability Questionnaire) Petitioner testified that she interpreted the questions to be asking her how the accident had impacted her rather than what her level of pain was. Petitioner had rarely seen a doctor before her accident and afterwards she was going to numerous doctors and physical therapy visits. Similarly, prior to the accident she had been a very avid gym participant, working out at least six days a week doing heavy weightlifting and working as

a personal trainer on the side. Petitioner was also a runner doing 5K races but could not do that after the accident. Thus, the accident had impacted her recreational activities at the level of a nine. Her pain level was not a nine. Petitioner denied lifting or running since the accident. While she acknowledged trying to run after speaking with Dr. Eavenson, it jarred her neck and she became too stiff to do so.

Petitioner testified that she doesn't feel like she could work as a police officer right now due to her level of pain which is most severe in her neck, shoulders and head although she has some pain in her low back and arms. According to Petitioner the arm pain comes and goes. Petitioner testified to some numbness in her arms and down into her hands but it changes from day to day. On the advice of Dr. Gornet, Petitioner is not taking any medication.

Petitioner denied any problems with headaches, her neck, or her low back prior to the accident. According to Petitioner, her pain is progressively worsening. She experiences pain in her neck, shoulders, head, lower back, hips and arms. She has constant pain through her neck and head. She always has a headache almost to migraine status. The pain in her shoulders is sometimes sharp. She has a dull pain in her low back. She tries not to move her head back or forward very far or to look up because it will hurt. Petitioner acknowledged that when she first sat down to testify at the hearing she made a comment to the Arbitrator that she would have difficulty turning her head to look at her. Her neck range of motion is perhaps 45 degrees to the right and 80 degrees to the left.

Petitioner acknowledged that in the past she played football in 2012 but it wasn't an organized team . Petitioner testified that she cannot keep her hands up for a long period of time. She cannot grasp things as well because she has less muscle strength in her arms and shoulders. She cannot lift weights or run. Lifting laundry baskets causes pain. She cannot sit or stand longer than 30 to 45 minutes. She cannot lift her arms overhead. Bending, stooping and squatting causes pain. Bending over to tie shoes causes pain. If she bends over, she must physically hold her head up from dropping too low. The driving trip of about 70 miles for her evaluation by Dr. Stiehl caused stiffness in her neck and low back.

Petitioner admitted that her pain has not interfered with her ability to interact with her friends in social situations, and she goes to bars, movies and bonfires. In mid-October 2015, she walked along with her boyfriend and children as they picked up pumpkins at a pumpkin farm. (RX7, 2-3)

Petitioner acknowledged that in September 2015 Petitioner traveled to Florida to visit her boyfriend's ailing parents. The drive from her home to the airport was 18 to 20 minutes. The flight to Florida was an hour and 40 minutes. The trip from the airport in Florida to her accommodations was 30 minutes. While in Florida she went to the beach, walked on the beach and sat in a chair. She went out to restaurants. She went shopping at an outlet mall. She visited a lookout tower where she posed sitting and leaning on a "fake alligator." In two photos taken at the tower Petitioner demonstrated her ability to smile as she posed, twisting her head, rotating her torso, balancing on her left hip and/or reaching her left arm around into the alligator's mouth. (RX8) Petitioner testified that her neck bothers her every day but it wasn't a high pain level in Florida.

Petitioner's medical bills are contained in PX 7.

<u>The Arbitrator concludes:</u>

1. Issue (F) Causal Connection; Issue (K) Prospective Medical Care.

   Petitioner's current condition of ill-being in her cervical spine is causally connected to her undisputed accident of February 2, 2015. This conclusion is based upon a chain of events and Petitioner's testimony. Petitioner testified to no prior problems with her neck or any problems with headaches. It appears that she has had no further accidents or injuries to her neck since the accident. The Arbitrator does believe that Petitioner is suffering from some headaches and range of motion issues as a result of the accident but the true extent of these complaints and whether they truly necessitate surgery at this stage is less clear. Also less clear is whether or not the MRI findings

are causally related to the accident. The Arbitrator was not persuaded by the opinions and testimony of either Dr. Gornet or Dr. Stiehl.

In finding Dr. Stiehl's opinions unpersuasive, the Arbitrator notes that Dr. Stiehl only examined Petitioner on one occasion (although Dr. Gornet has essentially only examined Petitioner once also). While Dr. Stiehl is a board certified orthopedic surgeon, he testified that his particular specialty has been trauma-based and then adult reconstructive surgery primarily of the hip and knees. Half of his practice is devoted to independent examinations (with 95% of them being for employers) and, most importantly perhaps, he has not performed any spine surgery since 1982. While Dr. Stiehl believed Petitioner had sustained a cervical strain/minor whiplash injury, had reached maximum medical improvement at the time of his exam, and that she had a normal examination, these opinions were based, on an incorrect perception of Petitioner's pain complaints from the start. At the time of the exam Dr. Stiehl had Petitioner complete a pain questionnaire usually used by physicians who are rendering impairment ratings. Dr. Stiehl was of the opinion that Petitioner's responses to these questions were inconsistent with his objective findings as her score suggested someone who would be severely disabled. Dr. Stiehl apparently took Petitioner's responses to the pain questionnaire at face value and never discussed her responses with her. Petitioner provided a credible explanation for her responses (and, in the end, her score) at the arbitration hearing. Had Dr. Stiehl been made aware of this (or asked about it) his opinion might have changed. As he himself testified, using the questionnaire saved him from having to ask some questions. In this instance, it might have been beneficial to ask some additional questions. Dr. Stiehl also acknowledged on cross-examination that headaches, joint stiffness, and trapezial symptoms (all of which Petitioner has) can all be found with a cervical disc herniation. At no point in Dr. Stiehl's examination report did he even mention what Petitioner's presenting complaints were on the date of his examination. At most he refers to "significant symptoms" which appear to be a reference to her pain questionnaire responses, as opposed to a list or summary of specific complaints. Dr. Stiehl's report is silent with regard to any mention of headaches which appears to be Petitioner's primary complaint. Furthermore, neither Dr. Stiehl's report nor testimony addressed the issue of annular tears.

That is not to say that Dr. Gornet's records and testimony aren't troubling either. They are. Dr. Gornet's opinion and recommendations were based on an assumption that Petitioner was injured in a high speed, or head on, motor vehicle accident. While there is some uncertainty as to the rate of speed of the vehicles at the time of the accident as the rate of speed of neither vehicle was reported[1], Petitioner did not know how fast the cars were traveling, and, Petitioner's car had slowed prior to impact, the Arbitrator takes significant issue with whether or not Petitioner's vehicle was struck "head on." The photographs found in RX 3 don't indicate a head on collision. Dr. Gornet was not shown the photographs nor did he ever provide any explanation as to what he specifically meant by a "head on" collision. It is unclear if he truly understood the details of the accident. Furthermore, Dr. Gornet appears to be unaware of Petitioner's history (as provided to Dr. Lupardus) of arthritis-like symptoms in her upper extremities pre-dating the accident herein.

Another troubling aspect of this case is Dr. Gornet's lack of documentation. As he acknowledged in his deposition, he only actually examined Petitioner on one occasion – their first visit. Thereafter, he kept Petitioner off of work and recommended an extensive three level disc replacement based solely on that first exam and, essentially, subjective complaints on Petitioner's part. He has never clearly stated a diagnosis in his office notes and Dr. Boutwell has given Petitioner injections for cervical radiculopathy, cervical cervicalgia, and bilateral cervical radiculopathy, none of which have been diagnosed by Dr. Gornet. Dr. Gornet has recommended surgery based upon Petitioner's representation that her headaches and neck pain significantly impact her quality of life; yet, Petitioner is able to engage in certain activities if she wishes – ie., skip a day of treatment to spend time with her daughter, socialize with friends, and fly down to Florida and recreate and sightsee. Of particular concern is Petitioner's testimony regarding the extent of her pain and limitations and yet the photographs of her in Florida posing with the alligator seem quite contradictory. She does not appear to be in any pain whatsoever in those photographs. While that is an isolated image and Petitioner testified she wasn't in as much pain at that time and

[1] However, the ER notes suggest a "relatively slow rate of speed"

that her range of motion to the left is less limited than that on the right, they cast a real cloud on the true nature/extent of Petitioner's injury and whether her complaints are so significant as to warrant the extensive surgery being recommended by Dr. Gornet.

In summary, the Arbitrator concludes that Petitioner's current condition regarding her cervical spine is causally connected to her undisputed accident. The Arbitrator believes that Petitioner is suffering from some headaches and limited range of motion as a result of the accident. She also believes that Petitioner's participation in physical activities as she did pre-accident has been curtailed. However, the Arbitrator cannot conclude that Petitioner's condition is such that the surgery proposed by Dr. Gornet is reasonable or necessary as a result of the motor vehicle accident. Dr. Gornet's opinion that Petitioner needs surgery due to her work accident is not persuasive as it appears he is under the impression Petitioner was involved in a head-on collision and she was not. Both Dr. Gornet and Dr. Stiehl agreed that Petitioner's examination, objectively, was relatively normal and Dr. Gornet also acknowledged that Petitioner's "herniated" discs are really the lowest level of herniation. Thus, objectively, Petitioner's condition does not seem that severe in terms of objective findings making a recommendation of a three level disc replacement (perhaps four before all is said and done) very drastic. Furthermore, Dr. Gornet's recommendation for surgery is really rather speculative at this point as he testified he would require an updated MRI and myelogram prior to proceeding with surgery. Thus, Petitioner has failed to prove that the proposed surgery is reasonable and necessary as a result of Petitioner's motor vehicle accident.

Petitioner also failed to prove that her current condition of ill-being in her lumbar spine is causally related to her work accident. While Petitioner did have some low back pain immediately after the accident and indicated some low back "aching" in her pain drawing when initially examined by Dr. Gornet she has undergone no significant treatment to her lumbar spine, her MRI was normal with no evidence of disc injury, and Dr. Gornet felt it appeared to be improving. Petitioner has voiced no low back complaints to Dr. Gornet since then and neither Dr. Stiehl nor Dr. Gornet has recommended any treatment to Petitioner's lumbar spine. While Petitioner has often reported low back complaints to the chiropractor and/or Mr. Voss, neither expressed an opinion that her complaints were due to the motor vehicle accident and, more importantly, Petitioner's low back complaints wax and wane over time and are, on occasion (as shown by the last visit with Multicare Specialists on October 5, 2015), inconsistent with one another (she denied any low back pain to one and minimal low back pain to the other). Certainly, the photographs of her taken in Florida, don't suggest any ongoing low back problems or complaints.

2. Issue (J) Medical Expenses.

Petitioner is awarded the medical bills set forth in Petitioner's Exhibit 7, totaling $5,664.16, subject to the Medical Fee Schedule. Respondent shall be given a credit for any medical bills it has paid through its group medical plan for which credit may be allowed under Section 8(j) of the Act and shall hold Petitioner harmless for any bills for which it is receiving said credit. The bills with "zero" balances are not being awarded and the Arbitrator further notes that no bill from Pain & Rehab Specialists was included in PX 7.

3. Issue (L) Temporary Total Disability Benefits.

Petitioner is awarded temporary total disability benefits from February 3, 2015 through October 21, 2015, a period of 37 2/7 weeks. Respondent disputed liability for any temporary total disability benefits but stipulated that if Petitioner were found to be entitled to temporary total disability benefits it would only be for the period from February 3, 2015 through May 13, 2015 (the date of Petitioner's examination with Respondent's Section 12 examiner, Dr. Stiehl). The Arbitrator awards temporary total disability benefits somewhat reluctantly as she finds it difficult to believe that Petitioner could not be working for Respondent in some restricted fashion; however, Petitioner advised Dr. Stiehl that she could only return to work in a full duty capacity. Thus, the award is given consistent with the Arbitrator's causation determination set forth herein and noting that Respondent's

basis for contesting temporary total disability was premised on Dr. Stiehl's opinion of Petitioner being at maximum medical improvement rather than any lack of an objective basis for keeping Petitioner off work. Respondent is entitled to a credit for the full salary paid to Petitioner through June 15, 2015.

****

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Glenn Sledd,

Petitioner,

16IWCC0685

vs.

NO. 11 WC 22744

Sharkey Transportation, Inc.,

Respondent.

DECISION AND OPINION ON REMAND

This matter comes before the Commission on remand from the Appellate Court of Illinois, Third District. In an order dated February 5, 2016, the Appellate Court found that the Commission's October 15, 2014 award of TTD benefits and past medical expenses was against the manifest weight of the evidence and remanded the case to the Commission with directions to determine the appropriate amount of past medical expenses to which Petitioner is entitled based on his work-related injuries. In accordance with the Appellate Court's order, we hereby modify our prior decision to vacate the award of 56 and 2/7 weeks of TTD and modify the award of medical bills to only those bills related to Petitioner's neck, back and left leg: 1) Monee Fire Protection bill for emergency services on February 27, 2011 ($857.60) and 2) Tri-Rivers Health Care bill for services of Dr. Barnes on August 19, 2011 ($180).

The Appellate court found that he Commission's award of past medical expenses was against the manifest weight of the evidence where it was based, in part, on expenses associated with the evaluation or treatment of a condition of ill-being that was not causally related to Petitioner's employment, that being Petitioner's syncopal episode which precipitated the accident. Following the accident, Petitioner received emergency care from Monee Fire Protection on February 27, 2011 and a bill for $857.60 was included in Petitioner's exhibit of claimed medical expenses (Petitioner's Exhibit #7). The remainder of Petitioner's claimed medical expenses correspond to evaluation and diagnosis of a suspected cardiac cause of Petitioner's syncopal episodes, with the exception of one examination by Dr. Barnes on August 19, 2011 for Petitioner's neck, back and extremity complaints. On that date, Dr. Barnes ordered a CT scan of Petitioner's lumbar spine and an EMG for further evaluation. We therefore award the $180 charge from Tri-Rivers Health Care for services on August 19, 2011.

On March 27, 2012, Petitioner was cleared by Dr. Talley to return to driving. Petitioner was under treatment with Dr. Talley on referral of Dr. Barnes for further evaluation of the potential cardiac cause of Petitioner's syncopal episodes. Petitioner admitted that he was restricted from driving as a result of his suspected cardiac condition and not as a result of the back, neck or knee injuries he sustained on February 27, 2011. Our prior award of TTD was against the manifest weight of the evidence where it was improperly based on Petitioner's incapacitation from work due to a non-work-related condition of ill-being and was not otherwise

supported by the record. Therefore, we vacate our award of 56 and 2/7 weeks of TTD benefits.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Commission Decision on October 15, 2014 is modified as stated herein.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $1,037.60 for medical expenses under §8(a) and §8.2 of the Act. Providers of out-of-state procedures shall be reimbursed at the lesser of that state's fee schedule amount or the fee schedule amount for the region in which the employee resides. Respondent shall hold Petitioner harmless for amounts paid by its group health insurance on account of the February 27, 2011 accident.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall authorize and pay for medically necessary medical treatment intended to diagnose, treat, or relieve the effects of the Petitioner's injuries to the lumbar spine, cervical spine, and left knee sustained on February 27, 2011, including but not limited to the CT of the lumbar spine and EMG recommended by Dr. Barnes on August 19, 2011.

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; on the finding that the award has been reduced on review by the Commission, Circuit Court and Appellate Court no interest is due.

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.

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: OCT 2 8 2016
RWW/plv
o-10/4/16
46

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DALLAS HAMM,

Petitioner,

16IWCC0686

vs. NO: 15 WC 19323

HENKELS & McCOY,

Respondents.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causation, temporary total disability, and medical expenses both current and prospective and being advised of the facts and law, reverses the Decision of the Arbitrator, finds Petitioner did not sustain his burden of proving an accident on April 1, 2015 caused a condition of ill-being of his right shoulder, and denies compensation.

By way of background, three claims were consolidated and arbitrated together. There were three separate accident dates all alleging injury to Petitioner's right shoulder, with Par Electric the Respondent in 14WC37190, and Henkels & McCoy the Respondent in 15WC19322 and 15WC19323. The Arbitrator found Petitioner proved all three alleged accidents which all caused his current condition of ill-being. In 14WC37190, the accident apparently was stipulated, and the Arbitrator awarded Petitioner 23&6/7 weeks of temporary total disability benefits but found Respondent, Par Electric, not liability for temporary total disability and medical expenses incurred after March 11, 2015. In 15WC19322 and 15WC19323 the Arbitrator found accidents on April 1, 2015 and April 3, 2015, respectively. In those claims the Arbitrator awarded Petitioner 37&2/7 weeks of temporary total disability benefits, to the date of arbitration, and ordered Respondent, Henkels & McCoy, to pay medical expenses incurred after March 12, 2015 as well as prospective treatment. In a separate Decision, in 14 WC 37190, the Commission finds that Petitioner's current condition of ill-being was causally related to his work accident on June 16, 2014 and assessed all benefits against the Respondent there, Par Electric.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January, 24, 2016 is hereby reversed, that Petitioner had failed to sustain his burden of proving his accident on April 1, 2015 caused the current condition of ill-being of his right shoulder, and compensation is denied.

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

DATED: OCT 2 8 2016

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

RWW/dw
O-10/4/16
46

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 McCLEAN	)	☒ Reverse Causal Connection	☐ Second Injury Fund (§8(e)18)
			☐ PTD/Fatal denied
		☐ Modify:	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DALLAS HAMM,

Petitioner,

16IWCC0687

vs.

NO: 15 WC 19322

HENKELS & McCOY,

Respondents.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causation, temporary total disability, and medical expenses both current and prospective and being advised of the facts and law, reverses the Decision of the Arbitrator, finds Petitioner did not sustain his burden of proving an accident on April 1, 2015 caused a condition of ill-being of his right shoulder, and denies compensation.

By way of background, three claims were consolidated and arbitrated together. There were three separate accident dates all alleging injury to Petitioner's right shoulder, with Par Electric the Respondent in 14WC37190, and Henkels & McCoy the Respondent in 15WC19322 and 15WC19323. The Arbitrator found Petitioner proved all three alleged accidents which all caused his current condition of ill-being. In 14WC37190, the accident apparently was stipulated, and the Arbitrator awarded Petitioner 23&6/7 weeks of temporary total disability benefits but found Respondent, Par Electric, not liability for temporary total disability and medical expenses incurred after March 11, 2015. In 15WC19322 and 15WC19323 the Arbitrator found accidents on April 1, 2015 and April 3, 2015, respectively. In those claims the Arbitrator awarded Petitioner 37&2/7 weeks of temporary total disability benefits, to the date of arbitration, and ordered Respondent, Henkels & McCoy, to pay medical expenses incurred after March 12, 2015 as well as prospective treatment. In a separate Decision, in 14 WC 37190, the Commission finds that Petitioner's current condition of ill-being was causally related to his work accident on June 16, 2014 and assessed all benefits against the Respondent there, Par Electric.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January, 24, 2016 is hereby reversed, that Petitioner has failed to sustain his burden of proving his accident on April 1, 2015 caused the current condition of ill-being of his right shoulder, and compensation is denied.

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

DATED: OCT 2 8 2016

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

RWW/dw
O-10/4/16
46

STATE OF ILLINOIS)
) SS.
COUNTY OF JEFFERISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DAVID STAFFORD,

Petitioner,

16IWCC0688

vs. No. 11 WC 18678

STATE OF ILLINOIS – VIENNA CORRECTIONAL CENTER,

Respondent.

OPINION AND DECISION ON PETITION PURSUANT TO §§19(h) & 8(a)

This matter comes before the Commission on Petitioner's "Petition for Review of Prior Award and Prospective Medical Care Pursuant to Section 19(h) & 8(a), of the Illinois Workers' Compensation Act." A hearing was held in Mt. Vernon on April 5, 2016 before Commissioner White. The parties were represented by counsel and a record was taken.

Initially the claim was arbitrated under §§19(b) & 8(a). The Arbitrator entered a decision on July 6, 2011 finding Petitioner proved a compensable accident on April 12, 2011 causing a condition of ill-being of his left leg and ordering prospective left knee arthroscopy. On remand after surgery the Arbitrator awarded Petitioner 75.25 weeks of permanent partial disability benefits representing loss of 35% of Petitioner's left leg.

Findings of Fact and Conclusions of Law

1. Petitioner testified that after his previous testimony on October 10, 2013 he received additional medical treatment because his "right knee started hurting while [his] left knee was bad." He had "sharp pain, swelling and a lot of fluid was being drained out of it." He continued working as a correctional officer. He had eight-hour shifts on concrete floors. They did wing checks every 30 minutes "so we pretty much well walk all night long." He had no previous injuries or workers' compensation claims regarding his right knee.

2. Petitioner had total knee replacement because of his pain. His doctor got approval prior to that surgery. The surgery improved his condition and he was able to return to work and currently has no restrictions. Petitioner was "still sore, but it's getting better all the time.

3. Petitioner also testified he was off work after surgery from April 21, 2015 to June 15, 2015 but was not given any workers' compensation benefits; there was no explanation. Petitioner is a deer hunter but can no longer climb trees with bad knees. He loves basketball and sports, and that was out with his knees; but he was "playing a little bit now so that's better." He takes over-the-counter Ibuprofen twice a day.

4. On cross examination, Petitioner testified that his original claim was for his left knee and his right knee was not part of his initial claim. His right knee began to hurt during the eight months he was off work after his left "ACL replacement."

5. The medical record reveals that on November 8, 2013, Petitioner presented to Dr. Mall on referral from Dr. Choi. He reported a new problem of his right knee after putting more pressure on that knee because of problems with his left knee. Dr. Mall noted bilateral reduced range of motion and moderate effusion. Dr. Mall diagnosed mild right knee arthritis with possible meniscal pathology and post left knee arthroscopy and debridement with arthritis, and bilateral knee pain and arthritis. He administered injections and aspirated the knees bilaterally.

6. On January 3, 2014, Petitioner returned to Dr. Mall after an MRI. Dr. Mall seemed to indicate that the MRI was not of excellent diagnostic quality. He diagnosed right knee medial compartment arthritis, possible meniscal tear, and mild patellofemoral arthritis. His right knee had "become symptomatic given his problems with the left knee," though the pathology may not have been caused by the left knee injury. They discussed an arthroscopy.

7. Dr. Mall later diagnosed bilateral knee osteoarthritis of the patellofemoral and medical compartments. Petitioner reported his bilateral knee pain was affecting his daily activities. Dr. Mall thought Petitioner had exhausted conservative treatment and recommended bilateral arthroplasty; Petitioner was young enough (44) that he could have the procedures done simultaneously. He again opined that the trouble with the left knee caused a change in gait contributing to the right knee becoming symptomatic.

8. Dr. Mall testified by deposition on May 29, 2014. About 40% of his practice involves the shoulder, 40% the knee, and 20% other body parts. He began treating Petitioner after his suffered a work-related injury to his left ACL. Eventually, he performed ACL reconstruction surgery. He performed that surgery rather than a knee replacement because of his young age. Petitioner had had significant cartilage damage and continued to have some pain and reduced range of motion in the left knee after surgery, but he was able to return to work. There was always the possibility the procedure would be a temporary measure and that he would need additional treatment in the future.

9. Petitioner returned to Dr. Mall in January 2013 reporting right knee pain. Previously, Petitioner may have mentioned some soreness in his right knee "in passing," but nothing substantial enough to treat. Dr. Mall did not mention any such report in his records. After x-rays and his examination, Dr. Mall diagnosed some mild arthritis in the right knee, as well as likely meniscal injury. He removed fluid and administered an injection to relieve discomfort. He received some relief from the procedures, but the pain returned relatively quickly, which he believed was indicative of a mechanical aspect to the pain. Dr. Mall explained if the pain was generated only because of the arthritis, the relief should have lasted a longer period of time.

10. The MRI, though not of great quality, confirmed some cartilage injury in the right knee, likely a tear. Petitioner did not report any traumas other than the original accident causing the initial left knee injury. Dr. Mall noted that the risk of developing arthritis after an ACL tear is much more likely than in the general population. He believed that at some point Petitioner will need total knee replacement of the left knee. The eventual need for left knee replacement was causally related to his 2011 work injury.

11. Dr. Mall also testified that he did not believe that the injury to Petitioner's left knee caused the cartilage injury to the right knee. However, Petitioner still had deficiency in his left knee after the ACL surgery. His resulting limp resulted in excess force on the right knee that could actually lead to further cartilage loss and make the pre-existing condition of the right knee symptomatic. The affected gait could have resulted in both symptoms of pain from pre-existing cartilage loss in the right knee and faster degradation of that cartilage. Currently, Dr. Mall recommended a diagnostic arthroscopic right knee surgery to determine the extent of damage to the meniscus. Petitioner's right knee is not likely to improve absent surgery because his left knee was still dysfunctional.

12. On cross examination, Dr. Mall testified he did not believe Petitioner's right knee condition was caused by the work accident causing the injury to his left knee or even that he suffered a discreet injury to his right knee. He developed symptoms over time and the left knee condition aggravated or contributed to his right knee condition. Dr. Mall agreed that the January 3, 2014 MRI report indicated there might be *sequelae* of an old trauma. However, Dr. Mall did not believe one could really tell that there was scarring from an old trauma from the MRI. Not only is it difficult to precisely determine scarring, one cannot put a time frame on the pathology. He also did not believe whether a radiologist could tell if a condition was acute or chronic.

13. Dr. Mall agreed that a patient's weight can be one of several factors in developing arthritis because the heavy weight places more force on the joints. Dr. Mall was pretty sure Petitioner had a meniscal tear, but would want it confirmed. It appears the radiologist thought Petitioner had such a tear and his symptoms were consistent with a tear. Dr. Mall testified that he had conversations with Petitioner about some occasional right knee problems, but there was nothing specific.

14. On July 3, 2014, Petitioner was examined by Dr. Lehman at the direction of Respondent pursuant to §12 of the Act. In Dr. Lehman's report he noted that Petitioner's chief current complaint was pain and discomfort in the right knee. He reported an injury to the left knee slipping on concrete on April 12, 2011. He had significant physical therapy and surgery on the left knee. Subsequent to rehabilitation of that knee he developed complaints referable to the right knee. Petitioner stated "he has overloaded the right knee based on limping and overstress on the right knee."

15. On examination, Petitioner was 6'2" and 309 lbs; "he is a large gentleman." Dr. Lehman noted no swelling and normal range of motion in both knees. He exhibited mild pain over the median joint line of the right knee and both knees had visible varus, but no varus or valgus instability. The rest of the examination appears to have been normal. X-rays showed chronic long-term varus and "bilateral symmetric medial joint space collapse, total collapse;" there was "absolutely no joint space in the right medial tibiofemoral joint."

16. Dr. Lehman then outlined three treatment notes of Dr. Mall from November 9, 2012, November 8, 2013, and January 3, 2014. He noted that his diagnosis was degenerative joint disease of the right knee, primarily patellofemoral and medial tibiofemoral. The MRI in January 2014 showed a complex flap tear involving the medial meniscus. Dr. Lehman also noted that the MRI showed significant degenerative arthritis without apparent "acute pathology with complete decimation and extrusion of the medial meniscus due to loss of hoop stresses." Rather it shows "chronic long term changes" and Petitioner was currently at end stage degenerative arthritis. The process seems to be related to his bilateral varus deformity, which was suggestive of congenital predisposition. He also noted Petitioner BMI was 39.7.

17. Dr. Lehman also testified that Petitioner's subjective complaints were consistent with objective findings. Petitioner had reached maximum medical improvement in his right knee, apparently based on his conclusion that Petitioner did not suffer a compensable injury to his right knee. His condition was not related to the work injury to the left knee. Petitioner could work with restrictions of no kneeling, no running, and no repetitive squatting. These restrictions were not related to any work injury but rather his long term degenerative joint disease. Dr. Lehman opined "that the patient's degenerative arthritis in his knee is totally independent and absent of stresses from his left knee are directly related to congenital predisposition," again noting the bilateral varus in his knees, as well as an accentuated BMI.

18. Dr. Lehman testified by deposition on March 17, 2015. He is board certified in orthopedic surgery with a subspecialty in sports medicine. He performs surgery three days a week and that includes knee surgeries. Independent medical examinations make up about .7% of his practice; about 64% of which is for defense and 35% for plaintiffs. At Respondent's request he examined Petitioner's right knee on October 7, 2014, reviewed medical records, and issued a report.

16IWCC0688

19. On examination, Petitioner was 6'2" and 309 lbs. Though his weight varied during treatment is was generally over 300 lbs. Dr. Lehman noted no swelling in either knee, normal range of motion, and normal strength. He exhibited mild pain over the median joint line of the right knee and both knees had visible varus (bow-legged), "so he's overloading the medial side of both knees." He could not fully extend the left knee but could the right knee. His ACL and PCL were intact and there was no instability.

20. Dr. Lehman took x-rays at the time of the examination which showed bilateral "obliteration of the joint space collapse medially or on the inside of both knees. There was absolutely no joint remaining space on either knee on the medial compartment." Dr. Lehman noted that the MRI also showed significant loss of cartilage on the medial side, "so there was significant osteoarthritis of the knee." There was no fluid or anything else suggestive of an acute process.

21. Dr. Lehman explained that the bow-leggedness puts greater pressure on the medial side of the knees bilaterally, and crushes the cartilage on that side. So by the time he took the x-rays there was total collapse of the cartilage and there was no joint spacing whatsoever which had been made by the articular cartilage and meniscus. Generally, prior to such total collapse, Dr. Lehman would advise patients to lose weight, prescribe a brace to reduce stress, and might try an injection to regenerate the articular cartilage or prevent further joint space loss. However, once the joint space begins to collapse, it will continue to degenerate, especially in a patient with an "accentuated BMI."

22. Dr. Lehman also testified he gleaned from the medical records that Dr. Mall related Petitioner's left knee symptoms and pathology were related to his injury and that the pathology of the left knee irritated the right knee causing the need for arthroscopy of the right knee. Dr. Lehman disagreed with both conclusions. First, on the issue of causation, he believed the conditions of both of Petitioner's knees were caused by his congenital bow-leggedness and preexisting end-stage arthritis. Petitioner's condition was degenerative and not acute in nature. Specifically, the right knee was basically worn out and he did not believe one "could make a case that was in any way related to his left knee." Second, Dr. Lehman disagreed that the recommended arthroscopy of the right knee was indicated. There was no basis to believe that procedure would alleviate Petitioner's end-stage arthritis. If there was surgery, it should be arthroplasty.

23. In Dr. Lehman's opinion, Petitioner's end-stage arthritis was caused by two factors; his congenital predisposition by his varus bow-leggedness and his BMI of 40. "It's impossible not to [have degenerative arthritis] when your BMI is over 35." Petitioner's job activities were not the cause of his end-stage arthritis.

24. On cross examination, Dr. Lehman agreed that in his report he noted that Petitioner's symptoms were consistent with his objective findings and he found no evidence of symptoms magnification. However, he really did not believe that patients develop symptoms or pathology in one knee because of putting more weight on it due to an injury to the other knee.

16IWCC0688

25. Dr. Lehman also testified he did not "believe people compensate to the level of overloading or damaging the other knee." One never hears such a theory in sports medicine, and he believes that would also apply to the public in general. He has not seen it in his practice. He thought "it's a workers' comp thing."

26. Dr. Lehman did not recall Petitioner making any previous complaints about his right knee in the medical records. He thought it was correct that he only complained of right knee pain after he had the left knee injury.

27. Dr. Lehman was asked about Dr. Mall's testimony that while Petitioner received some relief from the injection into the right knee, the pain returned relatively quickly. Based on that result, Dr. Mall opined the result was indicative of a mechanical aspect to the pain, because if the pain was generated only because of arthritis, the relief should have lasted a longer period of time. Dr. Lehman responded that was not his experience in his practice and that premise was "ludicrous. It's absolutely ridiculous." Dr. Lehman indicated that the amount of relief realized by an injection is directly related to the extent of the degeneration in the joint. "To say that you can make any inference about mechanical versus arthritis symptoms based on response to cortisone injection is unfounded in any orthopedic in the last 150 years."

28. Dr. Lehman was then asked about the ability to date findings on an MRI. He responded that one "can generalize disease patterns" and grossly date changes. If a patient has an acute process he/she would have bone marrow edema, swelling, and acute findings. The only thing you can tell from an MRI is patterns. In Petitioner's case the MRI showed a complex tear of the meniscus; "that's an avascular process" which can only happen with a loss of blood supply. In addition, Petitioner had tricompartmental osteoarthritis which is very rare and meant he had "pretty severe arthritis." Therefore, he could conclude that it was chronic and longstanding, but he could not ascribe a precise date the arthritis started.

29. Dr. Lehman also disagreed with Dr. Mall's assessment in his deposition that Petitioner had mild arthritis in the right knee, did not have a lot of joint space narrowing, and that joint line tenderness indicated he had a meniscal injury. When he saw Petitioner, which was about a year after Dr. Mall's x-rays, Petitioner had no joint space remaining. He did not believe a single year's-worth of degeneration could account for such a change. He thought this was a chronic long-term process even there were no medical records indicating any symptoms prior to November 2013.

30. Dr. Lehman believed that people with advanced arthritis can be asymptomatic because they modify their behavior to mitigate symptoms, like using an elevator instead of using stairs, limiting walking before pain is produced, *etc.* He again testified that he did not believe the left knee injury lead to his right knee symptoms whatsoever.

16IWCC0688

31. On redirect examination, Dr. Lehman re-reviewed the x-rays of the knee from November 8, 2013 (Dr. Mall's x-rays). He again noted in the right knee there was virtually no joint space medially; "there's obliteration of the medial joint space." The joint space on the medial side was collapsed in both knees. That's indicative of bow-leggedness, loss of joint space, and end-stage arthritis. The condition was degenerative and chronic.

32. On April 23, 2015, Dr. Lehman issued an addendum report. First, he summarized his previous report. He opined that Petitioner was not a candidate for bilateral knee replacement because of his age, 45, and his BMI of 40. These factors make more likely "early exit and loss of function as relates to loosening and failure of the bilateral total knees." He recommended Petitioner should lose weight. His work accident had no relation to his need for treatment of his arthritis.

33. Ironically, also on April 23, 2015, Dr. Mall performed bilateral knee arthroplasty, lateral retinactual lengthening, and right patellar tendon repair for bilateral knee osteoarthritis, bilateral patellar tilt and lateral retinactual tightness, and intraoperative patellar tendon injury.

34. On June 9, 2015, Dr. Mall noted Petitioner was doing well and made progress despite the fact that Workers' Compensation stopped physical therapy and "he has had his medical insurance also revoked." He gave Petitioner some exercises but thought the discontinuation of physical therapy increased the "likelihood of failure following his surgery."

35. Also on this date, Dr. Mall issued a missive in response to an inquiry by Petitioner's lawyer, asking for comments on a report by Dr. Lehman. First, he disagreed with Dr. Lehman's statement that Petitioner's obesity (6'2," 310 lbs, BMI of 39) was the only cause of his developing arthritis. He noted that 35% of all patients with an ACL injury show evidence of arthritis within 10 years, which is higher than the 10% instance in the general population. Similarly, an ACL injured knee develops arthritis in 20.3% of cases while the general rate is 4.9%.

36. Dr. Mall also disagreed with Dr. Lehman's opinion that Petitioner's right knee condition was not associated with his left knee injury. He noted that Petitioner suffered a flexion contracture of his left knee preventing him from fully straightening it. That results in increase quadriceps activity and tiring. "Gait analysis studies have also shown that this significantly affects the opposite knee, finding that there is an increased extension and adduction movement of 15% or greater and force plate studies have shown higher forces on the opposite leg as well. Dr. Mall continued that 46% of patients who receive a knee arthroplasty have the other knee replaced within 10 years. It is even more common for patients under the age of 60 "likely related to increase in activity level." However, it has also been hypothesized that the cause was increased stress on the opposite leg during recovery.

37. Dr. Mall also noted that Dr. Lehman opined arthroplasty was not indicated due to Petitioner's age and size, which resulted in a low likelihood of success. Dr. Mall responded basically that Petitioner had failed conservative treatment and his condition was sufficiently severe that it affected his ability to perform activities of daily living and his job activities. Surgery was the only alternative to simply living with the pain and symptoms. He also noted that the largest increase in arthoplasties is in younger patients. Data suggest that 91% of younger patients with arthoplasties do not need a revision within 20 years. In addition, "implant survival was 88% in the morbidly obese, 95% in the obese, and 97% in the non-obese." Finally, on the issue on when Petitioner should be able to return to work. Dr. Mall noted that 71-83% of arthroplasty patients return to work within 3-6 months. However, Petitioner was not receiving physical therapy his return to work in that time frame would be difficult.

38. Dr. Mall again testified by deposition on October 14, 2015. He continued to treat Petitioner for his knees subsequent to his previous testimony. He last saw Petitioner the previous day. Petitioner had bilateral total knee placements and had done well. They had a good result in the left knee and there was a slight patellar tendon tear during surgery on the right knee, in which Petitioner was having more problems. Nevertheless, Petitioner had a very good result and was released to full duty on August 25, 2015. He would not yet put Petitioner at maximum medical improvement because he was continuing to improve. He usually waits about a year to declare an arthroplasty patient to be at maximum medical improvement.

39. Dr. Mall also testified his causation opinions have not changed since his previous testimony. He reviewed the report of Dr. Lehman and wrote a rebuttal. First, he disagreed with Dr. Lehman's statement that Petitioner's obesity was the only cause of his developing arthritis. He noted patients with an ACL injury had a much higher rate of developing arthritis than the general population. It has been shown that there is cartilage degradation and cell death after an ACL injury, and "cartilage death" can lead to osteoarthritis.

40. Also, Dr. Mall noted that Petitioner suffered a flexion contracture of his left knee preventing him from fully straightening it causing greater force on the right knee. So, Petitioner likely developed left knee arthritis from the ACL injury and the subsequent flexion contracture caused accelerated the arthritis of the right knee. Dr. Mall disagreed with Dr. Lehman's conclusion that knee replacement was not indicated because of Petitioner's age and size because "the medical literature really does not support that." Obese individuals have good outcomes from arthroplasty, and Petitioner was already able to increase his activity and could bike 20 miles.

41. The last treatment note in the record is dated March 29, 2016. Dr. Mall noted that Petitioner was doing much better and was able to lose 35 lbs because of reduced pain in his knees. He had full strength and good range of motion bilaterally. Dr. Mall recommended continued home exercise program and would see him for three-year surveillance x-rays.

The compensability of the condition of ill-being of Petitioner's left knee has been litigated and is now the law of the case. We agree that the deterioration of his left knee and eventual need for left knee arthroplasty was related to his initial accident/injury from April 12, 2011. The Commission finds the opinion of Dr. Mall regarding the need for arthroplasty more persuasive than that of Dr. Lehman. Therefore, Petitioner is entitled to have paid all expenses associated with that procedure. He is also entitled to whatever temporary total disability and additional permanent partial disability benefits arising therefrom. The issue thus becomes whether Petitioner has sustained his burden of proving his right knee condition, and resulting right knee arthroplasty, is attributable to his compensable left knee injury. The Commission concludes that he has not.

While the Commission finds the opinion of Dr. Mall more persuasive than Dr. Lehman regarding recommended treatment, we find the opinion of Dr. Lehman more persuasive on the issue of causation of Petitioner's condition of ill-being of the right knee. First, the Commission finds Dr. Lehman's opinion regarding the extent of Petitioner's underlying arthritis more convincing than Dr. Mall's. The Commission also notes that Dr. Lehman found no evidence of any acute processes in the development of Petitioner's right-knee arthritis and that all of the pathology was due to the progression of the degenerative condition. Dr. Lehman's argument concerning the combination of the severity of Petitioner's degenerative joint disease, his varus deformity, and obesity as the cause of the end-stage arthritis in Petitioner's right knee is persuasive. In addition, his rebuttal to Dr. Mall's argument that the limited duration of relief from the injection pointed to acute/traumatic injury rather the degenerative joint disease was also persuasive. Therefore, the Commission finds that Petitioner did not sustain his burden of proving the condition of ill-being of his right knee was causally related to his April 2011 accident and denies compensation for that condition.

The next issue becomes the benefits to which Petitioner is entitled based on the worsening of his work-related condition and subsequent left knee arthoplasty. As noted above, Petitioner is entitled to have all medical costs associated with treatment of the left knee paid for by Respondent. He is also entitled to temporary total disability benefits for the time he was off work after treatment for that condition. Petitioner testified he was off work from April 21, 2015 to June 15, 2015. There was no evidence submitted to the contrary. The Commission cannot differentiate the period of temporary total disability attributable to the left knee arthoplasty rather than the right knee arthroplasty. Therefore, the Commission awards Petitioner temporary total disability benefits for the entire eight weeks he was off work.

Regarding additional compensation for permanent partial disability after the left knee arthroplasty, the Commission notes that Petitioner had a very good result from the surgery. He was able to return to work at full duty in his regular job and therefore did not lose any potential income. Petitioner testified that he was still sore, but getting better every day. The record indicates he was able to ride a bicycle for 20 miles and was able to lose 35 pounds due to increased activity. His age, younger than 50, indicates he would likely live with the condition for less than 20 years of his working life. Based on the entire record before us, the Commission concludes that Petitioner should be awarded an additional 21.5 weeks of permanent partial disability benefits representing an additional loss of 10% of the use of the left leg for a total permanent partial disability award of the loss of 45% of the left leg.

16IWCC0688

IT IS THEREFORE ORDERED BY THE COMMMISSION, that Petitioner's Petition for Relief Pursuant to §§19(h) & 8(a) is hereby granted with regard to the condition of ill-being of his left knee.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $729.50 per week for a period of 8 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 for all expenses for treatment of Petitioner's left knee incurred since October 10, 2013 under §8(a) of the Act, pursuant to the applicable medical fee schedule.

IT IS FURTHER ORDERED BY THE COMMISSION, that Respondent shall pay Petitioner an additional permanent partial disability award of $656.55 a week for 21.5 weeks because Petitioner's disability has increased by the loss of 10% of the use of the left leg since the initial permanent partial disability award.

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: OCT 2 8 2016

Ruth W. White

Charles J. DeVriendt

Stephen J. Mathis

RWW/dw
O-10/4/16
46

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

Katrina Collman,

Petitioner,

16IWCC0689

vs.

NO: 14 WC 39007

SOI/Office of Comptroller,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses 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 January 13, 2016, 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.

In addition, Dr. Beatty's insists that no condition is idiopathic and all compressive neuropathies would be work-related unless proved to be related to another cause. Again in my opinion, that assumption is inaccurate. In my experience most doctors have theorized that many, if not most, cases of compressive neuropathies are idiopathic in nature. In addition, Dr. Beatty's assumption is completely at odds with the legal axiom that in workers' compensation claims, the claimant has the burden of proving accident and causation. Basically, Dr. Beatty seems to posit that the employer has the burden of proving affirmatively that Petitioner's work activities did not cause her condition; that position is legally incorrect.

Finally, Dr. Beatty's criticism of Dr. Calfee seems to be misplaced. Dr. Beatty testified that Dr. Calfee "just says when reviewing the literature it does seem that more manual labor and repetitive lifting is frequently noted to increase the chance of lateral epicondylitis. *** But that doesn't pertain to our patient, our situation, the vocation, so and so forth." So he basically discounts Dr. Calfee's opinion that manual labor and repetitive lifting is a risk factor for epicondylitis because Petitioner does not engage in such activities. That is exactly the point Dr. Calfee was making in explaining his opinion. I find the opinions of Dr. Calfee more persuasive than those of Dr. Beatty.

Based on the record before us, I would have found that Petitioner did not sustain her burden of proving a causal connection between her work activities and her bilateral epicondylitis, reversed the Decision of the Arbitrator, and denied compensation. For the reasons outlined above, I respectfully dissent.

Ruth W. White

RWW/dw
46

Ruth W. White

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: OCT 2 8 2016
o10/4/16
RWW/rm
046

Charles J. DeVriendt

Joshua D. Luskin

Dissent

I respectfully dissent from the Decision of the majority. I would have found that Petitioner did not sustain her burden of proving that her bilateral epicondylitis was related to her work activities, reversed the Decision of the Arbitrator, and denied compensation. Petitioner is a court reporter. The Arbitrator found that her job activities were of such a nature to cause her epicondylitis. He relied on the causation opinion of Dr. Beatty, which he found more persuasive than that of Respondent's Section 12 medical examiner, Dr. Calfee.

Dr. Calfee's agreed with Dr. Beatty's diagnosis of bilateral epicondylitis. However, he did not believe Petitioner's work activities as a court reporter caused her tennis elbow. Dr. Calfee stressed that current literature indicates that typing in itself does not increase the risk for epicondylitis. He noted that while her work does involve repetitive finger motion, it does not involve a lot of lifting or repetitive lifting and twisting with a lot of elbow flexion and extension, which are the most common risk factors for developing epicondylitis.

Unlike the Arbitrator, I do not find Dr. Beatty's opinion persuasive. In arriving at his opinion, he relied on a 2001 publication and testified that since that time there has not been any change in medical opinion regarding the relationship between compressive neuropathies and normal benign hand activities. In my opinion, that conclusion is inaccurate. I believe that the predominant current medical opinion posits that activities must involve more than simple repetitive finger manipulation to cause compressive neuropathies. Rather, activities must involve forceful gipping/grasping, vibration, or the extreme and extended flexion/extension of joints. Petitioner did not prove that her work activities involve such forces.

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

16IWCC0689

COLLMAN, KATRINA
Employee/Petitioner

Case# **14WC039007**

SOI-OFFICE OF COMPTROLLER
Employer/Respondent

On 1/13/2016, 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 0.47% 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:

0487 SMITH MENDENHALL SELBY & COLE
DOUG MENDENHALL
PO BOX 8248
ALTON, IL 62002

3291 ASSISTANT ATTORNEY GENERAL
DIANA E WISE
201 W POINTE DR SUITE 7
SWANSEA, IL 62226

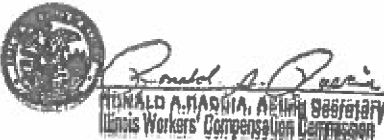
0498 STATE OF ILLINOIS
ATTORNEY GENERAL
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601-3227

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

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

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

JAN 13 2016



STATE OF ILLINOIS)
)SS.
COUNTY OF Madison)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Katrina Collman
Employee/Petitioner

Case # 14 WC 39007

v.

Consolidated cases: ____

State of Illinois, Office of the Comptroller
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 **Arbitrator Lee**, Arbitrator of the Commission, in the city of **Mt. Vernon**, on **10/8/2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **5/5/14**, Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, Petitioner *did* sustain an accident that arose out 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 $**108,408.56**; the average weekly wage was $**2,084.78**.

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

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

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

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

ORDER

Respondent shall pay reasonable and necessary medical services of $4,810.50 , as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall authorize and pay for the proposed bilateral elbow surgeries as recommended by Dr. Michael Beatty.

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

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

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

[signature]
Signature of Arbitrator

12/18/15
Date

ICArbDec19(b)

JAN 13 2016

Katrina Collman vs. State of Illinois
14-WC-39007

The Arbitrator finds the following facts:

Petitioner has worked as a court reporter for the circuit court in Madison County, Illinois for 32 ½ years. Most recently she works out of a court reporter pool with assignments to associate and circuit judges as needed. As a court reporter she reports to the courtroom with her stenographic machine, recording testimony and then preparing transcripts as needed. In preparing transcripts she uses a laptop computer with a keyboard.

She first saw Dr. Penn in Maryville, Illinois on May 5, 2014. For several months before that she was having pain in her arms while using her steno machine. She was taking over-the-counter medication which didn't really help. The pain started in her left arm from the elbow down to the wrist. Within a few weeks of seeing the doctor, the right arm was also painful from the elbow down to the wrist.

She stated that while using her steno machine she would drop her hands down for a rest on her lap. Then as she lifted her hands to go back on the record she would feel the pain start in the elbow and down to the wrist. The problem came on in the spring of 2014. At that time she was handling lengthy civil trials. She may have had some daily copy trials at that time. Her exhibit, showing transcript income in 2014, listed higher figures for several months in early 2014.

She identified the machine used by the court reporter at arbitration as exactly the same as hers. She described her position as straddling the machine while sitting down with the machine almost on the lap. She stated that, with demanding or technical material, more strokes are entered on the machine because it involves more syllables; this results in more strokes of the hands and arms. She tends to strike the keys harder when keeping up with faster, technical testimony. She lifts her hands and flexes her wrists. Also she reaches for the number bar at the top of the machine when entering numbers.

When different people speak in testimony at trial there is a symbol for each person. The left hand is used to make a designation of the change in speaker. She is right-hand dominant. State licensing requires that she be able to enter 225 words per minute. People talk faster than that. It can be intense trying to keep up.

She reviewed the exhibit titled "demands of the job" prepared by her supervisor Debra Wallace. On that list of duties an entry showed that she would be required, on average, to perform 4 to 6 hours per day with typing and hand manipulation. There could be days where longer hours are required. On trials requiring daily transcript preparation she prepares a transcript after court to deliver to the attorneys within 24 hours. She might be required to type into the night.

She produces transcripts on a laptop computer with keyboard and an external mouse. The set up is with a chair and computer table which are adjustable. The software on the steno machine creates a partial transcript

which has to be edited. An audio recording is also used to review the transcript. Non-stenographic duties include filling out paperwork to keep a record of work performed.

When she notified her supervisor of problems in May of 2014 her work schedule was adjusted. She presently gets assignments only to hearings that are anticipated to be short.

Dr. Penn injected her left elbow in May 2014 and later her right elbow area. The injections gave a little bit of relief but it was not long-lasting. Surgery was scheduled for November 2014. Because she wanted a second opinion, she scheduled an appointment with Dr. Michael Beatty in Edwardsville. Under his direction she had physical therapy. The therapy was not helpful although the therapist did review the ergonomics of her work area.

In January 2015 Dr. Beatty recommended surgery on her elbows. She is requesting that the arbitrator approve surgery. She is trying to protect her arms so that she can continue work. At home she uses a cleaning service and no longer vacuums. Smaller volumes of milk containers and laundry detergent are used to avoid straining her arms. She has no outside activities such as tennis, golf, bowling or other hand intensive hobbies. The symptoms in her arms and elbows came on at work.

She was honest and truthful with the independent medical examiner, Dr. Calfee. She is aware that her condition is commonly called tennis elbow. At her job she has no duties which require swinging of her arm or bringing her arm in and flexing the arm out. There is no heavy lifting. There is no repetitive prolonged gripping. Transcript charges are $3.15 per page for originals and one dollar per page for copies. In using the computer to prepare transcripts there is quite a bit of typing. Different keys are used in the software program to edit with use of the "F" function keys at the top. The keyboard is used constantly.

Dr. Penn diagnosed left lateral epicondylitis on May 5, 2014 and injected the affected area. The history indicated a problem in the elbow over several months which was gradually getting worse. On June 2, 2014 she complained of the same problem on the right elbow. He injected that elbow as well and advised her to remain off work for several days. On August 4, 2014 he injected the right elbow again. When she returned October 21, 2014 she continued to have problems with both elbows. At that point he recommended surgery and planned a date in November, 2014.

Dr. Michael Beatty, a plastic surgeon, examined her on November 10, 2014 and also diagnosed bilateral, lateral epicondylitis. He recommended therapy with use of medication and elbow sleeves. She underwent 12 therapy sessions at Apex physical therapy and returned to see him on January 5, 2050. She told him that doing her work caused pain in the elbows. Since cortisone injections and therapy had not resolved the problem he recommended bilateral extensor origin repairs.

Dr. Beatty testified that her duties as a court reporter likely caused the lateral epicondylitis which he diagnosed and treated. He felt the mechanism of injury was the hand and finger movement involved in typing on

the stenographic machine and keyboard. He used an illustration showing the forearm, extensor muscles and extensor tendons. The illustration showed a flexing of the fingers and tightening of the extensor muscles putting stress on the extensor tendons. The repetitive movement of the fingers and wrist in typing and keystrokes on the stenographic involved this type flexion. Micro tears occur with scar tissue and inflammation until the pain becomes chronic. He cited a treatise on musculoskeletal disorders from the National Research Council as supportive of his conclusions.

The proposed surgery would remove the damaged tissue and reattach the tendon to bone. She could expect to be off work for approximately 8 to 10 weeks while recovering from two surgeries which would be several weeks apart.

On cross-examination he stated he disagreed with the conclusions of Dr. Calfee, the Section 12 examiner. He had not viewed the petitioner' s worksite or stenography machine. He assumed the machine was similar to that of the court reporter attending the deposition. He is aware of court reporters and how they use their stenographic machines. He would not agree that the cause of lateral epicondylitis is mainly idiopathic.

A question on the intake forms from Dr. Penn asks "what makes the pain symptoms worse" and the answer line was blank. Dr. Beatty felt that Dr. Penn should have clarified and filled in that answer with the patient. Petitioner advised Dr. Beatty that her symptoms occurred while typing at work. He felt that the majority of her time at work would involve using a stenographic machine and computer keyboard. He believed she would do data entry typing every day. He could not give the exact number of hours that she types per day. He assumed that she would get breaks during hearings when people were not speaking on the record.

He agreed that there are people who develop lateral epicondylitis unrelated to the workplace.

Dr. Calfee, an orthopedic surgeon, performed a Section 12 examination of petitioner July 8, 2015. He agreed with the diagnosis of left and right lateral epicondylitis. He also agreed that she needed surgery since conservative measures had not resolved the condition which has existed for more than one year. He also agreed she should be limiting her time in the courtroom until surgical management. He did not believe her work as a court reporter caused the condition. He acknowledged she experienced pain at work. His report stated that he could not find any consistent evidence in published primary research indicating typing would increase the likelihood of tennis elbow.

He testified that he reviewed various records of treatment to petitioner to formulate his diagnosis and opinions. She did not have any notable sports or hobbies. He did understand that being a full-time court reporter she spent the majority of your time typing and transcribing data from legal proceedings. He also stated on direct that he would not discount the fact that she had symptoms at work. On cross he acknowledged that he oftentimes relates the timing of symptoms to the cause. But he would not say the typing was a causative factor. He did acknowledge that the court reporter at his deposition was at least firing the muscles of the forearm

involved in tennis elbow. He also agreed lateral epicondylitis is a cumulative trauma disorder. He does not have any other explanation for the cause of Petitioner's condition.

Therefore the Arbitrator concludes:

Issues C and F, Accident and Causation. The Petitioner testified credibly concerning the onset of her elbow pain at work as a court reporter while in the courtroom taking testimony on the stenograph machine. Dr. Beatty, a board certified plastic surgeon, explained the causal connection between the repetitive typing activity and the development of lateral epicondylitis. His testimony was more persuasive than that of the Section 12 examiner, Dr. Calfee. Dr. Calfee agreed that the symptoms of the condition were occurring at work. Supportive of causation is his agreement that Petitioner should continue to limit her work duties pending surgery; this suggests that normal work activity would serve to aggravate or worsen the condition. Dr. Calfee had no other explanation for the cause of Petitioner's condition. Petitioner's current condition of ill-being, bilateral lateral epicondylitis, is causally connected to her employment. Based upon the finding of causation and accident occurred that arose and in the course of Petitioner's employment.

Issue K, Prospective Medical Care. Respondent shall authorize and pay for the proposed surgery by Dr. Beatty.

Issue J, Medical Services. Petitioner's treatment was reasonable and necessary and respondent is ordered to pay $4,810.50 as listed in PX4 pursuant to Section 8.2 of the Act. Respondent shall receive credit for any bills paid to date and shall receive credit for bills paid by group health coverage and shall indemnify and hold petitioner harmless pursuant to Section 8(j) of the Act.

Last page

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 McCLEAN)	☐ Reverse Choose reason	☐ Second Injury Fund (§8(e)18)
		☐ PTD/Fatal denied
	☒ Modify:	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DALLAS HAMM,

Petitioner,

16IWCC0690

vs. NO: 14 WC 37190

PAR ELECTRIC,

Respondents.

DECISION AND OPINION ON REVIEW

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

By way of background, three claims were consolidated and arbitrated together. There were three separate accident dates all alleging injury to Petitioner's right shoulder, with Par Electric the Respondent in 14WC37190, and Henkels & McCoy the Respondent in 15WC19322 and 15WC19323. The Arbitrator found Petitioner proved all three alleged accidents which all caused his current condition of ill-being. In 14WC37190, the accident apparently was stipulated, and the Arbitrator awarded Petitioner 23&6/7 weeks of temporary total disability benefits but found Respondent, Par Electric, not liable for temporary total disability and medical expenses incurred after March 11, 2015. In 15WC19322 and 15WC19323 the Arbitrator found accidents on April 1, 2015 and April 3, 2015, respectively. In those claims the Arbitrator awarded Petitioner 37&2/7 weeks of temporary total disability benefits, to the date of arbitration, and ordered Respondent, Henkels & McCoy, to pay medical expenses incurred after March 12, 2015 as well as prospective treatment.

Findings of Fact and Conclusions of Law

1. Petitioner testified he worked as an electrical lineman through the IBEW and was almost finished with his apprenticeship. Job duties of a lineman include restoring power, building new lines, climbing poles, and digging holes; it involves a lot of physical work.

2. On June 16, 2014 he was working for Par Electric building new lines. On that date he slipped and went to catch himself and "dislocated [his] shoulder. It felt like it came out of the socket." He had no previous problems with his right shoulder. A co-worker reported the accident and "safety guys came out and took" him to an Emergency Department. They referred him for physical therapy.

3. Petitioner had physical therapy at OSF for a few weeks. The doctor at OSF referred Petitioner to Dr. Li, an orthopedic surgeon, who ordered an MRI. He was on light duty from the accident to about September 26, 2014, at which time Dr. Li performed surgery and took him off work. He had a lot of postoperative physical therapy. He then had work hardening. Dr. Li released him to full duty as of March 11, 2015. His shoulder progressed but it still was not 100% "by any means," but he returned to work because he was released to return to work. His shoulder was still weak and painful but he thought it would probably improve with work.

4. Petitioner got onto a job with Henkels & McCoy about March 23, 2015 through the union. He worked in the exact same job as he had with Par. On April 1, 2015 his shoulder still had some pain and weakness. He threw a big roll of electric tape to a co-worker on a crane hoist. He had a lot of pain in his right shoulder. He kind of ignored it because he did not want to think he re-injured his shoulder. He babied his shoulder the rest of the day.

5. Petitioner testified he went to work the next day even though his shoulder was very sore. On April 3, 2015, which was a Friday, he threw a wire grip tool to a co-worker on a crane hoist. His shoulder "did the exact same thing it had done" on April 1st. He felt it "come out of the socket" and he had pain; he then knew it "wasn't a fluke." He estimated he tossed the tool 15 to 20 feet. It's an activity that is common in his job. He again finished his workday, but again had to baby his shoulder.

6. Petitioner returned to Dr. Li on April 6, 2015. He ordered a new MRI and put him on light duty. But there is not much light duty work available in his field. Henkels & McCoy could not accommodate his restrictions. He just told them he hurt his shoulder, but "just thought it was from the previous injury" so he "never even did any kind of paperwork on it."

7. Petitioner had a second surgery on July 8, 2015. He had been on light duty the entire time since April 6, 2015; nobody had offered him work within those restrictions. He was still under the care of Dr. Li. He still has pain in his shoulder and his strength was "not great." He has currently "gotten into the strength building in therapy."

8. On cross examination, by the lawyer for Par Electric, Petitioner testified Par authorized the surgery performed on September 26, 2014 by Dr. Li. He was paid temporary total disability benefits after that surgery. In physical therapy after the first surgery he complained of 2/10 ongoing pain in the front of his shoulder. Dr. Li had him concentrate on overhead exercises in physical therapy.

9. Petitioner also testified he may have mentioned that his son jumped on his shoulder on November 19, 2014 causing pain. However, he did not report in December of 2014 that he hurt his shoulder trying to catch his dog; he doesn't have a dog. He had a functional capacity evaluation ("FCE") at Dr. Li's recommendation, in January 2015, and suffered no dislocations through that, physical therapy, or work hardening.

10. Petitioner further testified that there were no dislocation events until he started working for Henkels & McCoy. He did slip on ice in February 2015 and pulled a muscle in his back, but he did not hurt his right shoulder. Petitioner felt like he dislocated his shoulder in the two incidents in April 2015, and Dr. Li had not recommended an MRI or surgery prior to those incidents. Petitioner had surgery for a dislocation of his right shoulder when he was 13, which was 17 or 18 years ago.

11. On cross examination, by the lawyer for Henkels & McCoy, Petitioner testified that he attributed his right shoulder injury in June of 2014 to work he was doing for Par. He came under the care of Dr. Li at that time and with whom he still treats. He has been under the care of Dr. Li continuously since September 2014. He was never released from treatment by Dr. Li. He already had an appointment scheduled with Dr. Li for April 6, 2015 at the time Dr. Li released him to full duty on March 11, 2015.

12. Petitioner further testified that it sounded right that Petitioner started working for Henkels & McCoy on March 30, 2015, which was a Monday. He went through some training on both March 30th and March 31st, with some work also in the field. He did not seek medical treatment immediately after the April 1st incident. He had pain in his shoulder prior to that incident, and continued to complain to Dr. Li about limitations regarding overhead activities. He worked both Saturday and Sunday after the April 3rd incident. He did not file any accident reports with Henkels & McCoy.

13. On redirect examination, Petitioner testified that even though he did not file any paperwork with Henkels & McCoy, he told his foreman about the incidents in April 2015. He did not have any problems with, or treatment for, his shoulder for the 10 years prior to the June 16, 2014 accident.

14. The medical record reveals that on August 14, 2014, Petitioner presented to Dr. Li on referral from Dr. Moody. Petitioner reported injuring his shoulder six weeks previously when he fell at work and tried to catch himself with his right arm (Par accident). He actually felt his shoulder dislocate and relocate. He had physical therapy and conservative treatment with no relief of pain, or of his weakness and instability. Dr. Li diagnosed a right shoulder labral tear due to dislocation and recommended surgery.

15. On September 26, 2014, Dr. Li performed right shoulder arthroscopy with debridement of extensive tensynovitis and repair of capsulolabral Bankart-type separation for type 1 superior and posterior labral tears, tensynovitis, and capsulolabral tear.

16. Petitioner commenced post-operative treatment including a cortisone injection and physical therapy. After about 26 physical therapy sessions Petitioner reported 2/10, which was pretty consistent throughout the physical therapy.

17. On January 15, 2015, Petitioner had an FCE, which was considered valid with Petitioner providing maximum effort. He was able to operate consistently at the medium physical demand level; however, he was not sufficiently improved to return to unrestricted work. His perceived physical demand capabilities were slightly lower than the ones observed to perhaps a light to medium level. Petitioner began work conditioning 11 days later.

18. On March 10, 2015, in physical therapy, Petitioner reported no significant issues from the previous session. He had progressed rapidly the last three weeks of work conditioning. In the previous sessions he did not complain of pain but he did complain mostly of fatigue. He had met all goals in work conditioning. He was to be released to full duty the following day. After about 28 sessions, Petitioner was discharged from work conditioning.

19. On March 11, 2015, Petitioner returned to Dr. Li, who noted he had completed work conditioning and was ready to return to work. He discharged Petitioner to full duty, but he did not discharge him from treatment.

20. On April 6, 2015, Petitioner returned to Dr. Li. Petitioner reported he returned to work the previous week. There were two episodes which were concerning; one when he threw a roll of tape and one when he threw a grip (Henkels & McCoy incidents). These overhand motions caused him discomfort. He felt like his shoulder dislocated after throwing the tape but did not feel that sensation when throwing the grip. On examination strength and range of motion were full. Dr. Li ordered an MRA.

21. An MRA, taken on April 16, 2015 after "2014 surgery and dislocation of the right shoulder twice the previous week," showed a diffuse lateral tear with no rotator cuff tear and old posttraumatic and postsurgical changes in the glenoid rim.

22. On April 22, 2015, Dr. Li noted the MRA showed "diffuse lateral tear with no rotator cuff tear and old posttraumatic and postsurgical changes in the glenoid rim" and "SLAP tear present." Dr. Li recommended arthroscopic repair of the SLAP tear. They would await a scheduled Section 12 examination.

23. On April 28, 2015, Petitioner asked Dr. Li whether his condition was the result of the original injury and subsequent surgery. Dr. Li indicated that it was related to the original injury of June 16, 2014. He wrote in a "restriction: the right shoulder condition is related to the" June 16, 2014 injury.

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24. On May 4, 2015, Dr. Paletta examined Petitioner at Respondent's direction, and issued a report. He noted that he had seen Petitioner previously on February 16, 2015 for evaluation of the same shoulder. His original injury was on June 16, 2014 as a result of a fall at work. He was originally diagnosed with a labral tear or Bankart lesion. Dr. Li performed arthroscopic stabilization or Bankart repair on September 24, 2014. When Dr. Paletta saw him on February 16th, he was doing well with good strength, good function, good stability, and only minimal motion losses. It was Dr. Paletta's impression that he could return to work after he completed work hardening, within a month or so.

25. Dr. Paletta noted that Petitioner returned to Dr. Li on February 25, 2015, after the previous Section 12 report, and he continued work hardening. Petitioner reported he completed work hardening and was released to work at full duty on March 11, 2015, but it took him a couple of weeks thereafter to secure employment.

26. Petitioner reported that within a week of returning to work he had two incidents. First, he threw an about 2-lb roll of electrical tape to a co-worker. He felt the shoulder slip out of place and he had to manipulate it a little to get it back in place. A couple of days later, he threw a grip weighing a few lbs to a co-worker in a bucket about 12 feet overhead. He again felt the shoulder slipping out and had to manipulate it to get it back into position.

27. Petitioner returned to Dr. Li on April 6, 2015. He was concerned about a possible recurrent labral tear and ordered an MRI. The MRI showed a diffuse labral tear including a SLAP tear. Dr. Li noted that the repair of the glenoid appears to be intact, but recommended a revision shoulder stabilization surgery due to "some stretching of the capsular labral complex." After his examination and review of the MRI, Dr. Paletta diagnosed "extended superior labral tear status post previous anterior labral repair." The previous area of repair seemed to be intact. He agreed with Dr. Li's recommendation for a revision labral repair and he would also consider a biceps tenodesis. Because the new injury did not extend to the area that was previously repaired, Dr. Paletta attributed his current condition and need for revision surgery to the more recent incidents.

28. On July 8, 2015, Dr. Li performed right shoulder arthroscopy with debridement and chondroplasty of the humeral head, arthroscopic repair of the anterior and anterior inferior labrum, repair of a SLAP tear, biceps tenodesis, and removal of loose anchor for shoulder instability with labral tears, SLAP tear, grade 2 chondral injuries of the humeral head from dislocation, and loose anchor in the right shoulder.

29. On July 27, 2015, Dr. Li testified by deposition. He is a board certified orthopedic surgeon and specializes in shoulders, hands, and knees. He first saw Petitioner on August 24, 2014 after he was referred to him by Dr. Moody, an occupational medicine doctor. Petitioner had fallen at work and dislocated and relocated his right shoulder; he had persistent pain and instability thereafter. Dr. Li performed arthroscopic surgery with debridement of tensynovitis and repair of repair of a capsulolabral Bankart-type separation on September 26, 2014.

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30. Dr. Li explained that a Bankart-type separation is a separation of the tissue between the shoulder socket and the tissue that connects it to providing stability to the joint. The labrum maintains the humeral head within the socket and provides a cushion. Petitioner's trauma caused the tensynovium to become really inflamed and it grew "like a weed." It becomes hard to see inside the glenohumeral joint until the surgeon removes that tissue. When Petitioner dislocated, or when he relocated, his shoulder some bone chipped off of the socket and there was some damage to the ball.

31. Dr. Li also testified that the pathology he noted in the operative report is consistent with a patient falling on an outstretched arm. The pathology, as well as a Hill-Sachs deformity, increased the likelihood of future dislocations; that was why he performed the surgery. Dr. Li was able to accomplish what he wanted in surgery.

32. Petitioner had postoperative physical therapy and work conditioning to strengthen him so he would be able to return to work at his previous job as an electrician. Dr. Li released him to full duty on March 11, 2015, after he completed work conditioning. Petitioner's time for recovery was about standard for his type of surgery. Dr. Li would have told Petitioner he would probably experience some loss of range of motion both because the surgery tightened up the joint structure and there would be some scar tissue.

33. Petitioner returned to Dr. Li on April 6, 2015 and reported the two throwing incidents. He ordered an MRI and later performed arthroscopy with debridement and chondroplasty of the humeral head, labrum/SLAP tear repair, biceps tenodesis, and removal of a loose anchor on July 8, 2015. The SLAP tear was an extension of the previous labral tear "up to the region of the SLAP tear." However, he did not think it was "new tear."

34. Dr. Li also testified that some of Petitioner's condition was *sequelae* of the initial injury but he thought that there was a worsening of Petitioner's condition by the second dislocation. However, each dislocation made him more susceptible to subsequent dislocations. He had labral tears and the anchor from the previous surgery had loosened by the second dislocation, but the rotator cuff was intact. Dr. Li then opined that the original injury had not completely healed and the first injury caused the shoulder to dislocate after Petitioner threw the roll of tape. Because the tear was an extension of the initial tear, he related Petitioner's condition to the initial injury. The proximity between the second injury and the surgery was also a factor.

35. On cross examination, by the lawyer for Par Electric, Dr. Li testified the extended tear was not the result of the first accident. The extension of the tear was caused by the subsequent incidents. If he did not perform those actions, the re-dislocation probably would not have happened. He did not have a SLAP tear from the first accident. The tear extended to the extent that he chose to perform a biceps tenodesis. Dr. Li did not believe he was aware of any dislocations prior to the 2014 accident.

36. On cross examination by the lawyer for Henkels & McCoy, Dr. Li testified that if Petitioner had a previous dislocation 15 years previously that would have no impact on his opinions about causation of his current condition.

37. Dr. Li believed that an FCE in January 2015 rated Petitioner to be able to function at a medium physical demand level. He had work hardening after the FCE because that status was not sufficient to have him return to work in his regular job.

38. Dr. Li reviewed Dr. Paletta's Section 12 report, but only after he had released Petitioner. He did not know what Petitioner meant when he told Dr. Paletta that he felt his shoulder was unstable in 2/15. He understood that upon his release from work conditioning, Petitioner "had some limited scapular abduction, a-b-abduction, and decreased internal and external rotation." That would be consistent with his assessment at that time. He was not really concerned about a little loss of range of motion as long as Petitioner could meet his job duties. A loss of range of motion would be expected after the surgery Petitioner had. When he released Petitioner to full duty he asked that he return for follow up in four weeks. Petitioner was not released from care when he was released to full duty work.

39. Dr. Li further explained "there were some findings in the second surgery that weren't present in the first surgery, but there was still the finding – the crux of this is the finding where the shoulder re-dislocated, pulled out the anchor that was inserted to repair the labrum that was put in as a result of the original injury." Therefore, he thought Petitioner's subsequent condition related to the initial injury and resulting treatment.

40. On redirect examination, Dr. Li testified that the extension of the labral tear was based on Petitioner not completely healing from the first injury. It was "undeniable" that the loosening of the anchor was an extension of the first injury.

41. On re-cross examination, by the lawyer from Par, Dr. Li testified even if the second injury occurred 18 months after the first surgery he would still relate the condition to the initial injury. However, if he had not re-dislocated the shoulder the anchor would not have loosened. The second surgery probably would not have been necessary if there had not been the initial injury.

42. Dr. Paletta was deposed on October 11, 2015 by a lawyer for Par Electric. Dr. Paletta testified he is fellowship-trained in sports medicine; 60% of his practice relates to shoulders, 20% knees, and 20% elbows. About 40% of his patients are workers' compensation and about 3% of his practice involves Section 12 examinations. He sees about 100 patients a week and performs 12 to 15 surgical procedures a week.

43. He first saw Petitioner on February 16, 2015 and issued a report. He also saw him again and issued another report in May 2015. He reviewed medical records, mostly from Dr. Li, physical therapy notes, and an FCE. Petitioner reported that in the 8th grade he was in an accident in which he fractured and dislocated his right shoulder, requiring surgery. Once he healed and pins were removed he "had basically gone back to normal function with the shoulder."

44. At the first examination, Petitioner reported to Dr. Paletta that he was doing well in recovery from recent shoulder surgery. He had "some mild discomfort in the front of the shoulder" and was making continued progress in physical therapy. He was currently in work hardening. Dr. Paletta thought Petitioner was "nearly complete in his recovery," and he could work at full duty once work hardening was complete.

45. Dr. Paletta examined Petitioner again on May 6, 2015. Petitioner reported that he finished work hardening and had been returned to full duty. He reported two incidents that were associated with recurrent shoulder pain. Dr. Paletta agreed that "it (apparently referring to Petitioner's condition) was different that when [he] evaluated him initially." In the first incident he threw a roll of tape "a good distance" like a baseball. In the second incident he reported throwing a tool that weighed a couple of pounds about 12 feet. In both instances he felt the sensation of his shoulder slipping out and he had to manipulate the shoulder to get it back into position. Dr. Paletta did not consider that either activity constituted an occurrence of everyday living outside a sports context. Petitioner reported the pain was exactly the same as it was prior to his surgery.

46. Dr. Paletta noted Petitioner returned to Dr. Li who ordered an MRA. Dr. Paletta reviewed the MRA which showed that the labrum tear repaired in the surgery was still intact. It appeared that he had "a new labral tear that extended beyond the area that had been previously repaired." He diagnosed Petitioner "had an extended superior labral tear, or SLAP tear following previous repair of the anterior/inferior labrum." Dr. Paletta opined that the pathology shown on the MRA was a new tear. He noted that a SLAP tear can be the result of a throwing mechanism. Dr. Paletta agreed with Dr. Li recommendation for repeat labrum repair, but while he used the term "'repeat' it was going to be a repair in a different part of the labrum."

47. Dr. Paletta also noted that whether or not Dr. Li placed Petitioner at maximum medical improvement after the surgery made no difference in reaching his opinion about Petitioner's current condition. There was no evidence of a SLAP tear prior to, or during, surgery. Then after the throwing injuries the MRA clearly showed the SLAP tear.

48. Dr. Paletta was then asked to comment on the causation opinion in Dr. Li's deposition testimony. Dr. Paletta noted that the question posed to him contained new information that he was previously provided. He had no information about a "loose anchor" and if there were evidence that the previous labral repair had failed, that might change his causation opinion. Full information would include an operative report and operative photos. In fact, if Dr. Li's suggestion that Petitioner had not completely healed from the first labral tear were true, he would opine that the condition was due to the initial injury.

49. On cross examination by Petitioner's lawyer, Dr. Paletta testified he had no criticism of the treatment provided Petitioner by Dr. Li. The surgical procedures he performed would be same procedures Dr. Paletta would have performed. As an independent medical examiner, Dr. Paletta is "completely bound by the information made available to" him. He did not have the observations Dr. Li made during surgery when he authored his May 2015 Section 12 report.

50. Dr. Paletta was recalled for deposition by Respondent Par Electric on November 19, 2015. He testified that when he testified previously it was primarily about the need for a second surgery for Petitioner. At that time he was not aware that Petitioner actually had a second surgery and did not have access to the operative report. Since that testimony he had been provided that information.

51. Thereafter, he prepared a third report dated October 9, 2015. Dr. Paletta found most salient, Dr. Li's statement in the operative report that he "evaluated the site of the previous repair and it was loose and [he] could see that the dislocation had caused one of the anchors to pull loose." Dr. Li also performed a biceps tenodesis, which was not indicted at the time of the initial surgery.

52. Based on all the information now available to him, Dr. Paletta now diagnosed "recurrent tear of the anterior labrum as well as a new tear of the superior labrum, or so called SLAP tear." He now opined that the need for the second surgery was caused by the two subsequent throwing incidents Petitioner reported. He noted that the operative report clearly showed a tear in a new area of the labrum and Dr. Li's impression that the anchor came loose due to the second dislocation. Typically, anchors fail due to trauma; the first repair would not have failed if not for the throwing incidents.

53. Dr. Paletta also noted that Petitioner had made a full recovery and returned to full duty. Dr. Li did not document any signs of residual instability at the time he released him. In the history Petitioner provided Dr. Paletta he indicated he did well until the two subsequent incidents.

54. On cross examination, by a lawyer for Respondent Henkels & McCoy, who did not pose any questions at the initial deposition, Dr. Paletta agreed that the last medical record he reviewed in preparation of his latest report was Dr. Li's note from August 20, 2015. He had not been asked to review any records after that date, nor was he asked to review Dr. Li's deposition testimony. He was asked to review the additional records the day after his previous deposition.

55. Dr. Paletta received black & white copies of the intraoperative photos; actual films are generally in color. He agreed that his most recent report indicated that the photos were not helpful in differentiating the mechanism of loosening of the anchor; he could not "not even see the loose anchor in this photo." There was also no photo of the chondral damage Dr. Li noted. He agreed that Dr. Li personally observed the pathology of Petitioner's shoulder.

56. Dr. Paletta noted that the last note he had from Dr. Li after the first surgery was from March 11, 2015 releasing him to full duty. He did not recall whether Dr. Li found him to be at maximum medical improvement at that time. If there was no specific note declaring Petitioner at maximum medical improvement, it would be fair to say that Dr. Li did not consider Petitioner to actually be at maximum medical improvement. He was not aware that at that time Dr. Li requested Petitioner follow up with him a few weeks after he returned to work.

57. On cross examination by Petitioner's lawyer, Dr. Paletta testified that the additional material he reviewed after his initial deposition was "absolutely" new to him.

58. On redirect, after reviewing his e-mail attachments, Dr. Paletta testified color intraoperative photos were sent to him by e-mail but he printed them out to review them; he does not do well reviewing photos on a computer. In viewing the color images he still could not see the anchor, though he did see evidence of loosening of the previous repair and the SLAP tear. In commenting on Dr. Li's reference to the proximity between the second injury and the initial surgery, Dr. Paletta noted that the injury was more temporarily proximate to the throwing incidents. In addition, the anchor loosening was associated with the second dislocation. The fact that Dr. Li did not place Petitioner at maximum medical improvement did not have any effect on his opinion, because Dr. Li believed Petitioner was able to perform all of his work duties.

The Arbitrator did not specifically address the issue of accidents in the body of his decision. He began his analysis with causal relationship of all the accidents. As noted above, Par Electric stipulated to the accident in 14WC37190. However, Henkels & McCoy did not stipulate to accidents in 15WC19322 & 15WC19323. In its brief Henkels & McCoy argues the Arbitrator erred in finding accidents on April 1, 2015 and April 3, 2015 because Petitioner neither reported the incidents nor sought immediate medical attention as a result of them.

The Commission affirms the Arbitrator's determination that Petitioner suffered three distinct accidents on June, 16, 2014, April 1, 2015, and April 3, 2015 which is implicit in his decision. Petitioner's testimony about the incidents was credible and corroborated by the treatment notes of Dr. Li. There is no evidence contradicting his testimony about suffering such accidents. In addition, it was understandable that he did not seek medical attention, because he had an appointment already scheduled with Dr. Li in a few days. Similarly, his failure to report the incidents was understandable because he personally attributed his re-injury to his previous accident, an impression apparently supported by his conversation with Dr. Li.

On the issue of causation, the Arbitrator found that Petitioner's current condition of ill-being was causally related to both the initial accident/injury on June 16, 2014 and the subsequent throwing incidents in April 2015. The Arbitrator concentrated his decision on the causal connection of the secondary incidents, which in effect he found to be intervening accidents breaking the causal connection from the initial accident. The Arbitrator noted the change in Petitioner's subjective complaints after those incidents. He also found the causation opinion of Dr. Paletta more persuasive than that of Dr. Li. He specifically noted Dr. Paletta's testimony that the failure of the anchor was traumatic in nature. He also found Dr. Li unpersuasive because if Petitioner had not completely healed he would not have released him to full duty.

The Commission agrees with the Arbitrator that Petitioner suffered accidents in April 2015 subsequent to the initial accident and injury of June 16, 2014. The fundamental issue before the Commission becomes whether those accidents were sufficient to become intervening accidents breaking the causation from the initial accident. We find that they did not and that Petitioner's current condition of ill-being relates back to his initial accident on June 16, 2014.

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In this instance, the Commission finds the causation opinion of Dr. Li more persuasive than that of Dr. Paletta. Dr. Li actually personally observed the pathology of Petitioner's shoulder during surgery. Based on that observation, Dr. Li opined that the original injury had not completely healed and the first injury caused the shoulder to dislocate after Petitioner threw the roll of tape. Because the tear was an extension of the initial tear, he related Petitioner's condition to the initial injury. Dr. Li also noted that the proximity between the second injury and the surgery was also a factor. The Commission also finds noteworthy that while Dr. Li released Petitioner to full duty on March 11, 2014, he did not declare him at maximum medical improvement, he did not release him from treatment, and he actually scheduled a follow-up appointment.

The Arbitrator indicated he did not find Dr. Li's opinion persuasive because he would not have released Petitioner to work full duty if he thought he had not healed completely after his initial surgery. The Commission disagrees with the Arbitrator's assessment. The Commission notes that at times the practice of medicine is more of an art than a science. Sometimes, doctors' educated conclusions regarding a patient's current condition can be later found to be inaccurate or incomplete. Here, by opining that Petitioner had not completely healed from the initial injury, Dr. Li is tacitly accepting that he may have released Petitioner prematurely to work full duty in a heavy physically demanding level occupation. The Commission finds that by acknowledging that Petitioner had not fully healed from the initial accident when he released him Dr. Li testimony was actually more persuasive rather than less persuasive.

The Commission also notes that the only FCE, taken in January 2015, evaluated him as unable to return to his previous job and there was no FCE performed after Petitioner completed work hardening. Finally, the Commission also finds relevant the fact that Petitioner was never symptom free after his initial surgery. He complained of continued pain throughout his physical therapy and work hardening. Petitioner testified he still had pain and weakness when he returned to work, and that he returned because he was released to work not necessarily because he felt ready to return to work.

This case is similar to that of *Vogel v. Hogan Plumbing*, 03 I.I.C. 743, (filed October 22, 2003). There, the case was remanded to the Commission by order of the "Circuit Court of DuPage County entered October 7, 2002, which found that the auto accident on June 9, 1999 and subsequent accidents did not break the chain of causation between Petitioner's July 10, 1998 work accident and the pseudoarthrosis in that the work and auto accidents were concurrent causes of that pseudoarthrosis. The Circuit Court further remanded to the Commission to enter an award of medical and temporary total disability benefits." Complying with the remand order in *Vogel*, the Commission assessed such benefits against the employer.

Therefore, even if the Commission accepts the Arbitrator's conclusion that all the accidents are concurrent causes of Petitioner's condition of ill-being, that finding in itself would not be sufficient for the subsequent accidents to become intervening accidents thereby breaking the chain of causation from the initial accident on June 16, 2014. Therefore, the Commission finds that throughout the period relevant to these proceedings Petitioner's condition of ill-being of his right shoulder relates back to his initial accident on June 16, 2014.

Accordingly, the Commission finds that Respondent, Par Electric, is responsible for all medical expenses and benefits arising out of Petitioner's right shoulder condition. By separate Decisions, the Commission reverses the Decisions of the Arbitrator in 15WC19322 and 15WC19323; finding therein that Petitioner did not prove the respective accidents on April 1, 2015 and April 3, 2015 were intervening accidents causing his current condition of ill-being and denying compensation in those claims.

IT IS THEREFORE ORDERED BY THE COMMISSION, that Respondent pay to Petitioner the sum of $733.33 per week for a period of 61&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 all medical expenses thus far incurred for treatment of Petitioner's right shoulder under §8(a) of the Act pursuant to the applicable medical fee schedule.

IT IS FURTHER ORDERED BY THE COMMMISSION, that Respondent authorize and pay for all prospective treatment for Petitioner's right shoulder recommended by Dr. Li.

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, Par Electric, is hereby fixed at the sum of $75,000.00. The party commencing the proceeding for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in the Circuit Court.

DATED: OCT 2 8 2016

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

RWW/dw
O-10/4/16
46

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

16IWCC0690

HAMM, DALLAS
Employee/Petitioner

Case# **14WC037190**

15WC019322
15WC019323

PAR ELECTRIC
Employer/Respondent

On 2/2/2016, 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 0.46% 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:

5354 LAW OFFICES OF STEPHEN P KELLY
2710 N KNOXVILLE AVE
PEORIA, IL 61604

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

STATE OF ILLINOIS)
)SS.
COUNTY OF MCLEAN)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19 (B)

DALLAS HAMM
Employee/Petitioner

Case # 14 WC 37190

v.

Consolidated cases: 15 WC 19322, 15 WC 19323

PAR ELECTRIC
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 Arbitrator McCarthy, Arbitrator of the Commission, in the city of Bloomington on December 22, 2015. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

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

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

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

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

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

G. [ ] What were Petitioner's earnings?

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

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

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

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

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

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

N. [x] Is Respondent due any credit?

O. [ ] ______

On the date of accident, June 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 $57,200.00; the average weekly wage was $1,100.00.

On the date of accident, Petitioner was _31_ years of age, _married_, with _1_ children under 18.

Petitioner is entitled to TTD benefits for the period of September 26, 2014 to March 11, 2015.

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

Respondent shall be given a credit of $17,390.40 for TTD, $0.00 for TPD, $0.00 for maintenance, and $19,885.37 for other benefits, for a total credit of $37,275.77.

ORDER

This case proceeded pursuant to Sections 8(a) and 19(b) of the Act. The parties agree that no claims for PPD are being made at this time.

For the reasons set forth in the attachment to this Arbitration Decision, the Arbitrator finds that Petitioner has proven that his current condition is causally related to the alleged accident, as well as the accidents proven in the companion cases, 15 WC 19322 and 15 WC 19323. For the reasons set forth, the Arbitrator also finds the Respondent Par Electric not responsible for payment of medical treatment from April 3, 2015 through the date of arbitration, as well as TTD benefits for the same period of time.

The Arbitrator finds that Petitioner is entitled to TTD benefits for the period of September 26, 2014 to March 11, 2015, and for medical bills incurred prior to March 11, 2015. Petitioner is not entitled to any TTD or medical expenses after March 12, 2015 at Respondent's expense. The Arbitrator finds that Respondent is entitled to a credit for $37,275.77 for TTD and other benefits paid.

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

RULES REGARDING APPEALS Unless a *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. Dylan McCarty

Signature of Arbitrator

1/24/2016

Date

FEB 2 - 2016

FINDINGS OF FACT

16IWCC0690

The parties arbitrated three cases by consolidation. All of the alleged accidents involve the Petitioner's right shoulder. The main issue is causation among the three accidents with the Petitioner's injuries. The Arbitrator will use one Findings of Fact and Conclusions of Law on the three claims.

Petitioner testified that he worked for the Local 51 Union as an electrical lineman. He testified he was still an apprentice electrical lineman, but was almost finished with his apprenticeship. He testified that his typical job duties included building lines, climbing poles, digging holes, etc. He testified that his job essentially involved physical work.

Petitioner testified that he experienced an undisputed injury to his right shoulder on June 16, 2014 while working for Par Electric. He testified that he went to get off of a bucket and slipped. He testified that he grabbed a bar and dislocated his right shoulder.

He then testified to his subsequent treatment with OSF St. Francis, OSF Occupational Medicine and with Dr. Li. He confirmed that he underwent surgery on September 26, 2014, followed by physical therapy and work hardening. (Px. 4, 5) He testified that as of March 11, 2015, he was released to return to full duty work. (Px. 5) He testified that at the time his shoulder was not 100% and that it was still weak and painful.

Significantly, Petitioner admitted that during physical therapy, his FCE and work conditioning, he had no further dislocations to his right shoulder. He testified that in between his full duty release and the time he started working for co-Respondent, Henkels and McCoy, that he did not have any further shoulder dislocations. He testified that there were no recommendations for additional diagnostics such as an MRI. He testified that he was not being referred for any additional invasive treatments such as surgery.

His medical records through March 11, 2015 confirm there were no further reports of dislocations or recommendations for additional diagnostics or surgery. In fact, his medical records through March 11, 2015 document decreased complaints of pain and improved functional capabilities, which resulted in a release to return to full duty work on March 11, 2015. (Px. 5)

Petitioner was examined by Dr. George Paletta, an orthopedic surgeon, at Respondent Par Electric's request on February 16, 2015, which was prior to the two intervening accidents of April 1 and 3, 2015. Dr. Paletta noted Petitioner had mild complaints with minimal loss of range of motion, excellent strength and good stability. He recommended additional work hardening followed by a return to full duty work. He agreed that Petitioner's treatment through February 16, 2015 was reasonable, necessary and causally related to the June 16, 2014 accident while working for Par Electric. (Rx. 1, Ex. 2)

Petitioner testified that his medical benefits were approved by Par Electric through March 11, 2015 and that he was paid TTD benefits up until his full duty release on March 11, 2015 by Dr. Li. There are no disputes that Respondent, Par Electric, is responsible for the payment of medical and TTD benefits through March 11, 2015 when Petitioner was released at full duty by Dr. Li.

Petitioner testified that he eventually returned to work for co-Respondent, Henkels and McCoy, as an apprentice lineman. He testified that he was performing the exact same type of work that he performed for Par Electric.

Petitioner testified that he started working for Henkels and McCoy in late March 2015 and that he worked for seven days, from a Monday through Sunday. He testified that on the first day that he was employed he underwent training. He testified that on the second day he underwent a half day of training and worked a half day in the field. On that day, which was Wednesday, he was working on the ground with electrical line. He testified that he had a wide roll of electric tape and threw it up to other employees in a bucket. He testified that his shoulder dislocated and that he was in a lot of pain on April 1, 2015. He testified that when he finished work, his shoulder was very sore but that he returned to work on April 2, 2015. He testified that he engaged in limited use of the shoulder on that date.

He also testified as to a subsequent accident that occurred on April 3, 2015 while he was working for Henkels and McCoy. He testified that other employees in a bucket approximately 12 feet off the ground needed a wire grip. He testified that he picked up the wire grip and threw it upwards towards the other employees. He testified that he again experienced another dislocation in his right shoulder with increased pain.

He testified that throwing tape or grips to other employees is a normal part of his work duties. He testified that on April 3, 2015 he finished work but was "babying" his shoulder. He testified that he was also "babying" his shoulder during the remaining days he worked for Henkels and McCoy.

Petitioner testified that he experienced pain following the April 1, 2015 shoulder dislocation while working for Henkels and McCoy. He testified that his pain was greater than what he had prior to working for Henkels and McCoy. He testified the same regarding the April 3, 2015 incident. He testified that his pain following the incidents was greater than before either of the April 2015 incidents.

Petitioner testified that he had a regularly scheduled appointment with Dr. Li as a follow up to his original accident on April 6, 2015, and he gave Dr. Li a history of what happened to him on April 1 and 3, 2015. He testified that Dr. Li recommended he undergo another MRI and placed him on light duty work. Significantly, Petitioner testified that he told Dr. Li that his shoulder hurt following the April 1 and 3 incidents.

Petitioner testified that he then called Jeremy, his general foreman at Henkels and McCoy, telling him that he had hurt his shoulder. He said he did not go into detail because he thought the problem was related to his original injury. He said that he was not offered any light duty work.

The records of Dr. Li from April 6, 2015 document that Petitioner reported a history of the two intervening accidents occurring on April 1 and 3, 2015. Petitioner reported histories of the two accidents that were consistent with his testimony at trial. Dr. Li's records document that Petitioner had "two episodes which were concerning." Based on the report of the two incidents, Dr. Li referred Petitioner for an MR Arthrogram. (Px. 5)

Petitioner underwent another MRI on April 16, 2015. It was interpreted to reveal a diffuse labral tear. (Px. 2).

Petitioner was evaluated again by Dr. Paletta at Respondent Par Electric's request on May 4, 2015. Dr. Paletta noted the history of the two intervening accidents on April 1 and 3, 2015. Petitioner reported to Dr. Paletta that prior to the April accidents "everything felt great and I was doing great." Petitioner reported that upon returning to work for a new employer, co-Respondent Henkels and McCoy, he had two incidents that resulted in recurrent problems with the right shoulder. The histories he provided of those two incidents were consistent with his testimony at Arbitration and the medical records of Dr. Li. He reported feeling that his shoulder dislocated during both episodes with pain. (Rx. 1, Ex. 3).

Significantly, Dr. Paletta noted that Petitioner was reporting that his right shoulder as of May 4, 2015, which was before he underwent an additional surgery in July 2015, felt the same as it did following his June 2014 accident. Petitioner reported a sense of instability. (Rx. 1, Ex. 3) This indicates a significant worsening of his right shoulder condition following the two April incidents while working for Henkels and McCoy.

Dr. Paletta reviewed the April 15, 2015 MR Arthrogram and agreed with Dr. Li's recommendation for surgery. However, Dr. Paletta opined that the need for additional treatment and work restrictions was the result of the April 1 and 3, 2015 accidents while working for Henkels and McCoy. He felt that Petitioner had reached MMI as a result of the June 16, 2014 accident while working for Par Electric, but that two new accidents while working for a new employer with a new objective injury in the form of a new labral tear per Petitioner's MR Arthrogram caused the need for Petitioner to undergo an additional surgery.

Petitioner eventually underwent surgery performed by Dr. Li on July 8, 2015. He underwent a right shoulder arthroscopy with debridement and chondroplasty of the humeral head; arthroscopic repair of the anterior and anterior inferior labrum; repair of a SLAP tear; biceps tenodesis; and removal of a loose anchor. (Px. 3)

Dr. Li documented the following in his operative report:

> "There was clearly an anterior and anterior inferior labral tear. I evaluated the site of the previous repair and it was loose and **I can see the dislocation had caused one of the anchors to pull loose**." (Px. 3)

Dr. Li provided testimony via evidence deposition on July 27, 2015. (Px. 6) Dr. Li testified that he treated Petitioner for a fall at work in June 2014 that resulted in a dislocation. He testified that Petitioner's history was that he dislocated and then relocated the right shoulder in June 2014,, which resulted in "persistent pain and instability." (Px. 6, p. 5)

Dr. Li noted that the initial September 26, 2014 surgery revealed a Hill-Sachs deformity and other pathology that placed Petitioner at increased risk for future right shoulder dislocations. (Px. 6, p. 10) He testified that he was able to accomplish what he wanted to accomplish during the first September 26, 2014 surgery. (Px. 6, p. 11)

Dr. Li admitted that following work conditioning Petitioner was "released from care to return to work full duty," on March 11, 2015. He confirmed Petitioner was "released without restrictions." (Px. 6, p. 12) He testified that Petitioner recovered in a typical timeframe to return to full duty work for the kind of injury he had on June 16, 2014 while working for Par Electric. (Px. 6, p. 13)

Dr. Li testified that Petitioner returned to see him after going to work for Henkels and McCoy on April 6, 2015 and reported a history of the two incidents occurring on April 1 and 3, 2015. (Px. 6, p. 14-15) He confirmed that he performed another surgery on July 8, 2015 to repair, among other things, a SLAP tear, which he confirmed was the result of a tear from "11 and 1 o'clock . . . on the clock face," versus the area that was previously repaired from "2 to 6 o'clock" during the September 2014 surgery. (Px. 6, p. 15) Dr. Li testified that the SLAP tear was an extension of the prior labral tear that resulted from the June 2014 accident while working for Par Electric, (Px. 6, p. 20), and felt the new extended tear was related to the September 2014 surgery and Petitioner's incomplete recovery from same. (Px. 6, p. 25)

He testified that the July 2015 surgery revealed Grade II articular changes of the humeral head that represented a "worsening" from the September 2014 surgery. Dr. Li testified that some of the worsening was "sequelae" from the June 2014 injury, but also admitted that there was "some additional injury from the second dislocation episode of April 1, 2015. (Px. 6, p. 16)

He testified that an anchor placed during the September 2014 surgery was found to be loose during the July 2015 surgery. He testified that "when [Petitioner] dislocated" the shoulder again in April 2015, Petitioner "**pulled the anchor out of the bone**." (Px. 6, p. 18)

Dr. Li was asked whether it was his opinion that the need for an additional surgery in July 2015 was causally related to the June 2014 accident involving Par Electric or the April 1 and April 3, 2015 incidents involving Henkels and McCoy. Dr. Li testified that the "original surgery had not fully healed." (Px. 6, p. 24) He testified that during the April incidents involving Henkels and McCoy, the throwing "actions caused the capsule to – well, the shoulder to dislocate and the capsule to pull away and the anchor to pull out." As a result, he causally related to need for the July 2015 surgery to "be a consequence of the treatment from his first injury." (Px. 6, p. 25)

Dr. Li opined that the proximity in time between Petitioner's September 2014 surgery, his March 2015 full duty release, and the recurrent dislocations in April 2015 also provided him with a basis to causally relate the need for additional surgery to the June 2014 accident. (Px. 6, p. 26)

On cross-examination, Dr. Li admitted the following:

- That Petitioner did not have a SLAP tear extending from 11 and 1 o'clock as a result of the June 2014 accident or noted during the September 2014 surgery. (Px. 6, p.27, 28);

- That the SLAP tear was an extension of the prior labral tear "as a result of [the] two incidents that [Petitioner] described [as] throwing the tape and throwing the grip." (Px. 6, p.27);

- That but for the April 1 and April 3 incidents while working for Henkels and McCoy, which resulted in dislocations, Petitioner would not have experienced a new SLAP tear. (Px. 6, p.28);

- That he used two new anchors during the July 2015 surgery to replace two anchors. (Px. 6, p. 29);

- That the tear from the June 2014 injury "did not extend as high as what would be required to perform a biceps tenodesis," (Px. 6, p.29), a procedure the Arbitrator notes was performed during the July 2015 surgery. (Px. 3);

- That there were new findings of lesions on the glenoid and humeral head during the July 2015 surgery that were not present per Dr. Li during the September 2014 surgery. (Px. 6, p. 30-31);

- That he was not concerned with a "little loss of range of motion" when he decided to release Petitioner back to full duty work on March 11, 2015. (Px. 6, p. 36);

- That there were "some findings in the second surgery that weren't present in the first surgery." (Px. 6, p. 39);

- That the re-dislocation of April 2015 "pulled out the anchor that was inserted to repair the labrum that was put in as a result of the original injury." (Px. 6, p. 39).

- That if Petitioner did not have the April incidents involving re-dislocations, Dr. Li would not have needed to perform the July 2015 surgery. (Px. 6, p. 42); and

- That he testified "of course [Petitioner] did," when asked whether Petitioner "had another dislocation or another accident resulting in the need for further surgery." (Px. 6, p. 42)

Dr. Paletta provided testimony via evidence deposition on October 1, 2015 and November 19, 2015. On October 1, 2015, during direct examination, Dr. Paletta initially testified consistent with his narrative reports prepared following his February 16 and May 4, 2015 examinations. (Rx. 1)

Dr. Paletta testified that Petitioner reported a history of two incidents occurring on April 1 and 3, 2015, which involved over hand throwing motions. He testified that the act of throwing a roll of electrical tape or a grip would not be considered an ordinary act of everyday living. (Rx. 1, p. 12-14) Dr. Paletta testified that Petitioner reported a history on May 4, 2015 of pain in the shoulder that was "identical to the pain he was experiencing prior to the" September 2014 surgery. (Rx. 1, p. 14)

Dr. Paletta testified that at the time of his second evaluation of the Petitioner on May 4, 2015 he had the recent April 16, 2015 MR Arthrogram and treatment notes of Dr. Li. (Rx. 1, p. 14) He testified that his review of the April 2015 MR Arthrogram revealed a new labral tear that extended beyond the area that was previously repaired. (Rx. 1, p. 15) He testified Petitioner had a Superior Labrum Anterior to Posterior (SLAP) tear that was not present during the original September 2014 surgery. (Rx. 1, p. 16)

Dr. Paletta initially testified it was his opinion that Petitioner experienced new accidents on April 1 and 3, 2015, which resulted in the need for Petitioner to undergo additional treatment. (Rx. 1, p. 17) He testified Petitioner experienced a new tear of the labrum. (Rx. 1, p. 16) He testified the throwing incidents were a competent cause for a SLAP tear. (Rx. 1, p. 17) He testified he was in agreement with Dr. Li's recommendation for additional surgery. (Rx. 1, p. 18)

Dr. Paletta testified it made no difference with respect to his opinions regarding causation whether or not Petitioner was formally placed at MMI by Dr. Li before he was released to full duty work or before the April incidents while working for Henkels and McCoy. (Rx. 1, p. 19-20)

Dr. Paletta testified that the status of Petitioner's right shoulder changed after the April 1 and 3, 2015 incidents with the development of a new SLAP tear. (Rx. 1, p. 21) He testified that Petitioner symptoms changed after the April 1 and 3 incidents where Petitioner reported increased instability and pain after the April incidents. (Rx. 1, p. 21-22) He testified that the April incidents required more extensive testing and treatment.

Finally, he testified that the April incidents changed Petitioner ability to work full duty. (Rx. 1, p. 22)

Dr. Paletta was then asked about Dr. Li's opinions regarding causation. Dr. Paletta was informed that Petitioner had undergone an additional surgery in July 2015 and was advised that Dr. Li partially based his causation opinions on the finding of a loose anchor. (Rx. 1, p. 22-23) Dr. Paletta was not aware prior to the October 1, 2015 deposition that Petitioner had undergone another surgery in July 2015. He did not have an opportunity to review the operative report prior to or during the deposition of October 1, 2015. (Rx. 1, p. 23-24)

Dr. Paletta reviewed some of Dr. Li's testimony and testified that "there is the suggestion that there was in fact not complete healing of the first labral tear, that there was failure of one of the anchors, and that an area of the labrum that had been previously repaired was not healed, and that the tear, the new tear extended from that area of the labrum upwards." Based on same, he opined that the need for the July 2015 surgery was possibly the result of an incomplete healing of the September 2014 repair. (Rx. 1, p. 25) **However, he also testified that while his opinions had changed based on Dr. Li's deposition testimony, he did not have "full information" including arthroscopy pictures and the operative report**. (Rx. 1, p. 26-27)

Following the deposition, Dr. Paletta was provided with the operative report and arthroscopy pictures by counsel for Par Electric and Dr. Paletta was asked to prepare a narrative report commenting on same. His report was prepared on October 9, 2015. (Rx. 2, Ex. 1).

Following his review of the previously unavailable documentation, Dr. Paletta opined that "the necessity of the second surgery was related to the two new incidences [of April 2015] causing the need for additional surgery." He noted that Petitioner had returned to full duty work and that at the time of that release there was "no evidence of any failure of the [September 2014] repair." He opined that the "arthroscopy photographs documented what appeared to be a traumatic failure of the proximal portion of the prior labral repair," with a failure of an anchor." He opined that anchor failures typically occur as a result of trauma. (Rx. 2, Ex. 1)

He opined that there was a progression of the prior labral tear to involve a new portion of the labrum and that therefore Petitioner experienced a traumatic labral tear from the April incidents. He opined, similar to Dr. Li, that "if those two throwing incidences had never occurred . . . it [was] unlikely that the first surgery would have failed as a result of the loosened anchor." He opined that the loosened anchor was not inevitable. He noted it would be uncommon for an anchor to loosen as a result of normal activities of everyday living, and that there was no evidence to indicate a loosening before the April incidents. (Rx. 2, Ex. 1)

He provided testimony again via evidence deposition on November 19, 2015. (Rx. 2) Both Petitioner's attorney and counsel for Henkels and McCoy objected to additional

testimony from Dr. Paletta, but did not cite to any relevant authority for why Dr. Paletta's deposition testimony could not be re-taken. Whether to allow the re-deposition of Dr. Paletta is within the arbitrator's discretion, see Janda v. U.S. Cellular Corp., 356 Ill.Dec. 329 (2011), and the arbitrator finds the deposition testimony of Dr. Paletta from November 19, 2015 to be admissible based on the fact that Dr. Paletta did not have complete information or documentation at his initial deposition in October 2015.

Dr. Paletta testified that he reviewed the operative report and arthroscopic photos. He testified consistent with his narrative report dated October 9, 2015. (Rx. 2, Ex. 1) He testified that Dr. Li himself noted in his operative report that "the site of the previous repair . . . was loose and I could see that the dislocation had caused one of the anchors to pull loose." (Rx. 2, p. 9)

He was asked why his opinions had changed again. Dr. Paletta testified as follows:

> "Because the operative report clearly documented that there was a new area of the labrum that was involved with the tear that was not present previously . . . That clearly demonstrates there was new injury to an area that had previously been normal. In addition, Dr. Li's impression was, from the time of surgery, that the previous repair was now loose and that the anchor was loose as a consequence of the dislocation episodes. Those factors taken together in addition to the review of the arthroscopy photos allows me to conclude within a reasonable degree of medical certainty it is my opinion that the need for the additional surgery was a result of those two incidents that occurred while throwing." (Rx. 2, p. 11)
>
> "The issue that was notable on the operative report and the arthroscopy photographs from the second surgery had to do with the loose anchor. Typically, anchors fail, in my experience, as a result of trauma. If they fail for any other reason, there's typically evidence of . . . what we call osteolysis where the anchor then becomes loose, and there was no evidence of that . . . at the time of [the July 2015] surgery. So it is highly unusual, in my opinion, for anchors to come loose on their own unless there's significant trauma that causes the anchor to fail or there's come reaction to the anchor that causes lysis of the bone." (Rx. 2, p. 11-12)
>
> "This gentleman had made a full recovery. He had returned to full duty. Dr. Li had not documented any residual signs or symptoms of instability at the time that he released him. And by the patient's own admission when I took his history, he was doing well up until those two incidents. So he had two distinct incidents with surgically documented evidence of a new portion of the labrum torn and surgically documented evidence of loosening of the previous repair. Those are the factors that say to me he clearly had a new injury and that this injury extended to a new part of the labrum and resulted in failure of the previous repair." (Rx. 2, p. 14)

On cross examination, Dr. Paletta admitted that the operative report findings and not the arthroscopy photos caused his opinions to change with respect to the loose anchor. He did however say that the new SLAP tear was visible in the photos, and the tear was not present during the first surgery. (Id at 19-20). Dr. Paletta also testified, in agreement with Dr. Li, that if the April 2015 throwing incidents had not occurred, the Petitioner's September 2014 labral repair would not have failed. (Rx. 2, p. 15)

Petitioner testified that he continues to undergo postoperative care with Dr. Li, (Px. 8), and there are no genuine disputes related to the reasonableness and necessity of same. The primary issue in dispute is who is liable for the medical treatment and off work benefits incurred after March 11, 2015 – Par Electric or Henkels and McCoy.

CONCLUSIONS OF LAW

(F, K, L) Is Petitioner's current condition of ill-being causally related to the injury? Is Petitioner entitled to prospective medical care? Is Petitioner entitled to TTD benefits?

The Arbitrator finds that the Petitioner's current condition is causally related to all three of the accidents which are the subject of these three consolidated claims. However, the Arbitrator also feels that the surgery of July 8, 2015 and the subsequent treatment and lost time from work is causally related to the Petitioner's two accidents at Henkel's and McCoy, and that Respondent is responsible for payment of those benefits.

First of all, the Petitioner's current condition is a right shoulder post two labral tears, one of which occurred in June 2014 and the other in April 2015. The Petitioner testified that when he was released by Dr. Li from his first course of treatment in March 2015, he still had weakness and pain in the shoulder. His testimony is consistent with the medical evidence. After three months of post surgical physical therapy, the Petitioner reported a nagging pain in the front of the shoulder and showed a mild deficit in flexion. (PX 5; 1-19-15) At his FCE two days later he was found to have significant right shoulder pain lifting 45 pounds, and found to be limited to work at the medium demand level. (Id) After an additional two months of work hardening, he was found on March 10, 2015 to have decreased strength with abduction. (Id) While Dr. Li did return him to full duty work, he testified that his original injury had not fully healed. (PX 6 at 24)

Certainly the Petitioner can pursue additional compensation for permanency from his first accident against Par Electric in a later proceeding.

Henkel's and McCoy are responsible for the second surgery and follow up care. The events which occurred on April 1 and 3 were shown to represent accidents arising out of his employment. Throwing rolled tape and wire cutters a fair distance to co-workers on the jobsite are not activities which create risks of injury equal to those experienced by members of the general public. They are employment risks. The resulted in classic

aggravations of the Petitioner's pre-existing condition, causally related to the subsequent care.

Dr. Li testified that the initial injury made the Petitioner more prone to future dislocations. The Petitioner testified that, while he did not experience any dislocations after his first surgery while in therapy, work hardening or taking the FCE, he did experience dislocations throwing the items at work. Dr. Li said that these dislocations caused abrasions to his humeral head, a tear in a different section of the labrum and a loosening of one of the anchors he'd placed in the shoulder to repair the original labral tear. (PX 6 at 15, 17, 27) Dr. Paletta agreed in his testimony. (RX 1 at 16-20; RX 2 at 10-11)

Henkel's and McCoy argue that the only reason that the Petitioner's arm dislocated on two occasions in April was because the anchor from the first surgery had not healed. Dr. Li seems to support their theory in his testimony, explaining that if more time had elapsed after the first surgery, the more likely one could conclude the shoulder had healed. (Id at 26) The Arbitrator does not find this persuasive. If April 2015 was not a sufficient amount of time for the anchors to heal from surgery performed over six months earlier, then why would Dr. Li have released the Petitioner to return to full duty electrical work? Why would not the shoulder have dislocated while the Petitioner was performing physical therapy and work hardening, or when performing an FCE?

Dr. Paletta was more persuasive. He said that the typical reason anchors fail was because of trauma. If not the result of trauma, there would be osteolysis, or resorption of the bone around the anchor. He noted that no such finding was referenced by Dr. Li in his operative report. (RX 2 at 12) Furthermore, he noted Dr. Li's own statement in the operative report that the "dislocation caused one of the anchors to pull loose." (PX 3)

In addition, Petitioner's symptoms changed by his own admission and based on his admissions to Drs. Li and Paletta. The Arbitrator notes above that Petitioner reported increased pain following the throwing incidents. Petitioner also admitted to Dr. Paletta that he felt increased instability following the April 2015 dislocations resulting from the throwing incidents, and that he felt his shoulder had returned to a condition it was at before he underwent the September 2014 surgery.

Also, there was a clear change in pathology following the April 2015 throwing incidents as documented in the records of Dr. Li, petitioner's April 2015 MR Arthrogram, his July 2015 operative report, and confirmed by the review of Dr. Paletta. Petitioner had a new labral tear, new adhesions, and a loosened anchor, all of which were not present at the time of his September 2014 surgery.

There was also no recommendation for surgery before the April 2015 incidents. There is no indication in the records that Dr. Li contemplated that Petitioner would ever need to undergo another shoulder surgery. Therefore, this factor weighs strongly in favor of finding Petitioner experienced intervening accidents while working for Henkels and McCoy.

Finally, he was able to work full duty before the April 2015 incidents per Dr. Li. Following the dislocating throwing incidents of April 1 and 3, 2015 Petitioner was placed on restricted work.

Based on the foregoing, the Arbitrator finds that Petitioner's accidents on April 1 and 3, 2015, and not the accidents of June 16, 2014, are causally related to the need for treatment and need for subsequent TTD benefits. Petitioner is therefore not entitled to any medical or TTD benefits at Respondent Par Electric's expense after March 11, 2015. Petitioner is entitled to TTD benefits from Henkels and McCoy from April 6, 2015 through December 22, 2015, the date of arbitration.

For the reasons stated above, the Arbitrator finds the medical treatment since April 3, 2015 to be causally related to the Petitioner's accidents at Henkels and McCoy. They are responsible for payment of the ensuing medical bills, as well as the Petitioner's ongoing treatment, which now consists of physical therapy.

(C; E) Did accidents occur on April 1 and 3, 2015 arising out of the Petitioner's employment and did the Petitioner provide notice to the Respondent?

For the reasons stated above on the discussion on causation, the Arbitrators finds the Petitioner did sustain accidents arising out of his employment with Henkels and McCoy on the two dates alleged.

The Arbitrator also finds the Respondent had sufficient notice of said accidents within the time required by statute. The Petitioner's testimony that he called his foreman, Jeremy, soon after he saw Dr. Li on April 6, at which time he was given work restrictions, constituted notice. He said that he told Jeremy that he had hurt his shoulder and gave him the restrictions. His testimony was not rebutted.

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

Terry Taylor,

Petitioner,

vs.

NO: 15WC 020367
15WC020368

SHERIDAN ROAD LIFESTYLE LTD,

Respondent,

16IWCC0691

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 11, 2016, 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.

16IWCC0691

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: OCT 2 8 2016
MJB/bm
o-10/25/16
052

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

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

TAYLOR, TERRY
Employee/Petitioner

Case# **15WC020367**
15WC020368

SHERIDAN ROAD LIFESTYLE LTD
Employer/Respondent

16IWCC0691

On 1/11/2016, 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 0.50% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in 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
JOHN R BERG
2100 W 35TH ST
CHICAGO, IL 60609

0238 WOLFE & JACOBSON LTD
PETER W JACOBSON
25 E WASHINGTON ST SUITE 700
CHICAGO, IL 60602

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

STATE OF ILLINOIS)
)
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION

19(b) ARBITRATION DECISION

TERRY TAYLOR
Employee/Petitioner

Case #15 WC 20367
15 WC 20368

V.

16IWCC0091

SHERIDAN ROAD LIFESTYLE, LTD.
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Robert Williams, arbitrator of the Workers' Compensation Commission, in the city of Chicago, on December 16, 2015. After reviewing all of the evidence presented, the arbitrator hereby makes findings on the disputed issues, and attaches those findings to this document.

ISSUES:

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

B. ☐ Was there an employee-employer relationship?

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

D. ☐ What was the date of the accident?

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

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

G. ☐ What were the petitioner's earnings?

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

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

J. ☒ Were the medical services that were provided to petitioner reasonable and necessary?

K. ☒ What temporary benefits are due: ☐ TPD ☐ Maintenance ☒ TTD?

L. ☒ Should penalties or fees be imposed upon the respondent?

M. ☐ Is the respondent due any credit?

N. ☒ Prospective medical care?

FINDINGS

- On January 19, 2015, and May 1, 2015, the respondent was operating under and subject to the provisions of the Act.
- On those dates, an employee-employer relationship existed between the petitioner and respondent.
- In the year preceding the injuries, the petitioner earned $39,000.00; the average weekly wage was $750.00.
- At the time of injuries, the petitioner was 47 years of age with two children under 18.

ORDER:

- The petitioner's request for benefits is denied and claims #15 WC 20367 and #15 WC 20368 are dismissed.

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

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

Robert E. Williams
Signature of Arbitrator

January 8, 2016
Date

JAN 1 1 2016

FINDINGS OF FACTS:

On January 15, 2015, the petitioner sought medical care for left knee pain at Ingalls Memorial Hospital. The incident is the subject matter of claim #15 WC 20367. He gave a history of his injury to the triage nurse and to physician assistant, Toni Abramovske, and reported to both that he had left knee pain for the past month. During triage, he reported going up some stairs at work and twisting his left knee the wrong way. PA Abramovske noted that his left knee pain had not been improving and he was going up stairs rather quickly and twisted his left knee. X-rays revealed mild degenerative changes and no acute fracture or dislocation. The examination revealed diffuse tenderness to palpation and pain with flexion of the knee joint. The diagnosis was a knee sprain. The petitioner continued to work in January 2015.

On May 7th, the petitioner sought emergency care at Christ Hospital for a left knee injury. The incident is the subject matter of claim #15 WC 20368. A normal range of motion was noted, he had tenderness to palpation to the posterior fossa of his left knee and along the joint and calf. X-rays revealed a small knee effusion, mild degenerative changes and no fractures or dislocations. A venous Doppler was negative for deep vein thrombosis. He was provided crutches and a knee immobilizer.

The respondent prepared a report of injury on May 14th. The petitioner prepared a written employee accident report on May 15th for a date of injury on January 9th due to twisting his left knee on some waste on the stairs he was ascending. The petitioner saw Dr. James Moravek at Mid America Orthopedics on May 15th and reported an emergency at work, running up stairs and twisting his knee. Dr. Moravek gave him a left anterolateral knee injection. A physical therapy evaluation was done on June 1st and the

therapist noted that the petitioner reported twisting his knee running up wet stairs on January 9th and waiting a month before seeking medical care at Ingalls because he just started his job and didn't want to take off work. The petitioner was restricted from using stairs on June 11th. An MRI on June 15th revealed a complex tear of his medial meniscus, a sprain of the medial collateral ligament, infrapatellar and distal quadriceps tendinopathy, mild tricompartmental degenerative changes with chondromalacia, and joint effusion. Dr. Moravek advised the petitioner of treatment options on June 24th.

On June 29, 2015, the petitioner sought a second opinion with Dr. Blair Rhode with Orland Park Orthopedics. Dr. Rhode opined that the petitioner's medial compartment joint space narrowing tearing was pre-existing, but that he sustained a medial meniscus tear when he fell and sustained an axial load to his left knee. An arthroscopic partial medial meniscectomy was recommended and reiterated at follow-ups through December 14, 2015.

FINDING REGARDING THE DATE OF ACCIDENT AND WHETHER THE PETITIONER'S ACCIDENT AROSE OUT OF AND IN THE COURSE OF HIS EMPLOYMENT WITH THE RESPONDENT:

Based upon the testimony and the evidence submitted, the petitioner failed to prove that he sustained an accident on January 9, 2015, or an accident on May 1, 2015, arising out of and in the course of his employment with the respondent. The petitioner admitted that there was no trauma or injury to his left knee on May 1, 2015. There is no evidence that there was a traumatic injury to the petitioner's left knee, that he used stairs or that he was exposed to an increased risk on May 1, 2015. The petitioner's request for benefits for claim #15 WC 20368 is denied and the claim is dismissed.

16IWCC0691

Apart from his report of going up stairs when he twisted his left knee, the petitioner gave many different versions regarding the cause and, more notably, the date of his knee injury. Contrary to the petitioner's testimony, it is significant that during his initial medical care at Ingalls, the petitioner reported to different individuals that he had left knee pain for a month after twisting his left knee going up stairs quickly. Also even though he reported January 9, 2015, as his accident date to the physical therapist on June 1, 2015, he again reported waiting a month after hurting his left knee before seeking medical care at Ingalls. The petitioner did not report a liquid or any other hazard on the stairs, only that he was quickly going up the stairs and twisted his knee the wrong way. There are too many inconsistencies between the petitioner's initial report and his testimony to be credible. The petitioner is not believable. The petitioner failed to prove that he sustained an injury to his left knee on January 9, 2015, or that he was exposed to an increased risk at any time while ascending stairs. The petitioner's request for benefits is denied and claim #15 WC 20367 is dismissed.

FINDINGS REGARDING WHETHER TIMELY NOTICE WAS GIVEN TO THE RESPONDENT:

The petitioner failed to provide the respondent timely notice of his claim of injury for January 9, 2015. The respondent through its Director of Operations denied the receipt of any notice of a claim for an injury on January 9, 2015, before May 2015. Also, the petitioner's report to his initial medical providers places the date of his injury in early December 2014 not January 2015. It is not believable that the petitioner reported to the respondent an injury in January 2015 when at the same time he reported to his medical providers an injury in December 2014. The petitioner's request for benefits is denied and claim #15 WC 20367 is dismissed.

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

Lisa Hahn,

Petitioner,

vs.

U-46 School District,

NO: 14WC 033208

Respondent,

16IWCC0692

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b), having been filed by the Petitioner, herein and notice given to all parties, the Commission, after considering the issues of medical expenses, temporary total disability, 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 14, 2016, 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.

16IWCC0692

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: OCT 2 8 2016
MJB/bm
o-10/25/16
052

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

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

HAHN, LISA
Employee/Petitioner

Case# **14WC033208**

U-46 SCHOOL DISTRICT
Employer/Respondent

16IWCC0692

On 1/14/2016, 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 0.47% 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:

5438 MAINARD LAW OFFICE
HUGH MAINARD
230 S CLARK ST SUITE 152
CHICAGO, IL 60604

2461 NYHAN BAMBRICK KINZIE & LOWRY
DAVID VICTOR
20 N CLARK ST SUITE 1000
CHICAGO, IL 60604

NOIS)
)SS.
OF KANE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

LISA HAHN,
Employee/Petitioner

v.

U-46 SCHOOL DISTRICT
Employer/Respondent

Case # **14 WC 33208**

Consolidated cases:

16IWCC0692

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **BRIAN CRONIN**, Arbitrator of the Commission, in the city of **GENEVA**, on **July 13, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

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

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

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

N. ☐ Is Respondent due any credit?

O. ☐ Other

FINDINGS

On the date of accident, **5/22/2014**, 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 of her left shoulder ***is not*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$84,505.00**; the average weekly wage was **$1,625.10**.

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

ORDER

Denial of benefits

Based on his findings of fact and conclusions of law as to the issues of accident and causation, the Arbitrator denies the petitioner's claim for payment of TTD and medical 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

1-14-16
Date

JAN 14 2016

STATE OF ILLINOIS)

) ss.

COUNTY OF KANE)

16IWCC0692

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Lisa Hahn

v. **Case #14 WC 33208**

U-46 School District

STATEMENT OF FACTS

Petitioner's Testimony

The petitioner testified that she has been employed as a school teacher for 26 years. She has taught kindergarten for 15 to 16 years. Her first year at the Illinois Park School began on August 13, 2013. The petitioner testified that she taught "at risk" children. These children had no prior classroom experience and were at risk for literacy and often came from broken homes with no prior school experience.

The petitioner arrived at Illinois Park School on school days from 6:30 to 6:45 a.m., and the children arrived at 7:45 a.m.

The petitioner testified to her job duties at length. These included taking down 18-22 chairs from the table tops. She might have to move a table or some furniture. Sometimes she moved a big cabinet. On 3-5 occasions a week, she took down materials

from an overhead bin. The weight of such materials was fifteen pounds. She gathered all of the folders or library books and put them in the appropriate place. The petitioner's description of her school day included sitting with the children on a rug, singing and performing dance exercises and breaking down into journal groups. At lunchtime, she would walk the children down to the lunchroom and then prepare for the afternoon session. In the afternoon, the petitioner instructed the full group in math, and then she would break down the children into little groups for reading. The children typically would help clean and put away items at the end of the day. There was no staff in the classroom to assist her. The petitioner usually left the school for the day at 3:30 p.m.

The petitioner testified that she has a lung condition, bronchiectasis. A flare-up of this condition started at the beginning of May 2014 and she was away from school during the week prior to the alleged work accident. She had a high fever and symptoms that mimic pleurisy. This lung condition causes sharp pains in her back and while she was not under any work restrictions at the time of her alleged work injury, she was still taking antibiotics.

The petitioner testified that on May 22, 2014, she held a "beach day" for the children as she had just finished up teaching a unit on sea life. She also held the "beach day" because these "at risk" children may not have been to a beach. The petitioner set up a fishing display with magnetic fish. She provided beach balls and enough sand for the children to make sand castles. This beach party was held outside after lunch. The petitioner testified that no one helped her set up for such party, although her husband

brought the sand to school.

The petitioner described the type of set up involved in the "beach day". This included a play wading pool, which was 5 feet around and approximately 1 foot deep. She brought this wading pool downstairs, and had no problems carrying it. She then had to fill the pool with water from a sink in the classroom. She used a 10-gallon container and filled it up to the 8-gallon mark 6 times. She made 6 trips from the classroom to the "beach" area outside the school, which was a distance of approximately 50-75 feet. The 10-gallon container was rectangular and was less than 1 foot high. She poured the container into the wading pool six times. She carried the container with her hands at her side.

The petitioner also testified that she lifted two 20-pound sand bags to bring out to the event. She lifted and carried one bag over her shoulder. She lifted the other bag up to her neck. She also lifted and pushed a "sand table" that was on 2 wheels and was similar to a wheelbarrow. The sand table had 25 pounds of sand in it. The petitioner testified that she had to empty the 2 sand bags into the sand table. She also testified that she brought out two blankets, a plastic fishing pole, magnetic fish, chalk and books.

The petitioner testified that after she set up everything for "beach day," she noticed that her "whole back" started hurting. She was using her muscles and it hurt.

The petitioner testified that outside of her teaching, she "works out" and walks.

The petitioner then brought the children outside, took pictures and engaged with them. Because her back hurt, she could not play with them. She had difficulty getting up from the ground due to sharp pains in her back. An assistant took care of an autistic

child in her class.

When the beach party was over, the children came back into the classroom for 20 minutes before the school day ended. The children brought in the bubbles and blankets. The petitioner had to bring in the sand table and wading pool. This wading pool was filled with approximately 48 gallons of water. She bent over, grabbed the edge of the pool, lifted it up to head height and dumped it out. The petitioner still had pain when she dumped out the wading pool. Then, she carried this plastic wading pool back to her classroom to dry out. Subsequently, she wheeled in the sand table that held 40 more pounds of sand than when she wheeled it out for the beach party. Also, the sand was now wet since the petitioner had added a gallon of water so that the children could make sand castles. The petitioner was required to wheel the sand table up over a 5" step and into the school. No other clean up duties were required.

That afternoon, she went to the principal's office to see Apryl, the principal. The petitioner told Apryl that that beach party went well. Apryl told the petitioner that she was unable to attend the parties due to job demands. The petitioner then told April that her back was "killing" her. The petitioner planned on applying either ice or heat to her back. She and Apryl had a discussion about such modalities since Apryl's husband has had back problems. At the end of the day, the petitioner's back was hurting "a lot".

On the following day, Friday, the petitioner performed her typical activities at work. She did not alter her activities at work. She took Advil for the pain. After the school day ended, the petitioner's husband applied Icy Hot ointment to her back.

The next week at work, everything was normal except that her back continued to

hurt her. The petitioner did not sit of the floor to conduct the guided reading class because it was too difficult for her to get up and down. So, she sat in a chair.

On Friday of that week, the petitioner was required to pack up everything for the end of the school year. She suggested that there were activities that she could not perform due to her back pain. The petitioner did not shrink-wrap the shelves and instead had her daughter perform such task. The petitioner's husband stacked the furniture. In prior years, the petitioner did not need as much help for the end of school year pack up; she could shrink-wrap the shelves on her own and could stack the furniture unless a piece was extremely heavy. After May 22, 2014, the petitioner did not stack the furniture.

The schoolchildren do help with some of the end of school year activities. Also, the petitioner came in over the weekend to perform some of these tasks.

The prior year, the petitioner came into school over the weekend to perform some of the end of school year activities.

When asked if the petitioner had any conversations with Apryl about her back pain other than the one she had on the day of the beach party, the petitioner testified that she and Apryl "talked." To the petitioner's knowledge, Apryl did not witness any of her altered work activities after May 22, 2014.

The petitioner testified that subsequently, her back pain went away. She had only treated it with Icy Hot ointment. But then her left shoulder began to hurt. This shoulder pain was on the same side of her body as the flare-up in her lung condition. Her lung condition had hurt on the left side of her back by the ribs.

The petitioner testified that her back pain resolved 10 days to 2 weeks after May 22, 2014.

The petitioner testified that sometime in June 2014, "we were at a volleyball tournament" at Navy Pier in Chicago and stayed at a hotel. The petitioner further testified that she could not get comfortable at night and was unable to sleep due to the pain. Her husband told her that she must do something. The petitioner's father-in-law recommended that she see Dr. Alpert. The petitioner's left shoulder hurt. The petitioner further testified that she did not have "any muscle" in her left arm and that the arm "went straight down."

The petitioner testified that she is not the kind of person who runs to the doctor when she feels pain. The petitioner has a high tolerance for pain as it related to her lung condition.

On June 24, 2014, the petitioner saw Dr. Alpert. X-rays and MR images of her left shoulder were taken. She received a cortisone shot in the shoulder. The petitioner participated in a course of physical therapy that lasted through the end of July. The physical therapy regimen did not improve her condition, and Dr. Alpert recommended that she undergo shoulder surgery.

On July 29, 2014, the petitioner underwent left shoulder surgery. Dr. Alpert performed the surgery. The petitioner agreed with her attorney that the surgery consisted of a repair of the rotator cuff tear, subacromial decompression, distal clavicle resection and biceps tenodesis. She participated in a course of post-operative physical therapy, but was still having left shoulder pain. During the second 6-week course of

physical therapy, the doctor prescribed topical pain medication.

Once the summer ended, the new school year began on August 15, 2015 or August 16, 2015. The petitioner started the school year, although her left arm was in a sling. She worked with the children but there was a substitute teacher in the room who also worked with the children. Having a substitute teacher in the classroom at the same time a teacher is in the room is not a typical situation. The petitioner continued to be tested and to receive home visits. Apryl drove the petitioner to and from school. The petitioner had other "teammates" drive her.

The petitioner went to see her doctor. He told her that she could not go back to work.

The substitute teacher was taking over her teaching duties because the petitioner could not perform the job. The petitioner's last day at school was September 12, 2014.

The petitioner testified that her pay is spread out over the course of the school year. So, when she was receiving medical treatment over the summer, she was receiving a check. Then when she was unable to return to work, she tapped into her sick day bank until she exhausted her sick days in January 2015. The petitioner had accumulated a large bank of sick days over the years.

The petitioner continued with physical therapy in September 2014 and had an MRI of the shoulder in October 2014. The MRI showed that her rotator cuff was torn again and that it was "bone on bone." Then, she waited to hear from the respondent as to whether this was a workers' compensation case or not.

The petitioner went to see Dr. Lieber. She underwent physical therapy in Dr.

Lieber's office.

The petitioner underwent a second surgery on her left shoulder on April 2, 2015. The petitioner agreed with her attorney that such surgery consisted of a revision rotator cuff repair, revision subacromial decompression and revision AC joint resection. She participated in post-operative physical therapy 3 times a week, and then needed approval for 25 more sessions.

The petitioner saw Dr. Alpert two weeks before this trial. The petitioner is scheduled to see Dr. Alpert again on July 22, 2015. She still receives physical therapy. Dr. Alpert has never released her to return to full-duty work. She was put on a "no work duty" after the respondent did not accommodate her restrictions. Dr. Alpert wrote the "no work" restriction.

The petitioner testified that, currently, she is in constant pain. Her arm does not go higher than her chest or to the side.

The petitioner testified that she did not sustain an aggravation of her left shoulder condition after the 2014 school year ended. Since September of 2014, the only physical activity that she does is to walk.

Petitioner's Exhibit #1 accurately reflects her pay scale of $84,505.00.

Petitioner's Exhibit #3 consists of the medical billing documents, which she provided to her attorney. All of these bills relate to her left shoulder condition. Elgin Medical is her regular doctor, whom she has seen for blood work. There are notations relating to Blue Cross/Blue Shield. Her husband is covered by Blue Cross/Blue Shield. Petitioner has not used any of her medical benefits because she does not have health

insurance through the respondent.

Either January 20th or 21st, 2015 was the last day she received pay from her accumulated sick time. Since then, she has received 2 checks through Teachers' Retirement System ("TRS"). She has submitted bills through MATRIX, but has not received payment from MATRIX. MATRIX is the carrier for short-term disability. She did not know about TRS. She received 2 checks of $3,000.00 each. In April 2015, she received a third payment of $2,000.00, which was short-term disability, but may be part of TRS. The petitioner is now receiving long-term disability benefits.

TRS makes payments via direct deposit. MATRIX told her that they would issue a check, but she has not seen a check from them.

The petitioner testified that when she went back to work in August 2014, she told Apryl Lowe about her physical condition. Apryl drove her to and from school so she knew about the petitioner's physical condition. During all those times in the car, she and Apryl did not discuss the onset of her symptoms.

On cross-examination, the petitioner testified that on May 22, 2014, she experienced back pain. From May 22, 2014 through June 3, 2014, she performed her classroom duties with the exception of sitting in a chair instead of on the floor. During this time period, she did not see anyone for her back or shoulder. She did take antibiotics for her lung condition.

The petitioner testified that after May 22, 2014 through the end of the school year, she did not experience left shoulder pain. The pain settled in her left shoulder 10 days to 2 weeks after May 22, 2014. The petitioner then testified: "That's when I knew it was

the shoulder."

On June 18, 2014, she first phoned Dr. Alpert.

Besides the end of the school year activities, the petitioner's family assisted her with classroom chores. It is true that she could have asked the custodian for help.

The petitioner further testified that while she was teaching for the respondent, she retrieved supplies from the overhead bin 3-5 times a week.

The petitioner testified that she was paid sick time through approximately January 20, 2015.

The petitioner saw Dr. Lieber. To the best of her ability, she gave Dr. Lieber and other doctors a history.

On redirect examination, the petitioner testified that Dr. Lieber did not take a history from her, his nurse did. The nurse spent 15-20 minutes with the petitioner. The nurse did not ask her questions in any depth, certainly not the depth to which petitioner's attorney asked her. The petitioner testified that she did not tell Dr. Lieber that she had absolutely no symptoms for a period of 7-10 days after May 22, 2014.

Dr. Alpert did not receive as detailed a history of accident as she gave at trial.

The petitioner testified that her family did help out at other times of the school year. Her daughter would play games with the children and her husband would bring things to school such as ice or cooking supplies that she would need or the building needed. Her husband performed these tasks as a convenience to her.

Apryl Lowe's Testimony

Apryl Lowe testified on behalf of the respondent.

Ms. Lowe is the principal of Illinois Park School. At the time of trial, Ms. Lowe finished her 4th year at the school. Ms. Lowe knows the petitioner since the petitioner worked in her building for 1 year. Ms. Lowe had a conversation with the petitioner on May 22, 2014, although she did not recall the form of communication. The petitioner told her at that time that her back hurt.

At the beginning of the next school year, Ms. Lowe visited the petitioner at the petitioner's house. At that time, the petitioner told her that if Ms. Lowe did not get her an administrative job, the petitioner's husband wanted the petitioner to file a workers' compensation claim.

Ms. Lowe testified that the children at Illinois Park School are essentially low literacy children but are not so different from children in other kindergarten classes in the district since a lot of kids come from broken homes.

On cross-examination, Ms. Lowe was asked about the frequency of contact between the petitioner and her from May 23, 2014 until the end of the school year. Ms. Lowe responded that she walked around the building a lot. As an administrator, she meant to go to the petitioner's beach party, but had children with whom she was dealing. Ms. Lowe testified that she does not have a specific recollection of the conversation that she had with the petitioner on May 22, 2014.

During the school year-end pack up, Ms. Lowe knew the petitioner's family would be coming to the school. Ms. Lowe knew that the petitioner's back hurt at that

time. However, every teacher is responsible for packing up her classroom. Ms. Lowe noted that the petitioner's family previously came in to help move things and set things up. So, even when the petitioner was not impaired, her family helped out.

Once the petitioner receives written restrictions from her doctor that she should do desk activities at the most, it becomes a union issue. The petitioner was not provided with desk duty work.

Ms. Lowe did not know if the school district contributes to TRS.

Exhibits

The Arbitrator admitted into evidence Petitioner's Exhibits #1, #2 and #3.

The Arbitrator admitted into evidence Respondent's Exhibit #1.

CONCLUSIONS OF LAW

In support of his decision with regard to issues (C) "Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?", (E) "Was timely notice of the accident given to Respondent?" and (F) "Is Petitioner's current condition of ill-being causally related to the injury?", the Arbitrator finds as follows:

The Arbitrator finds that the petitioner did sustain an accident on May 22, 2014 that arose out of and in the course of her employment. The petitioner clearly indicated that she injured herself on May 22, 2014 while performing work activities that benefited the employer. Notice was given to Apryl Lowe on May 22, 2014. Therefore, notice has also been established.

The Arbitrator notes the following:

1. During her testimony, the petitioner never made any mention of any left shoulder injury that occurred at the time of the accident. In fact, the petitioner testified on cross-examination that during the time she was working for the respondent following the accident, she did not have left shoulder pain.

2. The petitioner's testimony failed to yield any evidence that she told her supervisor that she sustained a left shoulder injury and, in fact, the petitioner testified that she reported a back injury. This statement was verified by her supervisor, Apryl Lowe.

3. The petitioner continued to work following the accidental injury. She did not seek formal treatment for her back pain. So, no doctor restricted her work activities. The petitioner performed her full duties for an additional week following the accident. The petitioner testified that her back hurt during that week; she made no mention of

any shoulder pain. The petitioner also testified that during that week, she sat in a chair instead of on the floor during the guided reading class, and that she had her family help her with the school year-end pack-up. The petitioner testified that the pain "settled in [her] left shoulder" 10 days to 2 weeks after May 22, 2014.

4. At the initial examination of the petitioner on June 23, 2014 by Joshua Alpert, M.D., her treating physician, he recorded the following History of Present Illness:

"This 47-year-old female presents today with pain in her left shoulder that has been bothering her since May 22, 2014. She states there was no acute injury but noticed the pain after lifting heavy sand bags. She states she has more pain when lifting her left arm overhead. She rates her pain at 9/10. Her left shoulder is 0% of normal and she cannot sleep on it. The pain is constant." [Px 2, Dep. Ex. 2]

5. In the second paragraph of the December 15, 2014 Section 12 report authored by Lawrence David Lieber, M.D., he wrote:

"Ms. Lisa Hahn has a history of a work-related injury on May 22, 2014, working for Elgin School District U-46 as a teacher. The petitioner states she was setting up for a beach day, field day trip activity, and was lifting multiple bags of sand from floor to chest level and then carrying them about 100 yards as well as buckets of water. She stated that there were up to three to four bags of sand, weighing about 50 pounds, and seven to eight buckets weighing a minimum of 25 to 30 pounds. She states she developed increasing left shoulder pain approximately 10 days after the event. She gives no history of any isolated left shoulder injury." [Rx 1, Dep. Ex. 2]

The Arbitrator finds that the petitioner did sustain an injury that is causally related to the accident. However, the Arbitrator specifically limits this injury to the petitioner's back. The petitioner clearly testified that she had a back injury that required little treatment: she took Advil and her husband applied Icy Hot ointment to her back. While the Arbitrator recognizes that the petitioner did use her back, arms, legs and shoulders during the many activities she performed on May 22, 2014, he finds no evidence to indicate that she sustained an acute left shoulder injury. The petitioner testified that her back pain went away, but that her left shoulder then began to hurt.

The Arbitrator notes that both Dr. Alpert and Dr. Lieber are board-certified orthopedic surgeons.

Dr. Alpert testified that he performed a DEXA scan on the petitioner, which indicated that she has osteopenia. However, as far as Dr. Alpert knew, the petitioner had no pre-existing left shoulder complaints and no systemic degenerative bone condition. The x-rays taken of the petitioner indicated that she has a Type II curved acromion, which gives her a little bit higher risk when she elevates her arm for the rotator cuff to rub. Dr. Alpert opined that the work activity described on May 22, 2014 with the specific lifting noted in Dr. Lieber's report could be a contributing factor in the development of the condition and symptoms that ultimately brought her to his office and resulted in surgery. Dr. Alpert further opined that she was lifting heavy bags of sand and doing overhead activities, which absolutely could aggravate the rotator cuff and cause a small tear in the rotator cuff. [Px 2, pp. 15-20]

On cross-examination, Dr. Alpert testified that an aggravation of a biceps tendon

would result in pain in front of the shoulder or sometimes people complain of pain deep inside the shoulder. Dr. Alpert reiterated his opinion: "If somebody had never had any preexisting shoulder pain or complaints and there is no documentation of seeing a doctor or having shoulder pain before, and then does an activity and starts complaining of pain within 10 to 14 days after an activity, I think that would be causally related." However, Dr. Alpert also opined that he did not know what other activities she was doing within those 10 days and that it could have been any other number of activities that she could have been performing during that time that could have been the cause of the pain. Dr. Alpert opined that a rotator cuff tear can be either degenerative or acute, and that it is more likely that one can have a degenerative condition such as a rotator cuff tear or AC joint arthritis after the age of 40. The doctor stated that biceps tendinitis and subacromial bursitis are inflammatory conditions that develop for a variety of reasons. He also stated that rotator cuff tears and the AC joint arthritis can cause subacromial bursitis. The biceps tendinitis can be caused by either an acute injury, or by overuse, i.e., wear and tear over time. Dr. Alpert further testified that he was not aware of any pre-existing complaints or problems with the petitioner's left shoulder, but that he did not review any prior records, just the records that he had. [Px 2, pp. 21-28]

On redirect examination, Dr. Alpert testified that whether one complained of shoulder pain right away or within 10 days, he still thought it would be related. [Px 2, p. 29]

Dr. Lieber opined that the activities the petitioner performed during work were not significant enough to aggravate and/or cause a rotator cuff tear. Dr. Lieber further opined that if in fact those activities caused a rotator cuff tear or aggravated a rotator cuff tear or caused a shoulder problem, the petitioner would have had immediate pain and would have sought immediate treatment. There would not have been this situation of ten days or so of asymptomatic period. Finally, from an objective standpoint, based upon the MRIs and even the operative findings, Dr. Lieber opined, there was no evidence of any acute abnormality within the shoulder that could be associated with the May 22, 2014 event. [Rx 1, pp. 10-11]

On cross-examination, Dr. Lieber testified that the petitioner did not indicate that she had any neck complaints during that 10-14 day post-accident period. Dr. Lieber testified that if one has a shoulder problem that one damages through activity, the shoulder is going to hurt. If one has a neck problem, one could initially have symptoms in the shoulder or arm that are caused by the neck due to radiculopathy. So, if you have a shoulder problem, you will not complain of neck pain, but if you have a neck problem, you could initially complain of shoulder pain. [Rx 1, pp. 21-23]

Dr. Lieber suggested that it did not matter whether the buckets of water weighed 15 pounds or 50 pounds. The mechanism of injury is what matters. If she had picked up the bucket with an extended arm at waist level and tried to lift it overhead and felt a pop in her shoulder when she did it, that would be a different scenario. [Rx 1, pp. 32-33]

On redirect examination, Dr. Lieber testified that if the petitioner had symptomatic pain in the shoulder after the incident, that might change his opinion

regarding causal connection. Dr. Lieber also testified that from a mechanism of injury standpoint, if the petitioner performed overhead activities with immediate pain in the shoulder, his opinion regarding causal connection might change. [Rx 1, p. 36] The petitioner's attorney then asked Dr. Lieber the following question:

Q: ... Assuming for the sake of the question that the 1 centimeter rotator cuff tear, the AC joint arthritis, the bicipital tendonitis, the SLAP tear and the subacromial bursitis all preexisted May 22, 2014, so you are back in the beginning, can only overhead lifting activities make those conditions symptomatic?

A: No. [Rx 1, p. 38]

On recross examination, Dr. Lieber testified that it would not matter to him [with regard to causation] if the petitioner had symptoms in any other part of her body. [Rx 1, p. 40]

The Arbitrator finds the opinions of Dr. Lieber to be more persuasive than those of Dr. Alpert.

The Arbitrator questions the petitioner's credibility.

On June 23, 2014, she reported to Dr. Alpert that she has pain in her left shoulder that has been bothering her since May 22, 2014. The Arbitrator finds it curious that no mention was made in this chart note of a May 22, 2014 back injury.

At trial, the petitioner testified that after May 22, 2014, she did not have any pain in her left shoulder while she was working for the respondent.

Furthermore, the petitioner testified that during all those times in the car when Apryl drove her to school at the beginning of the 20014-2015 school year, she and Apryl

did not discuss the onset of her symptoms.

Moreover, the petitioner told Apryl Lowe that if Lowe did not get her an administrative job, her husband wanted her to file a workers' compensation claim.

Therefore, based on the foregoing, the Arbitrator finds that the current condition of ill-being of the petitioner's left shoulder is not causally related to the accident of May 22, 2014. Consequently, the Arbitrator denies the petitioner's claim for TTD benefits and outstanding medical bills. [Px 3]

Brian Cronin
Arbitrator

January 14, 2016
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

Kittie South,

Petitioner,

vs. NO: 15WC012094

Aldi,

Respondent,

16IWCC0693

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b), having been filed by the Respondent, herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, 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 January 27, 2016, 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 $21,847.00. 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: OCT 2 8 2016
MJB/bm
o-10/25/16
052

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

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

SOUTH, KITTIE
Employee/Petitioner

Case# **15WC012094**

16IWCC0693

ALDI
Employer/Respondent

On 1/27/2016, 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 0.41% 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:

1559 JAMES P LEAHY
1275 DAVIS RD
SUITE 131
ELGIN, IL 60123

0481 MACIOROWSKI SACKMANN & ULRICH
ROBERT E MACIOROWSKI
105 W ADAMS ST SUITE 2200
CHICAGO, IL 60603

STATE OF ILLINOIS)
)SS.
COUNTY OF KANE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Kittie South
Employee/Petitioner
v.
Aldi
Employer/Respondent

Case # **15 WC 12094**

16IWCC0693

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Doherty, Arbitrator of the Commission, in the city of Elgin, on December 21, 2015. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

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

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

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

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

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

G. [ ] What were Petitioner's earnings?

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

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

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

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

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

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

N. [x] Is Respondent due any credit?

O. [ ] Other ______

FINDINGS

On the date of accident, February 2, 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 $36,933.00; the average weekly wage was $710.25.

On the date of accident, Petitioner was 47 years of age, single with one dependent child.

Respondent shall be given a credit of $3,788.00 for TTD, $ -0- for TPD, $ -0- for maintenance, and $ -0- for other benefits, for a total credit of $3,788.00.

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

ORDER

RESPONDENT SHALL PAY PETITIONER THE REASONABLE AND NECESSARY MEDICAL EXPENSES INCURRED IN THE CARE AND TREATMENT OF HER CAUSALLY RELATED CONDITION PURSUANT TO SECTIONS 8 AND 8.2 OF THE ACT. RESPONDENT SHALL RECEIVE CREDIT FOR AMOUNTS PAID.

RESPONDENT SHALL PAY PETITIONER TEMPORARY TOTAL DISABILITY IN THE AMOUNT OF $473.50 PER WEEK FOR A PERIOD OF 46-1/7 weeks commencing 2/2/15 through 12/21/15.

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

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

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

Carolyn M. Doherty

Signature of Arbitrator

1/23/16
Date

ICArbDec19(b)

JAN 27 2016

FINDINGS OF FACT

The 47 year old Petitioner testified that she began working for Respondent Aldi on December 12, 2010. She began working as an associate for one year and then changed to the position of shift manager. Both positions required her to "throw loads." The shift manager position also required Petitioner to perform paperwork. Petitioner testified that the physical duties of an associate and shift manager required her to pull items off pallets which were stacked above her head in height on a power jack. As such, Petitioner was required to reach up above her head and remove items from the pallet to place it on the shelves. Specifically, Petitioner testified that she had to reach from above her head to the floor as well as from floor level to above her shoulders.

Petitioner testified that on 2/2/15 she started work at 7 am as a shift manager. Petitioner testified that she started to work stocking the special buy freezer items. Petitioner testified that this task required her to reach above shoulder level, pull items off pallets and place them in the short freezers. Petitioner testified that prior to this date, she never had a problem performing her job duties or with either shoulder. She testified that prior to the accident she worked 35 to 40 hours per week for 4 years with any problem in her shoulder.

Petitioner testified that she used the power pallet hand jack to move the pallet out to the small freezers located outside of the back store room in approximately the 4th store aisle in the customer shopping area. Petitioner estimated the power handle with attached gears weighed 10 pounds. She estimated that without attached controls the handle weighed approximately 7 pounds. Petitioner testified that while at the small freezers she went to manipulate the power jack forward using the power handle with her right hand. Petitioner testified that as she pushed the button the power handle dropped suddenly jerking her right arm and shoulder. Petitioner testified that the handle was hydraulic and was designed to drop slowly. Petitioner testified that she noticed that her shoulder felt "dislocated" and out of place. Petitioner testified that she continued to work for approximately one hour but had difficulty raising her right arm. She was able to move her right arm side to side but could not move her right arm overhead.

Petitioner testified that no one was in the store when the incident occurred. When the scheduled shift manager "Maggie" arrived, Petitioner showed her how the handle quickly jerked down. Petitioner testified that she then went to her car to take a break and gather herself. When she went back into the store Petitioner told Maggie that she had pain in her shoulder and that she had to see a doctor. An accident report was completed and Notice is not at issue.

At trial, a video was admitted at RX 8. All parties viewed the video prior to trial and the Arbitrator has viewed the video at RX 8 in its entirety. The video is dated 2/2/15 and depicts Petitioner at 8:32 am walking around a back room moving pallet jacks. She does not exhibit obvious pain behavior while moving the pallet jacks or disposing of garbage. Petitioner moves in and out of the back room. At 8:33:49 a woman identified as Maggie walks in a back room with Petitioner who is then depicted as clearly demonstrating for Maggie how the handle dropped. Petitioner is also seen demonstrating how her right shoulder was jerked downward. Maggie is also seen examining and manipulating the handle in what appears to be an attempt to see how the handle failed. The handle is seen quickly dropping. This demonstration concludes at 8:34:37. At trial, Petitioner testified that the incident occurred after she began her shift at 7 am and approximately 15 minutes before the video of her demonstrating the handle failure to Maggie was taken.

Respondent called Kevin Jomant to testify in his capacity as a district manager for Respondent. On 2/2/15, he was the district manager for the store where Petitioner worked. Mr. Jomant testified to having two conversations with Petitioner about the accident and the video. He confirmed that Petitioner told him that the

video did not depict her accident but rather only her demonstration of the accident as shown to Maggie after the fact. He further testified that Petitioner informed him that the accident occurred in Aisle 4 of the store. He further testified that there is no video of the actual accident as there is no camera in that area of the store. Mr. Jomant further verified that the handle is kept up by hydraulics and the machine will not move with the handle straight up. As a result, the handle must be pulled down 12 to 18 inches before the machine will operate. He verified that when Petitioner pulled the handle to begin machine operation, the handle fell quickly.

Petitioner called a friend to drive her to Sherman Hospital which is a Respondent occupational health clinic. The history indicates, "this is a 47 year old female who works at Aldi, who reports while at work today, the handle broke the power lift machine. The patient reports her arm was on the machine and the handle broke and yanked her right arm downward. The patient reports pain and difficulty moving the arm." PX 2. The examination showed tenderness to the right shoulder both anterolaterally and posteriorly with limited range of motion with abduction adduction and internal rotation. Plain x- rays were negative and she was assessed with a right shoulder strain, put into a right shoulder sling and restricted to no use of the right shoulder and prescribed naproxen. She was told to return in three (3) days. PX 2.

Petitioner was examined again at Sherman Hospital on 2/5/15. Petitioner was told she needed an MRI of her right shoulder to rule out a suspected rotator cuff tear based on complaints of pain and weakness and exam consistent with right rotator cuff injury. PX 2. The work restrictions were continued. Petitioner testified that she asked Kevin Jomant how to get the MRI and that on or about 2/11/15, Kevin gave her a number to call at Gallagher Basset. Petitioner ultimately spoke with "Donna" and then Candace Parks to whom she gave a statement regarding the accident. RX 9.

The MRI was authorized and Petitioner underwent the MRI on 2/13/15. The MRI showed a small full-thickness tear of the anterolateral l supraspinatus tendon at insertion measuring 7 mm anteriorly and posteriorly as well as a small amount of fluid within the substance of the infraspinatus tendon consistent with a small interstitial intrasubstance tear. The AC joint exhibited minimal capsular hypertrophic changes and there was mild marrow edema in the lateral clavicle adjacent to the AC joint. There was also findings of a small amount of glenohumeral joint effusion and a small amount of fluid in the subdeltoid bursa. The impression reads, "1. 7mm full thickness tear of the anterolateral supraspinatus tendon at insertion; 2. Minimal fluid signal in the infraspinatus tendon near musculotendinous junction probably representing small focus of interstitial intrasubstance tear; 3. Mild acromioclavicular joint arthrosis with laterally downsloping acromion." PX 2. Upon return to Sherman Hospital on 2/19/15, Petitioner was referred to an orthopedic doctor, Dr. Chhadia, based on the MRI results. Petitioner's work restrictions were continued.

Petitioner testified that she advised Respondent of the orthopedic referral. Petitioner testified that Candace Parks informed her that she had to see Dr. Atluri before seeing an orthopedic surgeon. Petitioner initially thought Dr. Atluri was a treating physician but subsequently learned that he was a Section 12 examining physician.

Petitioner saw Dr. Atluri on 3/24/15 for a Section 12 exam. RX 3. Petitioner reported a consistent history of injury at work while using a power jack to lift pallets. Petitioner reported that the hydraulics on the machine was malfunctioning and that the handle dropped suddenly downward jerking her right arm. Petitioner reported feeling that she "popped" her shoulder out of place. On exam, Dr. Atluri noted tenderness over the subacromial space as well as the bicipital groove, limited motion on the right and no inconsistencies on exam. He reviewed the MRI and noted "This is a poor quality study. This reveals arthritic changes at the acromioclavicular joint. The glenohumeral joint is reduced. There are some signal changes in the rotator cuff. There are signal changes

in the distal supraspinatus suspicious for a high-grade partial-thickness tear. No obvious full-thickness tear is seen. There is some edema at the AC joint." RX 3.

Dr. Atluri also reviewed Petitioner's medical records, photos of the power jack, and the video. Petitioner also demonstrated the position of her upper extremities indicating that her arms were partially flexed in front of her with her elbows partially extended. She further demonstrated how the handle suddenly fell downwards pulling her right upper extremity. He notes that the "video footage did generally correlate with the sequence of events described by the patient. However, I did not identify any upper extremity injury in the footage provided. Furthermore, the video footage of the power jack handle falling revealed a relatively low weight apparatus with a short arc of motion. Based upon my understanding of the patient's position of her upper extremity, the amount of force involved with handling the power jack handle and the video footage which does not reveal any significant upper extremity injury, Ms. South's right shoulder condition is not work related. This patient's rotator cuff (specifically the supraspinatus) would not be at risk when performing the duties she was describing. Furthermore, the amount of force imparted by the falling power jack handle could not have plausibly caused or contributed to her rotator cuff tear." RX 3.

His impression was right shoulder pain and possible rotator cuff tear. He opined that further treatment was necessary but not due to "any occupational condition." He suggested PT for six to eight weeks supplemented by cortisone injections. Without improvement, surgical intervention would be reasonable. Based on Dr. Atluri's opinion, Respondent issued a denial letter to Petitioner.

RX 5 contains photos of the Lafis power jack and handle. The handle is depicted as weighing 7.6 without attached controls and 10.47 pounds with controls. RX 6 is a repair order dated 2/2/15 noting the "broken control handle" on the power jack.

Petitioner then sought treatment through her group carrier from Dr. Cummins. Dr. Cummins prescribed surgery for her right shoulder which she underwent on 5/18/15. PX 8. The operative report shows the post operative diagnosis as: 1) right acromioclavicular arthralgia; 2) right subcromial bursitits;and 3) right rotator cuff tear. The procedures performed were: 1) right shoulder arthroscopic acromioplasty; 2) right shoulder arthroscopic distal clavicle resection; and 3) right shoulder arthroscopic rotator cuff repair. During surgery, a full-thickness rotator cuff tear involving the supraspinatus tendon was noted. PX 8.

Dr. Cummins prescribed physical therapy and the Petitioner underwent physical therapy at Athletico/Associated Physical Therapy from June 9, 2015 through November 19, 2015 (Petitioner's Ex. 10). The Petitioner remains under the care of Dr. Cummins and last saw Dr. Cummins on November 20, 2015. On the last visit with Dr. Cummins, the Petitioner continued to describe pain with overhead movements and Dr. Cummins moved her to a home exercise program and discussed reevaluation with an MRI and possible arthroscopic capsular release of adhesions if the non-operative treatment is not satisfactory. She was continued on light duty with no lifting more than 20 lbs. with the arm at side and occasionally 5 lbs overhead. She was advised to minimize repetitive use of the right arm and told to follow up in six weeks. PX 6.

Petitioner testified that she currently performs home exercises. Currently, Petitioner is only able to raise her right arm to approximately shoulder height. She is unable to raise her right arm above her shoulder level or overhead.

Dr. Cummins wrote a report dated August 12, 2015 (Petitioner's Ex. 11) in which he notes that the Petitioner

had immediate pain after the injury and subsequently, in a timely manner, presented to Advocate Sherman Hospital where she was placed in a sling. It was Dr. Cummins opinion after reviewing the video, that the Petitioner's right shoulder injury is consistent with the trauma she described as occurring at work related to the incident with the power jack on February 2, 2015. He noted that in general it is atypical to find full thickness rotator cuff tears in patients forty-eight (48) years of age without a significant injury causing the tear. He notes that a forceful jerking mechanism, such as occurred with the power jack, is a type of mechanism that could cause such a tear. PX 11.

Dr. Atluri was requested to review Dr. Cummins August 12, 2015 report and in his report of October 13, 2015 (Resp. Ex. 4) he indicated that he disagreed with Dr. Cummins that the rotator cuff tear was related to the reported February 2, 2015 incident. He stated while it is true the full thickness rotator cuff tears in that age group (48) are not as common as they are in individuals fifty years or older, this patient had a small full thickness tear with associated degenerative changes and a small right rotator cuff tear such as the one Ms. South had sustained is not unusual in this age group. He indicated he agreed with Dr. Cummins that a forceful jerking mechanism could contribute to a rotator cuff tear. However, he opined that the mechanism of injury must also include awkward positioning of the upper extremity with respect to the specific structure that had been damaged. In this case, he stated that the portion of the rotator cuff which was injured, the supraspinatus, would not be at risk with the patient's arms well below shoulder level. He stated that if her arms were above shoulder level and extended away from her body at the time of a "forceful jerking mechanism" then her rotator cuff could have been damaged. He stated that based on his understanding of the mechanism of injury provided by Petitioner, the video and "other materials provided for reviewing" it was his opinion that the rotator cuff tear could not have been caused by the incident described by Petitioner.

Dr. Cummins was deposed on September 23, 2015. Dr. Cummins is a board certified orthopedic surgeon with a board certification and a sub-specialty of sports medicine. After his first board certification in 2000, he took a Fellowship in shoulder surgery and sports medicine as he chose those for his sub-specialties (Deposition pg. 5-6). Dr. Cummins concentrates his orthopedic practice in shoulder surgery and performs approximately 300 shoulder surgeries a year (Deposition pg. 4-5). Dr. Cummins first saw Ms. South in April 2015 (Deposition pg. 9). He testified that Petitioner provided a history of injury to her right shoulder at work when the hydraulic handle released without warning and jerked her shoulder. PX 12, p. 9. He reviewed the MRI film and agreed with the written findings of the radiologist's report of February 13, 2015 that showed a rotator cuff tendon tear. (P11-12).

Dr. Cummins testified that it is difficult to tell on an MRI, particularly with a smaller rotator cuff tear, if it's from an acute injury or a degenerative process. Therefore, he based his opinion on patient history including whether the pain was old or new and the patient's age. PX 12, p. 12. He again stated that it was unusual to have a chronic rotator cuff tear at 47 years old and that it usually takes some sort of acute injury to cause a tear in a person that age. PX 12, p. 12. In his view of the MRI, no degenerative findings were noted in the glenohumeral joint or in the AC joint. Regarding the finding of mild marrow edema in the lateral clavicle adjacent to the AC joint, Dr. Cummins noted that edema can result from arthritis and from injury. PX 12, p. 13. Regarding the AC joint arthrosis, he noted that it appears to be a mild arthritis but he states that across a spectrum of patients' AC joints, there is a very high rate of arthritis in that joint and in the vast majority of those people. it is asymptomatic PX 12, p., 14. Again, the edema/fluid both in the AC and subachromial bursa and glenohumeral joint could result from trauma or degenerative process. PX 12, p. 15.

Dr. Cummins opined that Petitioner's conditions were causally related to the injury she described in her history (P-16). His opinion was based on the description of the event as forceful, the mechanism of injury, the MRI findings and the fact that Petitioner was without shoulder pain or problem prior to the event at work and then had shoulder pain and loss of function after the event. PX 12, p. 16). He opined that Petitioner sustained a forceful eccentric load sufficient to tear her right shoulder rotator cuff and cause Petitioner to seek immediate acute care. PX 12, p. 19-22. He considered the video in assessing the mechanism of injury as well. PX 12, p. 25.

On cross exam, Dr. Cummins testified that he did not know what force was involved when the handle dropped and did not know whether the handle was above at or below Petitioner's waist when it fell. PX 12, p. 30. He testified that Petitioner's arm was not above the shoulder level at the time of incident. PX 12, p. 32. He testified that the most common cause of rotator cuff tears is falling on an outstretched arm or lifting something too heavy, too quickly. He testified that in a downward pulling motion, the biceps tendon would be at more risk than the rotator cuff and that the biceps tendon in this case looked good. PX 12.

Dr. Atluri also testified via deposition. RX 7. He again stated that Petitioner provided a history of injury when she held a power jack handle with her right hand and it suddenly dropped downward pulling her right hand downward. RX 7, p. 11. Dr. Atluri testified that Petitioner did not describe any movement of her right arm at or above shoulder level and he did not see any such demonstration in the video of Petitioner reenacting the event for her co-worker. RX 7, p. 24. Although he found Petitioner to have a rotator cuff tear involving the supraspinatus he did not find the condition causally related to the incident described by Petitioner for several reasons. First, he testified that in his opinion, Petitioner "described a mechanism of injury when her arms were positioned below shoulder level and she was holding the handle of this pallet jack. She told me that the handle suddenly fell downwards pulling her right upper extremity downwards. The mechanism of injury is not plausible for causing a tear to the supraspinatus. The supraspinatus is not at risk when the arms are in that position." Next, Dr. Atluri opined that the MRI showed no acute abnormality based on a lack of effusion or large volume of fluid in the joint which would be present with an acute tear. Lastly, Dr. Atluri opined that Petitioner's actual physical findings support a chronic tear vs an acute tear. He explained that chronic tear patients complain of shoulder pain but have relatively well preserved function. With an acute tear, a patient's body has not had time to adapt and those patients cannot lift their arm. When he examined Petitioner, she had pain but her arm strength was good which he opined was consistent with a chronic tear and not an acute tear. RX 7, p. 31.

Dr. Atluri also opined that the incident did not aggravate or accelerate Petitioner's condition/rotator cuff tear. In stating his basis for this opinion, Dr. Atluri testified, "it is generally the same. The key point I would explain is that an aggravation requires some type of alteration in the actual tear. There would have to be an additional tear. There would have to be enlargement of the tear and that would be obvious on the MRI which was done so soon after the injury. ... So even if it was an aggravation, there would be effusion... there would be very obvious acute findings on that MRI, and in this case there weren't." RX 7, p. 32.

In further citing support for his opinions, Dr. Atluri testified that Petitioner did not exhibit any pain behavior on the video while demonstrating the handle failure because "her arm was never really in an at risk position or in a position where her rotator cuff would be symptomatic." He opined that given the position of her arms below shoulder level, the biceps would be at a higher risk for injury than the rotator cuff. RX 7, p. 33. Her biceps was not injured.

Dr. Atluri was asked to "counter" for the Arbitrator Petitioner's claim that she never had a problem with her right shoulder working with this hydraulic handle until 2/2/15 when the handle failed, her symptoms began and she sought medical care. He answered, "That history, if described by the patient, is not consistent with her actual clinical picture. The mechanism she described cannot have caused that rotator cuff tear. The MRI clearly, definitively, objectively shows that there was no acute rotator cuff tear or even any acute injury to the right shoulder. So there is no way that her symptoms could have been acutely caused by the incident she described. It is possible that she is accurately describing the onset of symptoms in terms of timing. It could be that she did not have very severe symptoms in the past and that in that general time frame is when her shoulder symptoms became noticeable, but that is only plausible if we accept that it is a chronic rotator cuff tear that was gradually becoming symptomatic. Not if we try to pin it on any specific acute event." He was then asked, "and would that be the same in terms of aggravation?" and he answered "yes." RX 7, p. 36-37.

On cross-exam, Dr. Atluri acknowledged that Petitioner was fine when she arrived at work and then later that day her arm was in a sling and she was told not to use it. RX 7, p. 52. He also testified that he believed Petitioner "had the rotator cuff tear and that she was performing those work activities even though the tear was present." RX 7, p. 58. On cross-exam he agreed that Petitioner was asymptomatic before 2/2/15 and if the history is accurate her chronic condition became symptomatic on 2/2/15. RX 7, pp. 75-76. However, he does not believe the dropping of the handle jack aggravated or accelerated her chronic condition despite the sudden appearance of symptoms. RX 7, p. 80.

CONCLUSIONS OF LAW

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

C. Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
F. Is Petitioner's current condition of ill-being causally related to the injury?

Petitioner credibly testified that she worked 4 years for Respondent without incident or problem involving her right shoulder. Petitioner arrived at work on 2/2/15 without right shoulder difficulty. Petitioner credibly testified that while operating a power jack on 2/2/15 her right hand was on the handle when it suddenly dropped due to a hydraulic failure. Petitioner credibly testified that her right arm was jerked downward and she initially felt her shoulder was "dislocated." Petitioner's reenactment of the incident for her co-worker is seen on video. Her credible testimony regarding this occurrence is also consistently represented in the accident report, the initial occupational health records and in her visits to Dr. Atluri and Dr. Cummins. No evidence to rebut the alleged accident was placed into evidence at trial. Based on the foregoing, the Arbitrator finds that Petitioner met her burden to prove that an accident occurred arising out of and in the course of her employment for Respondent on 2/2/15 by a preponderance of the credible evidence.

The Arbitrator further finds that Petitioner's current condition of ill-being in her right shoulder is causally related to the accident of 2/2/15. In so finding, the Arbitrator again notes Petitioner's un-refuted and credible testimony that she was without symptom in her right shoulder prior to this accident and that she sought treatment for her right shoulder pain shortly after the accident on the same day. The Arbitrator further notes that Petitioner advised each provider and the Section 12 examining physician that her arm

was jerked downward by the power jack handle in a forceful manner. In further support of the causal connection finding the Arbitrator specifically notes the video depiction of Petitioner demonstrating the event shortly after its occurrence, the immediate report of shoulder pain to the co-worker, the same day visit to occupational health, the referral for an MRI 3 days later, and the MRI results confirming a full thickness tear.

The Arbitrator notes that both Drs. Atluri and Cummins agree Petitioner had a right shoulder rotator cuff tear as seen on the MRI. The Arbitrator also notes the disagreement between Drs. Cummins and Atluri as to whether Petitioner's right shoulder rotator cuff tear was acute or chronic. The Arbitrator finds that given the contemporaneous nature of the symptoms and the accident as well as the immediate medical attention documenting the symptom onset, the Arbitrator finds that the symptoms in her right shoulder arose as a result of the accident, regardless of whether the origin of the tear was acute or chronic. The Arbitrator specifically finds that Petitioner's previously asymptomatic right shoulder became symptomatic as a result of the work accident on 2/2/15 resulting in the need for same day medical treatment and consistent medical treatment thereafter. In light of the foregoing, the Arbitrator finds Dr. Atluri's attempts to "counter" the fact that the previously asymptomatic Petitioner became symptomatic following the accident, unpersuasive.

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

Based on the Arbitrator's findings on the issues of accident and causal connection, and Respondent's dispute based on liability, the Arbitrator further finds that Respondent shall pay Petitioner the reasonable and necessary medical expenses incurred in the care and treatment of her causally related conditions pursuant to Sections 8 and 8.2 of the Act. Respondent shall receive credit for amounts paid. To the extent the parties stipulated to credit under Section 8(j), the Arbitrator finds that 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.

L. What temporary benefits are in dispute? TTD N. Credit

Based on the Arbitrator's findings on the issues of accident and causal connection, and on the treatment records of Dr. Cummins, the Arbitrator further finds that Petitioner was temporarily and totally disabled for a period of 46-1/7 weeks commencing 2/2/15 through 12/21/15. Respondent shall receive credit for amounts paid.

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 ST. CLAIR)	X Reverse	Second Injury Fund (§8(e)18)
	X ON REMAND FROM THE APPELLATE COURT	PTD/Fatal denied
		[X] None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Nichole Collins,

Petitioner,

vs. NO: 12 WC 10992

16IWCC0694

Kraft Foods,

Respondent,

DECISION AND ORDER ON REMAND FROM THE APPELLATE COURT

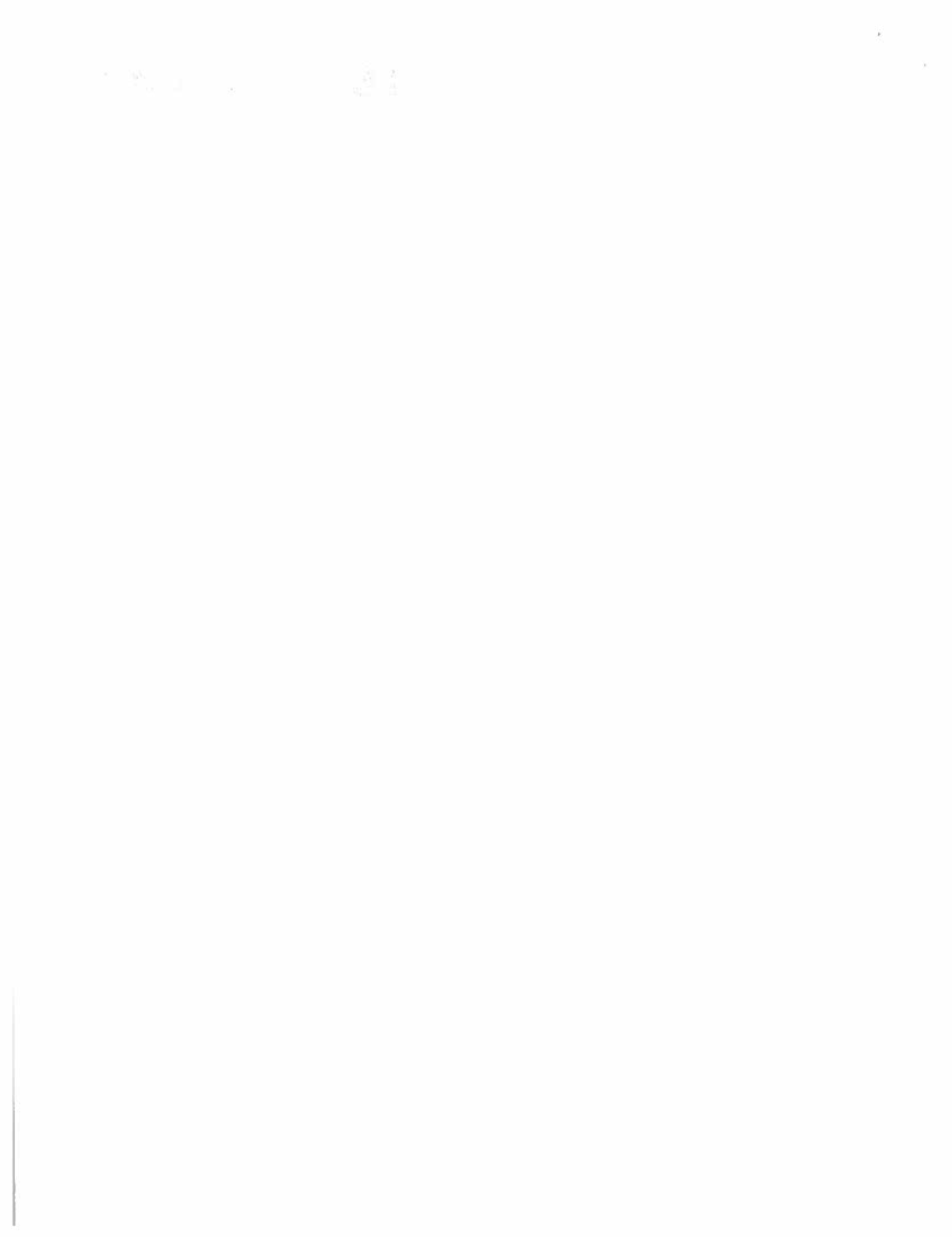
This matter had previously been heard and the Decision of Arbitrator Lindsay had been filed June 16, 2014. The Arbitrator found that Petitioner failed to prove accident that arose out of and in the course of employment, and failed to establish a causal connection between these accidental work related injuries and his condition of ill-being and no notice. The Arbitrator found as Petitioner failed to prove accident, causal connection, and notice, all other issues moot, all benefits denied. The matter was presented on Petitioner's Review and the Commission affirmed the Arbitrator's decision. Thereafter, Petitioner went before the Circuit Court of St. Clair County who reversed the decision, finding accident-(repetitive trauma), causal connection, and notice. Thereafter, Respondent appealed to the Appellate Court who affirmed the decision of the Circuit Court, and denied Respondent's motion, and remanded the case back to the Commission for determination of temporary total disability benefits, medical expense benefits, and permanent partial disability benefits.

- At the initial hearing, Petitioner alleged December 22, 2011-as date of manifestation-repetitive trauma-bilateral hands and arms). Petitioner testified she was a 40 year old employee of Respondent, who described her job (filler/machine operator) assembly line. Petitioner began working for Respondent part-time in April and then became full time in

November 2008. Petitioner is a diabetic but controlled just eating right. Petitioner 'believed' she had prepared a job description-(PX 7); she acknowledged her signature on the bottom of the description and she agreed it was an accurate representation of what she does at work. Petitioner had read decisions and job descriptions regarding three co-workers cases. Petitioner testified she had performed the jobs outlines in those decisions. Petitioner testified that she performed the jobs outlined in those decisions; same exact job. Petitioner testified that prior to her surgery she worked 12-hour shifts, 3-4 days per week. Petitioner testified that there was no part of her job as a machine operator that did not involve using her hands. Petitioner testified that during the course of her employment she began developing increased symptoms in her arms and hands. Petitioner testified the activity that she seemed to notice brought on most of the symptoms was lifting boxes to feed the machines and when she took handfuls of pouches to fill the magazines; all that is done by hand. Petitioner testified that at some point she went to see her family doctor for her problems. Petitioner agreed per the records of Southern Illinois Healthcare that she had symptoms of numbness and tingling back in 2007; she saw those records. Petitioner testified she never received a test for carpal or cubital tunnel syndrome. Petitioner did have a pre-employment physical with one of Respondent doctors.

- Petitioner testified that while performing her job duties she would have tingling in her fingertips and they would go numb at times and she had dropped boxes of handfuls or pouches, straws; big rolls of straws, and she had pain that shot up her arm, past her elbow to her shoulder. Petitioner testified that her doctor referred her for some testing regarding the problem; EMG/NCV she believed was done December 22, 2011-(alleged manifestation/date she knew of diagnosis). Petitioner testified that prior to that test she had never received that type of test previously for her hands or elbows. Petitioner did not have opportunity to speak to Dr. Naseer after the test was done. Petitioner had returned to her family doctor to get an update on the test results and she testified the first time she knew she had a work related condition was December 22, 2011; she believed when she had received those test results. Petitioner testified that when she found out the test results she informed Respondent; she believed she told her lead, Melinda Pullman, and her supervisor at the time, Ray Durbin-(noted present at hearing). Petitioner testified that she believed she asked or was given an accident/incident report and she believed she had signed it, but she did not have a copy of it.

- Petitioner testified that at some point she was referred to Dr. Anderson who ultimately performed surgery (she noted at the palms of her hands). Petitioner testified that prior to surgery things were not great for her. Petitioner stated that prior to surgery her hands were just numb and she was having problems with soreness and problems holding things. Petitioner stated after surgery her condition had improved for both hands. Petitioner was not referred for any therapy after surgery; the doctor had her wear her braces at night when she slept and advised to sleep with her arm out and she testified that helped a little also. Petitioner testified to this day her condition had remained improved. Petitioner testified that despite her improvement she does still have occasional problems depending on the level of her activity. Petitioner did not have any problems at the hearing with her hands resting in her lap. Petitioner testified that prior to surgery, just sitting she was still having big problems. Petitioner testified that since surgery what seems to still cause her



symptoms was like after performing her job at work she would have soreness in her wrists, her elbow and some tingling down her arm. Petitioner indicated that other than trying to clean or something like that she had no hobbies or activities that have been adversely affected. Petitioner indicated in her job she does use tools in the machines that vibrate; the entire machine itself vibrates and sometimes she has both hands on it. Petitioner testified that she does use a power washer at work and that does vibrate. Petitioner does take Tylenol or Aleve and she takes that whenever she has pain, maybe every 2-4 hours. Petitioner testified that when she is not having pain or symptoms she pretty much stays away from the medication. Petitioner was not taking any medications regarding her diabetic condition at this time. Petitioner testified that since this situation she had lost fifteen-(15) pounds.

- **ON REVIEW,**
  --Petitioner had argued that the Arbitrator's decision finding Petitioner failed to prove that she sustained accidental injuries that arose out of and in the course of her employment with Respondent and failed to give timely notice of said injuries is clearly erroneous and must be reversed. Petitioner argued that Petitioner did sustain accidental injuries that arose out of and in the course of her employment with Respondent which are causally related to her condition of ill-being; repetitive trauma. Petitioner argued the Arbitrator completely ignored prior case law which holds that job duties Petitioner performed as a machine operator can cause or contribute to the development of repetitive injuries. The Arbitrator erred in declining to comment on the cases and in failing to distinguish Petitioner's cases from any that had been previously found to be compensable by the Commission. Petitioner argued that it is clear that Petitioner's testimony on moving 96 or more pouches while working for the same employer in the same job position is entirely credible and in line with prior case law established by the Commission. Petitioner argued Petitioner's injuries manifested December 22, 2011. Petitioner argued that Petitioner gave timely notice of her injuries.
  --Petitioner argued that the medical services provided to Petitioner were reasonable and necessary; Petitioner is entitled to medical and TTD benefits under the Act.
  --Petitioner argued Petitioner sustained serious and permanent injuries that resulted in the 15% loss of her right and left hands.
  --Petitioner argued Respondent has engaged in unreasonable and vexatious behavior that warrants penalties under §16, §19(k), and §19(l) of the Act. Petitioner argued that liability is clear and Respondent engaged in a frivolous defense which did not present a real controversy. Petitioner argued that Respondent asked their examiner to change his opinion without factual or objective medical findings to warrant any change in opinion.

- The Circuit Court, thereafter, reversed the Commission decision finding accident, causal connection, and notice. Respondent appealed to the Appellate Court who affirmed the decision of the Circuit Court and remanded the case back to the Commission for determination of benefits.

The Commission notes that on the Request for Hearing sheet, Petitioner claimed 10 weeks of temporary total disability-(TTD), 2/26/13-5/7/13-($4,993.40).

The Commission notes that Petitioner evidenced medical bills from Petitioner's Review PX 1: evidenced total bills $17,792.00.

Dr. Ajao Oladele, Koch Health Center	$ 210.00
Gateway Regional Medical Center	$4,990.00
Dr. Naseer	$1,170.00
Dr. Peter J. Anderson, SW Illinois Orthopedics, Ltd.	$3,028.00
Edwardsville Surgery Center	$6,929.00
Vigilant Anesthesia Care	$1,465.00

The Commission notes that on Review, Petitioner had argued Petitioner sustained serious and permanent injuries that resulted in the 15% loss of her right and left hands. The Appellate Court noted bilateral CTS and left ulnar neuropathy benefits needed to be determined.
At the initial hearing, Petitioner testified that at some point she was referred to Dr. Anderson who ultimately performed surgery (she noted at the palms of her hands). Petitioner testified that prior to surgery things were not great for her. Petitioner stated that prior to surgery her hands were just numb and she was having problems with soreness and problems holding things. Petitioner stated after surgery her condition had improved for both hands. Petitioner was not referred for any therapy after surgery; the doctor had her wear her braces at night when she slept and advised to sleep with her arm out and she testified that helped a little also. Petitioner testified to this day her condition had remained improved. Petitioner testified that despite her improvement she does still have occasional problems depending on the level of her activity. Petitioner did not have any problems at the hearing with her hands resting in her lap. Petitioner testified that prior to surgery just sitting she was still having big problems. Petitioner testified that since surgery what seems to still cause her symptoms was like after performing her job at work she would have soreness in her wrists, her elbow and some tingling down her arm. Petitioner indicated that other than trying to clean or something like that she had no hobbies or activities that have been adversely affected. Petitioner indicated in her job she does use tools in the machines that vibrate; the entire machine itself vibrates and sometimes she has both hands on it. Petitioner testified that she does use a power washer at work and that does vibrate. Petitioner does take Tylenol or Aleve and she takes that whenever she has pain, maybe every 2-4 hours. Petitioner testified that when she is not having pain or symptoms she pretty much stays away from the medication. Petitioner was not taking any medications regarding her diabetic condition at this time. Petitioner testified that since this situation she had lost fifteen-(15) pounds.

The Commission finds that as the Appellate Court affirmed the decision of the Circuit Court's finding of accident, causal connection, and notice and remanded the matter back for determination of benefits due to Petitioner. The Commission, herein, with that finding, remands the matter back to the Arbitrator for determination of any and all benefits due.

IT IS THEREFORE ORDERED BY THE COMMISSION that the matter is remanded back to the Arbitrator for determination of temporary total disability benefits, medical expense benefits, and permanent partial disability benefits due.

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: OCT 2 8 2016
d-9/8/16
DLG/jsf
045

David Gore

Stephen Mathis

Mario Basurto

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

COLLINS, NICHOLE
Employee/Petitioner

Case# **12WC010992**

16IWCC0694

KRAFT FOODS
Employer/Respondent

On 6/16/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

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

0560 WIEDNER & McAULIFFE LTD
MARY C SABATINO
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Nichole Collins
Employee/Petitioner

v.

Kraft Foods
Employer/Respondent

Case # **12 WC 10992**

Consolidated cases: **N/A**

16IWCC0694

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Belleville**, on **April 15, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [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 the date of accident, **12/22/11**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident ***was not*** given to Respondent.

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

In the year preceding the injury, Petitioner earned **$38,948.71**; the average weekly wage was **$749.01**.

On the date of accident, Petitioner was 40 years of age, ***single*** with **1** dependent child.

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

Respondent is entitled to a general credit towards TTD for any short term disability/ non-occupational disability benefits paid in accordance with Section 8(j) of the Act.

Respondent is entitled to a general credit under Section 8(j) of the Act for any medical bills it may have paid.

ORDER

Petitioner failed to prove she sustained an accident on December 22, 2011 that arose out of and in the course of her employment with Respondent or that her condition of ill-being in her hands was causally related to her employment with Respondent. Petitioner also failed to prove she provided timely notice of her alleged accident as required by the Act. Petitioner's claim for compensation is denied.

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

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

Nancy Lindsay
Signature of Arbitrator

June 11, 2014
Date

JUN 16 2014

NICHOLE COLLINS V. KRAFT FOODS, *12 WC 10992*

FINDINGS OF FACT AND CONCLUSIONS OF LAW

At the time of arbitration the disputed issues were: accident; notice; causal connection; medical expenses, temporary total disability benefits; nature and extent; and penalties and attorney's fees. Two witnesses testified at the hearing: Petitioner and Ray Durbin. Petitioner alleges repetitive trauma injuries to her hands and arms with a manifestation date of December 22, 2011.

The Arbitrator finds:

According to the medical records admitted into evidence, on December 27, 2006, Petitioner was seen at Koch Health Center by Dr. Ajao Oladele (hereinafter referred to as "Dr. Ajao"). Petitioner had a variety of concerns including possible depression, a recurrent chest knot, and pain in her right forearm as well as the 3rd and 4th fingers of both hands which was reportedly worse with activities of typing and computer use. Her diagnoses that day included depression, a possible sebaceous cyst, possible diabetes mellitus, morbid obesity, and possible carpal tunnel syndrome. With regard to Petitioner's hand complaints, the plan was to obtain nerve conduction studies. (RX 5)

On March 5, 2007, Dr. Ajao again saw Petitioner for several concerns, including headaches, hair loss, and irritability. Dr. Ajao noted no hand or wrist complaints; however, Petitioner complained of lower extremity complaints and wondered whether she might have restless leg syndrome. As a follow-up to her earlier visit in December Petitioner had undergone lab work and Dr. Ajao now diagnosed Petitioner as diabetic. He also continued to diagnose possible carpal tunnel syndrome and continued to recommend a nerve conduction study. (RX 5)

A handwritten note from Dr. Ajao on October 15, 2007 notes that Petitioner was experiencing shooting pains in her hands, causing her fingers to go numb. She was unable to

raise her arm, and simply flexing her fingers hurt. Since Tylenol did not relieve her symptoms, she requested pain medication. She was instructed to present to the emergency room[1]. (RX 5)

Petitioner began working for Respondent in April of 2009 on a part-time basis and she became full-time in November of 2009.

Petitioner was seen by Dr. Ajao in follow-up on October 11, 2010, having last been seen on January 30, 2009[2]. She was noted to work on an assembly line and was on her feet for several hours during the day. Her primary complaints that day were that her feet hurt and her right hand would go numb, especially her fingers. She noticed the numbness in her hand mostly when lying down. Dr. Ajao also noted Petitioner's job involved "lifting [illegible] boxes and also separates and unfolds boxes." (PX 3, RX 5)

On December 9, 2011, Petitioner returned to Dr. Ajao with the chief complaint of tingling in the first and fourth fingers of her right hand. Dr. Ajao indicated that Petitioner had last been seen on November 4, 2010[3], and that "it does not matter what she is doing, whether she is on the computer mouse or involved in other activities, she notices numbness in the 1st, 2nd, 3rd, and 4th fingers of her right hand." The doctor recorded a prior medical history of hypertension, diet-controlled diabetes, hypercholesterolemia, anemia, and obesity. Petitioner was noted to be 5'9" tall and weighing 324 pounds with a body mass index of 47. She had a positive Tinel's sign in her right hand. Dr. Ajao's assessment was neuropathy of the right hand and morbid obesity. Nerve conduction studies, labs, and a mammogram were recommended. (PX 3; PX 4)

Dr. Riaz Naseer completed nerve conduction studies on December 22, 2011, at Gateway Regional Medical Center. Dr. Naseer noted "complains of numbness, patient is diabetic."

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[1] No ER visit is in the record.
[2] No January 30, 2009 office note is in the record.
[3] No November 4, 2010 office note is in the record.

Petitioner's studies were interpreted as showing bilateral carpal tunnel syndrome, right greater than left, and left ulnar neuropathy around the elbow. (PX 3, 4)

On January 5, 2012, Petitioner followed up with Dr. Ajao. She stated her hands hurt and that she could not open water bottles. On exam, tenderness was noted around the radial aspect of Petitioner's right wrist. Petitioner's past medical history was notable for hypertension, obesity, diabetes, hypercholesterolemia, and anemia. The doctor reviewed Petitoner's December 2011 EMG studies noting they revealed bilateral carpal tunnel syndrome, right more than left, as well as left ulnar neuropathy. Splints were prescribed. (PX 3)

Petitioner signed her Application for Adjustment of Claim on March 22, 2012. (AX 2)

Petitioner followed-up with Dr. Ajao on April 25, 2012. Her primary complaint was of achiness and numbness in her hands. Petitioner had been using her cock-up splints but still had pain in her forearms, especially on the right. Petitioner's medical history was significant for carpal tunnel syndrome, left ulnar neuropathy, diabetes mellitus, hypercholesterolemia, anemia, and obesity. The plan was to start her on a course of iron replacement and be seen by an orthopedic surgeon. (PX 3)

Dr. Peter Anderson, an orthopedic surgeon, evaluated Petitioner on May 8, 2012 regarding her complaints of wrist pain. Petitioner reported a history of numbness and tingling in her hand for "quite some time." He reviewed Petitioner's EMG, conducted an examination (positive Phalen's), reviewed her x-rays, and then diagnosed her with bilateral carpal tunnel syndrome and, having tried braces and the passage of time, recommended bilateral carpal tunnel releases. (PX 5)

Dr. Richard Howard conducted an Independent Medical Examination on August 6, 2012. A written report followed. (RX 1). Petitioner reported that her symptoms began after she began

working for Respondent. However, Dr. Howard noted he had reviewed medical records dating back to 2006 revealing similar symptoms. Additionally, he noted that Petitioner had a number of pre-disposing factors for developing carpal tunnel syndrome including diabetes, morbid obesity, gender, and age. He also reviewed post-incident medical records, a job description, and conducted a physical examination. He diagnosed Petitioner with bilateral carpal tunnel syndrome and left cubital tunnel syndrome. Although he noted that Petitioner's work might be considered "repetitive," in nature he believed it was only a "minor factor" in the development of her condition, as it was not particularly "grip intensive." He recommended bilateral carpal tunnel releases, but did not believe that the need for treatment was related to Petitioner's work due to the fact that Petitioner experienced similar symptoms prior to her employment with Respondent. With respect to the left cubital tunnel syndrome, Dr. Howard noted there were no objective findings on examination to support the same.

On October 16, 2012, Dr. Howard prepared an addendum IME report. (RX 2) In that report he clarified that by using the term "minor factor" he meant that Petitioner's work activities were no more significant than her activities of daily living. He reiterated that Petitioner's work was not particularly grip intensive and did not require significant grip intensive work.

Petitioner returned to Dr. Anderson on February 19, 2013. He continued to recommend bilateral carpal tunnel releases. (PX 5).

Petitioner underwent a right carpal tunnel release on February 26, 2013. (PX 5, 6) According to the History and Physical form pre-surgery, Petitioner's numbness and tingling was described as "chronic" in nature. Petitioner had problems with daily activities. No mention of work was made. (PX 6)

At her post-op visit on March 12, 2013 Petitioner was described as having had a nice result from her surgery and when she noted numbness and tingling in her fourth and fifth fingers she was advised that was an ulnar nerve problem. Proceeding with the left wrist was discussed and agreed upon. (PX 5)

Petitioner subsequently underwent a left carpal tunnel release on March 27, 2013. (PX 5, 6) In Petitioner's History and Physical form pre-dating surgery there is no mention of Petitioner's work activities and any correlation with her hand/wrist complaints. On April 9, 2013 Petitioner reported some scar sensitivity on the right hand along with a little numbness and tingling; however, overall she was improved. Petitioner was advised to massage the scar and wear her splint, if necessary. (PX 5)

Respondent took Dr. Howard's deposition on April 22, 2013. (RX 3) Dr. Howard is a board certified orthopedic surgeon with a certificate of added qualification in hand surgery. (RX 3, p.6) He testified that he performs about 20 carpal tunnel releases per month. (RX 3, p.7) Dr. Howard testified according to his report. (RX 3, p.9) Additionally, he stated that based upon the job description provided to him (marked as RX 4), as well as Petitioner's oral job description at the time of the examination, he did not feel there was anything particularly repetitive about Petitioner's activities. Therefore, he could not say to any degree of medical certainty that Petitioner's condition was exacerbated, accelerated, or aggravated by her work duties. (RX 3, p.12). He felt Petitioner would have needed carpal tunnel releases regardless of her occupation. (RX 3, p.13). He further noted that Petitioner had several predisposing factors to developing carpal tunnel syndrome including obesity, age, and diabetes. (RX 3, p.14). With respect to the left cubital tunnel syndrome, he did not recommend surgical intervention based on the lack of objective physical exam findings.

On cross-examination, Dr. Howard acknowledged that he had slightly misstated the prior treatment records in certain portions. For example, he noted he had summarized his review of the medical records stating Petitioner had been experiencing prior pain and numbness and tingling in her hands, whereas if one looked at the specific medical record from her prior complaints of pain, the words "numbness" and "tingling" might not have actually been found in the records. (RX 3, p.22). However, on re-direct examination Dr. Howard once again noted that there were medical records indicating pain and numbness in her hands pre-dating Petitioner's date of accident in this case. (RX 3, p.32)

On May 7, 2013, Petitioner followed up with Dr. Anderson. She reported she was doing "fine" overall, but she still had some numbness and tingling in her hands. Dr. Anderson recommended Petitioner wear her splint at night. Petitioner was released to return to work full duty in a week or so. He anticipated the ongoing numbness and tingling would resolve.. (PX 5)

Dr. Anderson placed Petitioner at maximum medical improvement (MMI) on June 4, 2013. He noted minor pain over Petitioner's incisions and that Petitioner was back working full duty. Some ulnar neuropathy was present on the left hand, but Dr. Anderson indicated he hoped this would get better with time. Petitioner was released to return as needed. (PX 5)

Dr. Peter Anderson's deposition was taken on January 23, 2014. (PX 11) Dr. Anderson is a board certified orthopedic surgeon. (PX 11, p.4) Dr. Anderson testified in accordance with his records, namely that he began treating Petitioner in May of 2012 at which time he recommended bilateral carpal tunnel releases, and they were performed in February and March. (PX 11, p.6-8) Dr. Anderson released Petitioner to full-duty work without restrictions in June of 2013. He had not seen her in follow-up since that time. (PX 11, p.7)

Dr. Anderson testified that despite the fact he did not have any mention of Petitioner's job activities throughout his medical records, he believed her job was, at a minimum, an aggravation of her bilateral carpal tunnel syndrome, and necessitated the need for bilateral carpal tunnel releases. (PX 11, p.11). He reached this opinion having been presented with a full page hand-written job description prepared by Petitioner wherein she described her job as a machine operator. (PX 11, p.10 - Dep. Ex. 2; PX 7) Dr. Anderson was asked to review it and comment on whether or not he believed her job activities were the cause or, at a minimum, an aggravating factor, and after reviewing the same, he testified he believed Petitioner's job contributed to the development and/or aggravation of Petitioner's symptoms in her hands. (PX 11, p.11)

On cross-examination, Dr. Anderson admitted he had never referenced Petitioner's job activities throughout his medical records and he did not know how long Petitioner had been working for Respondent. (PX 11, p.18-19) He indicated that he usually puts such information in his notes. Accordingly, he admitted he could not testify from memory as to what Petitioner's job duties were. In regard to the job description he reviewed on the spot, he had no answer as to what percentage of Petitioner's job she spent performing the various activities. (PX 11, p.20). However, he indicated that his opinion might change if Petitioner had breaks when using her hands. (PX 11, p.22). Additionally, when asked to explain in detail which job duties specifically would have caused an aggravation of her symptoms, Dr. Anderson testified that "typically carpal tunnel is aggravated by activity such as a lot of lifting, repetitive activity, heavy lifting, things like that." (PX 11, pp. 19-20) He did not know what percentage of Petitioner's job was spent with heavy lifting. In looking over Petitioner's job description he thought repacking 200 times a day was relatively repetitive but he didn't know if she did that back to back. Dr. Anderson further testified that he didn't consider six ounces as heavy lifting but twenty pounds would be. He also

acknowledged that everyone is different in terms of what they consider heavy lifting. When asked if performing a variety of different jobs throughout the day would matter, he replied "no" because Petitioner described lots of activities all of which used her hands. He did note, however, that having breaks might make a difference. (PX 11, p. 22)

Dr. Anderson further acknowledged that he did not review any of Petitioner's medical records prior to the December 22, 2011 EMG. (PX 11, p.15). Additionally, he agreed that Petitioner had several factors predisposing her to developing carpal tunnel, which included her age, being female, being obese[4], and suffering from diabetes. (PX 11, p.22). With regard to Petitioner's elbow, Dr. Anderson noted he described Petitioner as having ulnar neuropathy in his June 4, 2013 office note. The doctor testified he counseled Petitioner to sleep with her arm straight and avoid hyperflexing it -- "general things." He acknowledged Petitioner had less of a problem with her elbow than her hands. (PX 11, pp. 24-25)

At the arbitration hearing Petitioner testified that she was hired on April 6, 2009 and worked in a part-time capacity (30-40 hours/week) until November 30, 2009, after which she became full-time. Petitioner was a machine operator.

Petitioner testified that she performed work duties consistent with her handwritten job description, which was introduced at trial as PX 7. Specifically, she worked 12 hour shifts, 3-4 times per week. She stated she ran one machine and was required to lift about 96 boxes per shift filled with flat pouches weighing about 20 pounds each (or about 9 boxes per hour). She would carry the boxes five or six steps to the filler at about waist level. Then she would pick up 160-170 empty pouches and put them into the magazine. However, if the machine was full she would have to wait several minutes before filling it. "Floaters" were available to help load the boxes and pouches. The role of a floater is a separate position with Respondent, and the primary

[4] He acknowledged on cross that 5'9" and 325 lbs. would be obese. (PX 11, p. 22)

responsibility of a floater was to unload the boxes and load the machine with pouches so that the operator could perform mandatory quality checks.

According to Petitioner, if boxes came out improperly, Petitioner would open the box with a tool, repack the pouches, and then glue the box shut. She estimated that she did this about 20-25 times on a good day (when the machine was working efficiently), and 200 times per day on a bad day (when the machine was acting up). Petitioner also worked every other Saturday and helped clean the machines. She stated that the cleaning process took four hours, and she would use a power washer for about two hours, in addition to her other cleaning duties. Petitioner only used the power washer perhaps every two weeks.

Petitioner also conducted quality checks. She checked the seals on the pouches about every 20-30 minutes. She also performed temperature checks every 30-40 minutes. There were also several other quality checks Petitioner performed.

Finally, Petitioner stated that she sometimes had to "hand stack" in "secondary." This involved picking up four of the ten pack boxes and loading them onto pallets. However, she stated that there was normally a palletizer that handled this portion of the job. As a result, she was not typically required to hand stack during every shift.

Petitioner testified that the machine she worked on vibrated. She also occasionally used a power washer that vibrated.

According to PX 7 filling the magazines required Petitioner to extend her arms up and out to load, causing pain in her arm and neck areas. Petitioner also had to widen her hand to grasp filled boxes which caused "immense pain." Petitioner also experienced pain with prying open boxes, refilling, and sealing them. Using the power washer would cause "excruciating pain from [her] finger tips up to [her] neck." Finally, hand stacking made "every part of [her] hurt;

[her] arm, [her] hands, [her] neck; [her] back, and because [she stands] for so longs [sic] [her] feet as well." (PX 7)

Petitioner testified that she began developing increasing symptoms in her arms and hands while working for Respondent and that she especially noticed her symptoms when lifting boxes to feed the machines and when taking handfuls of pouches to fill the magazines. Petitioner testified that her hands would occasionally go numb and she would notice tingling in her fingers. Petitioner recalled dropping boxes of handfuls of pouches and big rolls of straws. According to Petitioner the pain would shoot up her arm, past her elbow, and into her shoulder. Petitioner testified that her family doctor referred her for nerve conduction tests which were performed on December 22, 2011.

Petitioner testified that she became aware that she had a work-related problem on December 22, 2011. She did not speak with Dr. Naseer (who performed the test) or anyone from his office after the test.

Petitioner testified that after she received her test results she informed Respondent. She "believed" she told her lead, Melinda Pullman, and her supervisor, Ray Durbin. She "believed" she asked to fill out or was given an accident/incident report and she "believed" she signed it.

Petitioner testified that prior to her surgery her hands were not that great and they were numb and sore and she was having trouble holding things. She did not have any physical therapy after the surgery. Her hands did improve after surgery but she still notices occasional problems depending on her level of activity. She had some complaints of soreness in her wrists and elbow, along with tingling after performing her job, but her hobbies or activities have not been adversely affected. She was not on any prescription medication, and only took Tylenol or Aleve as needed.

She had not had any follow up visits for hand pain after June of 2013. Petitioner testified that she has incisions over the palms of her hands due to the surgeries.

Petitioner testified that she had reviewed records from Southern Illinois Healthcare showing she had symptoms of numbness and tingling back in 2007; however, she further testified she was not tested for carpal or cubital tunnel syndrome at that time. She testified to being seen by one of Respondent's doctors, presumably pre-employment. Petitioner acknowledged she has been diagnosed with diabetes and that she controls it by eating correctly.

On cross-examination Petitioner testified that she believed she filled out an accident report in January of 2012 but she wasn't sure. The parties stipulated that Petitioner had no recollection of what was in her prior medical records but that whatever is contained in them is correct. She knew she had bilateral hand complaints in 2007 but didn't know if she did in 2006 -- she suspected she must have slept on her hand or something. She further acknowledged that in 2011 before her surgery she noticed complaints with "pretty much" any activity involving the use of her hands.

Petitioner testified that she was released to full duty and resumed the job she had before her injury. She has not been back to see Dr. Anderson or any other doctor for hand pain since Dr. Anderson released her. She has no doctor's appointments pending for her hands.

Petitioner's former supervisor, Ray Durbin, also testified at trial. Although he indicated that Petitioner told him she was having wrist pain and she requested a splint for her wrist, he could not recall when that occurred and denied that Petitioner reported a work-related injury. He further testified that he had reviewed Petitioner's personnel file and could not locate any Form 45 relating to alleged repetitive trauma; he was able to locate a Form 45 relating to an acute

shoulder injury filed in January of 2012. He stated that a Form 45 would have been completed if Petitioner had reported a work-related incident.

Mr. Durbin was also asked about Petitioner's job description and he "somewhat" disagreed with it -- primarily the part about loading 96 boxes of pouches. Having heard her testimony, he otherwise thought what she said was correct.

Respondent's Exhibit 4 is a job description for a filler operator. (RX 4)

It is unclear when Petitioner's Petition for Penalties and Fees was filed but a copy was served on Respondent on/about April 11, 2014 (AX 5) and Respondent filed its Response on April 14, 2014. (AX 6)

The Arbitrator concludes:

1. **As to C, whether an accident occurred that arose out of and in the course of Petitioner's employment, and as to F, whether the Petitioner's present condition of ill-being is causally related to the injury:**

The law is clear that in a repetitive trauma case the unique facts of each case must be closely and independently analyzed. Having done so, the Arbitrator concludes that Petitioner did not sustain an accident which arose out of and in the course of her employment with Respondent, nor is her condition of ill-being in her hands/wrists or arms related to her alleged repetitive trauma. The Arbitrator's decision is based on several factors: 1) Petitioner's lack of credibility regarding the onset of her symptoms; 2) the lack of corroboration within the medical records to support Petitioner's testimony; 3) Dr. Anderson's limited understanding of Petitioner's prior medical history and job duties; and 4) Dr. Howard's credible opinion which took into account Petitioner's prior complaints, pre-disposing factors, and job duties.

Whether one's alleged accident is based upon a theory of repetitive trauma or a specific trauma, the burden is still on the claimant to establish an accident by a preponderance of the credible evidence. In a case of specific trauma, a claimant's testimony as to accident can be deemed credible and persuasive if it is corroborated by, and consistent with, the objective medical records. If a claimant's testimony as to accident is detailed in the treating records, this gives weight to the claimant's testimony. This standard should be no less applicable in a repetitive trauma case. As such, the Arbitrator notes that Petitioner testified to the gradual increase in hand and arm symptoms while working for Respondent and that, eventually, she even noticed she was dropping things. However, this history is not noted in any of Petitioner's medical records. Work is never mentioned except for the visit of October 11, 2010 but that is in conjunction with Petitioner's complaints regarding her feet. There is no correlation between any work activities and her hand complaints. Furthermore, when Petitioner presented to Dr. Ajao on that date, she only had right hand complaints. When she next presented to the doctor on December 9, 2011, she still did not associate her complaints with her job for Respondent and her symptoms were still limited to her right hand. Of additional significance is the doctor's notation in December of 2011 that it didn't matter what Petitioner was doing -- her hands hurt. When Petitioner underwent her nerve conduction study on December 22, 2011 she did not associate her complaints with her work activities for Respondent; rather, it was noted that she was diabetic. Finally, Petitioner began treating with Dr. Anderson on May 8, 2012. His medical records are silent as to any reference/association/correlation between Petitioner's complaints and her work duties for Respondent. Additionally, his initial office notes are a little vague regarding whether he was addressing both of Petitioner's wrists or just her right wrist. In contrast, the medical records pre-dating Petitioner's employment with Respondent show bilateral hand complaints. In

sum, there is no corroboration in the medical records for Petitioner's testimony regarding a gradual onset of symptoms while working for Respondent. There are also missing records from Dr. Ajao pertinent to the time frame in issue.

A claimant also has the burden of proving by the preponderance of credible evidence that any alleged state of ill-being was caused by a workplace accident. See, e.g., *Parro v. Industrial Commission*, 260 Ill.App.3d 551 (1993). The existence of health problems of an employee prior to a work-related injury neither deprives the employee of a right to benefits nor relieves the employee of the burden of proving a causal connection between the employment and the subsequent health problems. *Neal v. Industrial Comm'n*, 141 Ill. App. 3d 289 (1986). The courts have established that when a pre-existing condition is aggravated by employment, it may constitute a work-related accident. *Peoria Motors v. Industrial Comm'n*, 92 Ill. 2d 260 (1982); *Cook Co. v. Industrial Comm'n*, 68 Ill. 2d 24 (1977). However, the claimant bears the burden of showing that the pre-existing condition was aggravated by the employment and that the aggravation occurred as a result of an accident which arose out of and in the course of his employment. *Lawless v. Industrial Comm'n*, 96 Ill. 2d 260 (1983); *Lyons v. Industrial Comm'n*, 96 Ill. 2d 198 (1983). Additionally, compensation will be denied where an injured employee's health has deteriorated so that any normal daily activity is an aggravation. *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill. 2d 193 (2003).

In this case, Petitioner had symptoms in her bilateral hands dating back to 2006. These symptoms developed well before her employment with Respondent. At one point, her pain was so severe that she requested prescription strength medication and was instructed to go to the hospital for treatment. She had even been advised to undergo an EMG/NCV on several

occasions but apparently never followed up. Petitioner also has risk factors associated with carpal tunnel syndrome.

Petitioner's credibility in this instance is called into question in two ways. One was her inability to remember her prior problems. Second, were the many times she testified to what she "believed" she had done -- as with the giving of notice. Despite her documented prior complaints of severe bilateral hand pain, numbness, and tingling, Petitioner testified that she had absolutely no recollection of undergoing any treatment prior to her employment with Respondent. She further denied any knowledge of being referred for an EMG/NCV despite being referred on two separate occasions in 2006 and 2007. The Arbitrator would expect Petitioner to recall, at least, some of her prior treatment given the severity of her complaints. Petitioner also gave a history to Dr. Howard of only experiencing symptoms for one year, despite the medical records to the contrary.

Based upon the lack of clarity and certainty in Petitioner's testimony, the Arbitrator concludes that Petitioner was not a credible historian regarding the development of her symptoms. The Arbitrator places greater reliance on the unbiased and objective medical records. In addition to Petitioner's credibility concerns and the lack of corroboration for her testimony contained within in the records, the Arbitrator finds Dr. Anderson's opinion lacks credibility in comparison to Dr. Howard's. It is well established that in repetitive trauma claims, the claimant generally relies on medical testimony establishing a causal connection between the work performed and the claimant's disability. *Nunn v. Industrial Comm'n*, 157 Ill. App. 3d 470, 477 (4th Dist. 1987). Although medical testimony as to causation is not necessarily always required, where the question is one within the knowledge of experts only and not within the common knowledge of laypersons, expert testimony is necessary to show that a claimant's work activities

caused the condition complained of. *Id.* at 478. In such cases there must be a showing that the injury is work-related and not the result of a normal degenerative aging process. *Id.*

In addition, even where a doctor provides an opinion as to causation, it is well established that a doctor's findings and opinions can be undermined, or even discarded, through reliance on inaccurate or incomplete information. *Comer v. Nabisco*, 1999 Ill. Wrk. Comp. LEXIS 532; See also, *Horath v. Industrial Comm'n*, 96 Ill.2d 349 (1980) (holding that treating physician's opinion was undermined by the fact that Petitioner gave a slightly different history in a subsequent examination).

Unlike Dr. Anderson, Dr. Howard had the opportunity to review all of Petitioner's medical records, including records documenting prior bilateral hand complaints dating back to 2006. Based on the prior records, Dr. Howard came to the conclusion that Petitioner would have required the bilateral carpal tunnel release regardless of her employment with Respondent. In contrast, Dr. Anderson testified that he did not review any of Petitioner's records prior to the December 22, 2011 EMG, and, therefore, he had no knowledge regarding the extent of Petitioner's prior complaints.

Dr. Howard also had the opportunity to review a written job description, in addition to taking a job description from Petitioner. Based on Petitioner's description, he did not believe that Petitioner's job duties were particularly hand intensive. Therefore, he could not say to any degree of medical certainty that her condition was exacerbated, accelerated, or aggravated by her work duties. While he did acknowledge that Petitioner's job duties would be a "minor factor;" he clarified that he meant Petitioner's job activities were no more of an aggravation than her activities of daily living. This would be consistent with what Petitioner told Dr. Ajao in December of 2011 -- it didn't matter what she was doing, her hands hurt.

Dr. Anderson did not record a job description in his medical records. He acknowledged that he typically would record a description if he had taken one. Ultimately, his understanding was based on a written job description from Petitioner (PX 7), which he did not review until the date of his deposition. In regard to the job description he reviewed on the spot, he had no answer as to what percentage of Petitioner's job she spent doing the various activities. (PX 11, p.20).

Additionally, it is undisputed that Petitioner had several factors which pre-disposed her to the development of carpal tunnel including obesity, diabetes, female gender, and age. In conjunction with the fact that Petitioner had carpal tunnel symptoms prior to her employment with Respondent, this further supports Dr. Howard's conclusion that Petitioner's current condition is not work-related.

In contrast, Dr. Howard's opinion was well reasoned and based on a complete understanding of Petitioner's prior history and job duties.

Finally, the Arbitrator notes that Petitioner's Application for Adjustment of Claim alleges bilateral arm injuries in addition to hand injuries. Petitioner has failed to prove she sustained a repetitive trauma injury to her arms/elbows. While nerve conduction studies revealed left cubital tunnel syndrome Petitioner was asymptomatic regarding the condition when seen by Dr. Ajao. Petitioner has voiced no right-sided elbow complaints nor has she been diagnosed with any right elbow condition.

2. As to E, whether timely notice was given of the accident:

Petitioner failed to prove she provided timely notice of her accident to Respondent. Section 6(c) of the Act requires an injured worked to report her injury to her employer within 45 days of the alleged work-related accident.

The Illinois Supreme Court has held that Section 6(c) of the Workers' Compensation Act prohibits any claims under the Act unless the employee gives notice of his injury within 45 days of the accident. *Lambert v. Industrial Comm'n.*, 79 Ill. 2d 243, 247 (1980). The giving of notice to the employer within 45 days of the accident pursuant to section 6(c) of the Workers' Compensation Act is jurisdictional and a prerequisite of the right to maintain a proceeding under the Act. *Ristow v. Industrial Comm'n*, 39 Ill. 2d 410, 413 (1968). Mere knowledge that the Petitioner was having problems with her hands is not sufficient to establish proper notice for a workers' compensation claim. In *White v. Industrial Comm'n*, 374 Ill.App.3d 907 (2007), although the employer knew the Petitioner was injured before the date in question, the record did not show the appraisal of "industrial injuries." The Appellate Court held that the purpose of the notice requirement is to enable the employer to investigate the employee's alleged industrial accident. White, 374 Ill. App. 3d at 911.

In *Robison v. USF Holland*, 6 IWCC 118, 2006 Ill. Wrk. Comp. LEXIS 136 (2006), the Commission denied claimant's request for benefits when notice was given 1 day after the time for providing notice had run under Section 6(c) of the Act. Noting that "Section 6(c) of the Act is a jurisdictional requirement and is not discretionary," the Commission advised that the Respondent is not required to show prejudice when notice is given outside the 45 day requirement. "The language of Section 6(c) of the Act provides that the element of prejudice is invoked only when some notice is given but that such notice is defective or inaccurate." In so holding, the Commission concluded claimant failed to provide timely notice and accordingly denied the claimant's demand for benefits for a work-related injury. A similar decision was reached in *Donley v. Kraft Foods, Inc.*, 12 IWCC 640, 2012 Ill. Work. Comp. LEXIS 636

(2012), where the Commission upheld the decision of the Arbitrator denying benefits based on a lack of notice. In that case, the Application was filed 59 days after the alleged date of injury.

In this case, Petitioner testified that she gave notice of the incident to her supervisor Ray Durbin, and her lead, Melinda Pullman, sometime after her manifestation date of December 22, 2011. She further testified that she signed a report of the incident. Although Mr. Durbin testified that he was advised at some point by Petitioner of her wrist complaints, he stated that Petitioner never reported the same as being work-related. Had she, a Form 45 would have been completed. Additionally, upon reviewing Petitioner's personnel file, Mr. Durbin was unable to locate a Form 45 relating to Petitioner's alleged repetitive trauma.

Mr. Durbin was able to locate a Form 45 relating to an alleged January 2012 incident involving Petitioner's left shoulder. The Arbitrator notes that the January 2012 Form 45 was completed relatively close in time to Petitioner's alleged manifestation date of December 22, 2011. This is significant in that it shows Petitioner was aware of the reporting procedures and understood how to report a work-related injury. Despite this fact, no Form 45 related to the December 22, 2011 repetitive trauma claim was prepared.

Finally, in weighing the testimony of Petitioner and Mr. Durbin on the issue of notice, the Arbitrator notes the certainty with which Mr. Durbin testified as compared to that of Petitioner who, at best, "believed" she gave notice and "believed" she filled out an incident/accident report.

Given the questions surrounding Petitioner's credibility raised above, the lack of any testimony from Petitioner relating to exactly when she provided notice to Respondent, and the lack of a Form 45 relating to the incident, the Arbitrator finds that Petitioner failed to prove that she provided timely notice of the alleged accident to Respondent.

All other issues are rendered moot. Petitioner's claim for compensation is denied and no benefits are awarded.

****

STATE OF ILLINOIS	)		
	) SS.		
COUNTY OF COOK	)		

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Akindayo Ilesanmi,
Petitioner,

vs.

NO: 13WC 38271

16IWCC0695

Comcast Corporation,
Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, notice, temporary total disability, permanent partial disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 6, 2015, 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: OCT 2 8 2016
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CJD/jrc
049

Charles J. DeVriendt

Joshua D. Luskin

Ruth W. White

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

ILESANMI, AKINDAYO
Employee/Petitioner

Case# **13WC038271**

13WC038272

16IWCC0695

16IWCC0695

COMCAST CORPORATION
Employer/Respondent

On 7/6/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0062 BELL & TEPLITZ
JOEL BELL
221 N LASALLE ST SUITE 1900
CHICAGO, IL 60601

1872 SPIEGEL & CAHILL PC
BRIDGET ZEIER
15 SPINNING WHEEL RD SUITE 107
HINSDALE, IL 60521

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)

Akindayo Ilesanmi
Employee/Petitioner

v.

Comcast Corporation
Employer/Respondent

Case # 13 WC 038271

Consolidated cases: 13 WC 038272

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Jeffrey Huebsch**, Arbitrator of the Commission, in the city of **Chicago**, on **May 13, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

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

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

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

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

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

G. [ ] What were Petitioner's earnings?

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

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

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

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

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

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

N. [ ] Is Respondent due any credit?

O. [ ] Other ______

FINDINGS

On the date of accident, **March 20, 2013**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**38,577.81**; the average weekly wage was $**741.88**.

On the date of accident, Petitioner was **31** 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

Claim for compensation denied. Petitioner failed to prove a causal connection between the accidental injuries of March 20, 2013 and his current condition of ill-being.

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

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

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

Signature of Arbitrator

July 6, 2015
Date

ICArbDec19(b)

JUL 6 - 2015

FINDINGS OF FACT

This matter was tried along with a consolidated case, No. 13 WC 038272 (date of accident: 10/5/2013). Arbitrator's Exhibit 1 was a Case Information Sheet, signed by the Parties, evidencing remittal of disqualification under Rule 7030.30 (d). Arbitrator's Exhibit 2 was the Request For Hearing Form for Case No. 13 WC 038271. Arbitrator's Exhibit 3 was the Request For Hearing Form in Case No. 13 WC 038272. Arbitrator's Exhibit 4 was the Amended Application Form for Case No. 13 WC 38271, changing the date of accident from March 23, 2013 to March 20, 2013. Petitioner's oral motion to amend the Application, as stated above, was granted by the Arbitrator.

Petitioner was employed by Respondent as a communication technician. His job duties included installation and service calls for telephone, internet and cable services.

Petitioner testified that on March 20, 2013 he injured his neck while working for Respondent. He was lifting equipment out of his locker and he felt a "tweak" or muscle pull in his neck. He continued to work. A few hours later, he had a lot of pain and could not turn his neck. He did not finish work. His supervisor took Petitioner to the clinic at Resurrection Health Care.

At Resurrection, Petitioner received an x-ray and was told he had muscle inflammation. The doctor at Resurrection recommended restricted duty, ice and heat and medications. The diagnosis was "Right cervical strain." Petitioner did not work limited duty. Petitioner returned to the clinic on March 23, 2013. The diagnosis was "bilateral cervical strain." Limited duty, Prednisone and stretching exercises were prescribed. Cervical x-rays done on March 23, 2013 were said to be normal. On March 27, 2013, Petitioner was feeling better while taking the medications. He still had pain. He wanted to return to work at full duty. Petitioner was released to full duty work, PRN, on March 27, 2013. The diagnosis was "cervical/upper back strain." Petitioner was instructed to use ice/heat, Ibuprofen if needed, and to work on AROM (stretching exercises?). (ResEx. 4)

Thereafter, Petitioner worked his regular job through October 5, 2013. Petitioner testified that he had pain. He did not get better over time. Petitioner said that he told his supervisor, Esau Ratliff and the HR Manager, Eric Reynolds, of his complaints of neck pain during this time. They did not offer medical treatment. Reynolds testified that he did not recall Petitioner telling him that his neck was bothering him. If Petitioner had done so, Reynolds would have put Petitioner in touch with the person who handles workers' compensation, Annette O'Malley, and would have referred Petitioner for treatment. Neither Petitioner nor Respondent called the supervisor as a witness.

Petitioner testified that he awoke on October 9, 2013 with a stiff neck. He called his supervisor and went to see his PCP, Dr. Denenberg.

Dr. Denenberg's records show that Petitioner was seen on July 2, 2013 for a physical exam. He had complaints of left knee and ankle pain and chest pain when he stretches. There were no neck or right shoulder complaints. The neck was supple on exam, which included palpation for the thyroid and lymphnodes and an examination for bruits. Petitioner did not recall any examination of his neck on July 2. He thought that the doctor's records would be correct.

On October 9, 2013, Petitioner gave a history of six months of neck pain. He twisted something six months ago, went to clinic, x-ray negative, muscle inflammation, gave pain meds, muscle relaxant, felt

better, uncomfortable at night when wants to sleep, tension if bends down to read, no numbness, tingling or weakness. Dr. Denenberg prescribed Finasteride and recommended therapy for the neck and ankle. Dr Denenberg referred Petitioner to Dr. Mikhael at Illinois Bone & Joint. (PetEx. 1, ResEx.3)

On Cross-Examination, Petitioner confirmed that he did not have any treatment for his neck from March of 2013 through October of 2013. He did not work for Respondent on October 6, 7, or 8.

Petitioner was sent to Resurrection Health Care by Respondent on October 10, 2013. He was seen by Dr. Shah (Dr. Shah had previously seen Petitioner on March 20 and March 27, 2013), who diagnosed a non work related upper back strain and released Petitioner back to full duty work. The history was of pain in the upper back since 3/20. There was no radiation of pain and no numbness. There was no weakness. There was normal range of motion, with no tenderness or spasm. Dr. Shah charted "Upper back strain. No significant history provided. Pt claims with initial neck injury on 3/20, I as a physician suggested modified duty. Since then pain is persistent. On 3/27, he told "has no pain", he lied. Now pain is upper back. He had problem with pillow causing him pain. He saw his PCP yesterday, who suggested PT. His insurance company refused PT due to pending balance." "Explained not work related injury, due to non significant history. Physical exam WNL. To full duty." The nurse's note says that Petitioner said that he did not have another injury. "It never got better." "Yesterday I woke up with sharp pain I had to call in sick." (ResEx. 4)

Petitioner was first seen at IBJ by Dr. Mikhael on October 17, 2013. Petitioner filled out a Medical History Form on that date stating that he had neck pain for six months, the last day worked was 10/5/2013 and the date of onset/injury was 10/9/2013. The history given to Dr. Mikhael was of a neck injury six months ago at work, lifting something. He has improved and his symptoms and range of motion are significantly better, but he still has posterior neck pain that travels in his right shoulder. It has not gotten any better over the last 4 to 6 weeks. The physical exam revealed some deltoid weakness on the right and was otherwise unremarkable. Dr. Mikhael thought that the problems was most likely musculoskelatel pain. The assessment was cervicalgia and right-sided deltoid weakness. A cervical MRI was ordered and the patient was to continue with the restrictions given by his PCP (the restrictions given by Dr. Deneberg are only in the Record to the extent that they are mentioned in Dr. Weber's report). (PetEx. 2)

The MRI was done of October 24, 2013. The study showed minimal annular bulging at C2-C3, mild bulging at C3-C4, with narrowing of the subarachnoid space, but no compression on the adjacent spinal cord with spurring resulting in stenosis on the right side (a concomitant protrusion would be difficult to exclude), bulging discs with annular tears at C4-C5 and C5-C6 were also noted. Dr. Mikhael thought that there was a right C3-C4 disc herniation and recommended a Medrol Dospak and referral to a pain specialist on October 25, 2013. Petitioner was taken off work as of that date. (PetEx. 2)

Petitioner had follow-up care with Dr. Hong Vo at IBJ. The history to Dr. Vo was of an injury at work on March 25, 2013, while looking down. The patient had neck and shoulder pain without radiation to the upper extremities. Dr. Vo diagnosed cervical radiculopathy and cervical herniated discs. A cervical ESI was performed and Petitioner reported 100% pain loss for 3 days. In follow-up on December 4, 2013, Dr. Vo noted full cervical range of motion. PT and Lyrica were prescribed. Dr. Mikhael's chart of February 6, 2013 relates Petitioner's right sided neck and scapular pain to an October, 2013 work injury. Petitioner continued to treat with IBJ through March 13, 2014. The bills were paid by group, but petitioner's coverage has run out. At the last visit with Dr. Mikhael on March13, 2014, the diagnosis was right sided neck and right shoulder pain after an injury at work, without neurologic deficit or weakness. The patient

should continue treatment with Dr. Vo. He should have an FCE. He was to remain on a 20 pound lifting restriction, subject to the FCE. The physical exam was negative on the last visit and Petitioner had full, painless range of motion of the neck and shoulder. The patient was at MMI from a surgical standpoint (he didn't need surgery). The diagnosis was: 1.) Cervicalgia; 2.) Right C3-C4 paracentral disc herniation. An APS completed by Dr. Mikhael on April 2, 2014 says that the patient is off work and could return with a 20 pound lifting restriction until he had a FCE. There was a history of an injury on March 25, 2013, taking equipment out of a locker. (PetEx. 2)

Petitioner was seen by Dr. Kathleen Weber for a §12 examination at the request of Respondent on February 24, 2013. Dr. Weber reviewed medical records and the MRI film and took a history from Petitioner, along with performing an orthopedic examination. Petitioner gave a history of an injury at work on March 23, 2013. He felt a tweak in his neck removing a cable from his locker. He had treatment at the clinic, was told he had muscle inflammation and went back to work 4 days later. Initially, he could not move his neck freely, but his range of motion eventually completely resolved. The doctor at the clinic asked him if he wanted PT and he said no. He continued to work without restriction and his range of motion continued to be fine. He thought that the pain would go away and then he had the same pain on October 9, 2013. He was fine when he went to bed, but when he woke up, he had difficulty moving his neck. He has been off work since then. The original "ongoing" pain from the March incident was in the posterior neck area. In October of 2013, it radiated into the scapula and right shoulder area. Petitioner denied prior or subsequent neck injuries. The physical exam showed minimal discomfort in the paraspinal muscles with full range of motion (pain at full flexion). Strength and sensation were intact. Dr. Weber thought that the MRI film revealed annular bulging at C2-3, C3-4, C4-5 and C5-6 with no herniation. Spurring at C3-C4 on the right contributed to minimal stenosis. Dr. Weber's diagnosis was mild cervical strain, resolved. Dr. Weber thought that there was no causal connection between the March incident and Petitioner's current condition regarding his cervical spine (albeit regarding a March 23, <u>2014</u> injury). Something else happened to Petitioner in October of 2013. He can work full duty, without restrictions. He continues to complain of subjective neck symptoms despite rest, ongoing treatment and PT. He should continue with a HEP. Perhaps a further ESI would benefit the patient. (ResEx. 1)

Petitioner testified that he had no prior neck or shoulder injuries and no subsequent injuries after March 20, 2013. He was fine before March of 2013. He feels better than he did before. He has pain in his neck towards the right shoulder. When questioned about the visit at Resurrection in October of 2013, Petitioner denied the history of 1 month duration of pain, denied the history of saying that he lied in March of 2013, denied a problem with his pillow. He had off and on pain after returning to work in March. The radicular symptoms arose in October.

After the IME, Petitioner returned to work for a few days. He worked in the office for a couple of days and then went out in the field. His pain increased when he lifted ladders and worked. Petitioner could not recall whether he played soccer between March and October of 2013. He believes that he needs more treatment.

CONCLUSIONS OF LAW

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

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 Arbitrator finds that Petitioner sustained accidental injuries which arose out of and in the course of his employment by Respondent on March 20, 2013, based upon the testimony of Petitioner and the medical records.

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

The Arbitrator finds that Petitioner failed to prove a causal connection between the accidental injuries of March 20, 2013 and his current condition of ill-being with respect to his neck and right shoulder.

The opinions of Dr. Weber on causation are credible and persuasive and most comport with the evidence adduced.

Unfortunately, the chart notes from Resurrection for the 3 visits in March of 2013 are missing. The Resurrection records do reveal that Petitioner was released to full duty, PRN, as of March 27, 2013.

Petitioner returned to his regular job, which obviously is a physical job, and did not seek medical care for his neck and right shoulder until after he awoke with a stiff neck on October 9, 2013. Petitioner said that he complained of neck pain during this time to his supervisor and the HR manager. The supervisor was not called by either party as a witness. The HR manager could not recall Petitioner complaining about his neck, but the usual practice (which did not occur here) would have been to refer the employee to the workers' comp contact and refer the employee for treatment. Petitioner did not recall if he played soccer between March and October of 2013.

Petitioner was seen by Dr. Denenberg for a physical exam on July 2, 2013, with a complete absence of neck/shoulder complaints or findings.

Petitioner filed a second claim for an accident date of October 5, 2013. The medical care after this date reveals subjective complaints of neck and shoulder pain that are not confirmed by objective findings, other than non-surgical pathology on the MRI. The strength, range of motion and neurologic findings that are noted by the physicians are remarkably benign throughout the course of treatment.

Based upon the above, the Arbitrator finds that Petitioner failed to prove a causal connection between the accidental injuries of March 20, 2013 and his current condition of ill-being.

WITH RESPECT TO ISSUE (L), WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY, TEMPORARY PARTIAL DISABILITY AND/OR MAINTENANCE, THE ARBITRATOR FINDS AS FOLLOWS:

As the Arbitrator has found that Petitioner failed to prove a causal connection between the accidental injuries of March 20, 2013 and his current condition of ill-being regarding his neck and right shoulder, the Arbitrator needs not decide the above 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 COOK	)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
			☐ PTD/Fatal denied
		☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Akindayo Ilesanmi,
Petitioner,

vs. NO: 13WC 38272

16IWCC0696

Comcast Corporation,
Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, notice, temporary total disability, permanent partial disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 6, 2015, 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: OCT 2 8 2016
o102616
CJD/jrc
049

Charles J. DeVriendt

Joshua D. Luskin

Ruth W. White

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

ILESANMI, AKINDAYO
Employee/Petitioner

Case# **13WC038272**

13WC038271

COMCAST CORPORATION
Employer/Respondent

16IWCC0696

On 7/6/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

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

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

0062 BELL & TEPLITZ
JOEL BELL
221 N LASALLE ST SUITE 1900
CHICAGO, IL 60601

1872 SPIEGEL & CAHILL PC
BRIDGET ZEIER
15 SPINNING WHEEL RD SUITE 107
HINSDALE, IL 60521

16IWCC0696

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)

Akindayo Ilesanmi
Employee/Petitioner

Case # 13 WC 038272

v.

Consolidated cases: 13 WC 038271

Comcast Corporation
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Jeffrey Huebsch**, Arbitrator of the Commission, in the city of **Chicago**, on **May 13, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

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

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

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

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

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

G. [ ] What were Petitioner's earnings?

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

I. [ ] What was Petitioner's marital status at the time of the accident?

J. [ ] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?

K. [ ] Is Petitioner entitled to any prospective medical care?

L. X What temporary benefits are in dispute?
[ ] TPD [ ] Maintenance X TTD

M. [ ] Should penalties or fees be imposed upon Respondent?

N. [ ] Is Respondent due any credit?

O. [ ] Other ______

FINDINGS

On the date of accident, **October 5, 2013**, Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship *did* exist between Petitioner and Respondent.

On this date, Petitioner *did 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 **$38,577.81**; the average weekly wage was **$741.88**.

On the date of accident, Petitioner was **32** 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

Claim for compensation denied. Petitioner failed to prove that he sustained accidental injuries which arose out of and in the course of his employment by Respondent on October 5, 2013.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

July 6, 2015
Date

ICArbDec19(b)

JUL 6 - 2015

FINDINGS OF FACT

This matter was tried along with a consolidated case, No. 13 WC 038271 (date of accident 3/20/2013).

Petitioner was employed by Respondent as a communication technician. His job duties included installation and service calls for telephone, internet and cable services.

Petitioner testified that on March 20, 2013 he injured his neck while working for Respondent. He was lifting equipment out of his locker and he felt a "tweak" or muscle pull in his neck. He received treatment at Resurrection Health Care on March 20, March 23 and March 27, 2013. On March 27, 2013, Petitioner was released to full duty, PRN, and he returned to his regular work as a communication technician.

Thereafter, Petitioner worked his regular job through October 5, 2013. Petitioner testified that he had pain. He did not get better over time. Petitioner said that he told his supervisor, Esau Ratliff and the HR Manager, Eric Reynolds, of his complaints of neck pain during this time. They did not offer medical treatment. Reynolds testified that he did not recall Petitioner telling him that his neck was bothering him. If Petitioner had done so, Reynolds would have put Petitioner in touch with the person who handles workers' compensation, Annette O'Malley, and would have referred Petitioner for treatment. Neither Petitioner nor Respondent called the supervisor as a witness.

Petitioner testified that he awoke on October 9, 2013 with a stiff neck. He called his supervisor and went to see his PCP, Dr. Denenberg.

Dr. Denenberg's records show that Petitioner was seen on July 2, 2013 for a physical exam. He had complaints of left knee and ankle pain and chest pain when he stretches. There were no neck or right shoulder complaints. The neck was supple on exam, which included palpation for the thyroid and lymphnodes and an examination for bruits. Petitioner did not recall any examination of his neck on July 2. He thought that the doctor's records would be correct.

On October 9, 2013, Petitioner gave a history of six months of neck pain. He twisted something six months ago, went to clinic, x-ray negative, muscle inflammation, gave pain meds, muscle relaxant, felt better, uncomfortable at night when wants to sleep, tension if bends down to read, no numbness, tingling or weakness. Dr. Denenberg prescribed Finasteride and recommended therapy for the neck and ankle. Dr Denenberg referred Petitioner to Dr. Mikhael at Illinois Bone & Joint. (PetEx. 1, ResEx.3)

On Cross-Examination, Petitioner confirmed that he did not have any treatment for his neck from March of 2013 through October of 2013. His last day of work was October 5, 2013. He did not work for Respondent on October 6, 7, or 8.

Petitioner was sent to Resurrection Health Care by Respondent on October 10, 2013. He was seen by Dr. Shah (Dr. Shah had previously seen Petitioner on March 20 and March 27, 2013), who diagnosed a non work related upper back strain and released Petitioner back to full duty work. The history was of pain in the upper back since 3/20. There was no radiation of pain and no numbness. There was no weakness. There was normal range of motion, with no tenderness or spasm. Dr. Shah charted "Upper back strain. No significant history provided. Pt claims with initial neck injury on 3/20, I as a physician suggested modified duty. Since then pain is persistent. On 3/27, he told "has no pain", he lied. Now pain is upper back. He had problem with pillow causing him pain. He saw his PCP yesterday, who suggested PT. His

insurance company refused PT due to pending balance." "Explained not work related injury, due to non significant history. Physical exam WNL. To full duty." The nurse's note says that Petitioner said that he did not have another injury. "It never got better." "Yesterday I woke up with sharp pain I had to call in sick." (ResEx. 4)

Petitioner was first seen at IBJ by Dr. Mikhael on October 17, 2013. Petitioner filled out a Medical History Form on that date stating that he had neck pain for six months, the last day worked was 10/5/2013 and the date of onset/injury was 10/9/2013. The history given to Dr. Mikhael was of a neck injury six months ago at work, lifting something. He has improved and his symptoms and range of motion are significantly better, but he still has posterior neck pain that travels in his right shoulder. It has not gotten any better over the last 4 to 6 weeks. The physical exam revealed some deltoid weakness on the right and was otherwise unremarkable. Dr. Mikhael thought that the problems was most likely musculoskeletal pain. The assessment was cervicalgia and right-sided deltoid weakness. A cervical MRI was ordered and the patient was to continue with the restrictions given by his PCP (the restrictions given by Dr. Deneberg are only in the Record to the extent that they are mentioned in Dr. Weber's report). (PetEx. 2)

The MRI was done of October 24, 2013. The study showed minimal annular bulging at C2-C3, mild bulging at C3-C4, with narrowing of the subarachnoid space, but no compression on the adjacent spinal cord with spurring resulting in stenosis on the right side (a concomitant protrusion would be difficult to exclude), bulging discs with annular tears at C4-C5 and C5-C6 were also noted. Dr. Mikhael thought that there was a right C3-C4 disc herniation and recommended a Medrol Dospak and referral to a pain specialist on October 25, 2013. Petitioner was taken off work as of that date. (PetEx. 2)

Petitioner had follow-up care with Dr. Hong Vo at IBJ. The history to Dr. Vo was of an injury at work on March 25, 2013, while looking down. The patient had neck and shoulder pain without radiation to the upper extremities. Dr. Vo diagnosed cervical radiculopathy and cervical herniated discs. A cervical ESI was performed and Petitioner reported 100% pain loss for 3 days. In follow-up on December 4, 2013, Dr. Vo noted full cervical range of motion. PT and Lyrica were prescribed. Dr. Mikhael's chart of February 6, 2013 relates Petitioner's right sided neck and scapular pain to an October, 2013 work injury. Petitioner continued to treat with IBJ through March 13, 2014. The bills were paid by group, but petitioner's coverage has run out. At the last visit with Dr. Mikhael on March13, 2014, the diagnosis was right sided neck and right shoulder pain after an injury at work, without neurologic deficit or weakness. The patient should continue treatment with Dr. Vo. He should have an FCE. He was to remain on a 20 pound lifting restriction, subject to the FCE. The physical exam was negative on the last visit and Petitioner had full, painless range of motion of the neck and shoulder. The patient was at MMI from a surgical standpoint (he didn't need surgery). The diagnosis was: 1.) Cervicalgia; 2.) Right C3-C4 paracentral disc herniation. An APS completed by Dr. Mikhael on April 2, 2014 says that the patient is off work and could return with a 20 pound lifting restriction until he had a FCE. There was a history of an injury on March 25, 2013, taking equipment out of a locker. (PetEx. 2)

Petitioner was seen by Dr. Kathleen Weber for a §12 examination at the request of Respondent on February 24, 2013. Dr. Weber reviewed medical records and the MRI film and took a history from Petitioner, along with performing an orthopedic examination. Petitioner gave a history of an injury at work on March 23, 2013. He felt a tweak in his neck removing a cable from his locker. He had treatment at the clinic, was told he had muscle inflammation and went back to work 4 days later. Initially, he could not move his neck freely, but his range of motion eventually completely resolved. The doctor at the clinic asked him if he wanted PT and he said no. He continued to work without restriction

and his range of motion continued to be fine. He thought that the pain would go away and then he had the same pain on October 9, 2013. He was fine when he went to bed, but when he woke up, he had difficulty moving his neck. He has been off work since then. The original "ongoing" pain from the March incident was in the posterior neck area. In October of 2013, it radiated into the scapula and right shoulder area. Petitioner denied prior or subsequent neck injuries. The physical exam showed minimal discomfort in the paraspinal muscles with full range of motion (pain at full flexion). Strength and sensation were intact. Dr. Weber thought that the MRI film revealed annular bulging at C2-3, C3-4, C4-5 and C5-6 with no herniation. Spurring at C3-C4 on the right contributed to minimal stenosis. Dr. Weber's diagnosis was mild cervical strain, resolved. Dr. Weber thought that there was no causal connection between the March incident and Petitioner's current condition regarding his cervical spine (albeit regarding a March 23, 2014 injury). Something else happened to Petitioner in October of 2013. The October, 2013 event was not related to work. He can work full duty, without restrictions. He continues to complain of subjective neck symptoms despite rest, ongoing treatment and PT. He should continue with a HEP. Perhaps a further ESI would benefit the patient. (ResEx. 1)

Petitioner testified that he had no prior neck or shoulder injuries and no subsequent injuries after March 20, 2013. He was fine before March of 2013. He feels better than he did before. He has pain in his neck towards the right shoulder. When questioned about the visit at Resurrection in October of 2013, Petitioner denied the history of 1 month duration of pain, denied the history of saying that he lied in March of 2013, denied a problem with his pillow. He had off and on pain after returning to work in March. The radicular symptoms arose in October.

After the IME, Petitioner returned to work for a few days. He worked in the office for a couple of days and then went out in the field. His pain increased when he lifted ladders and worked. Petitioner could not recall whether he played soccer between March and October of 2013. He believes that he needs more treatment.

CONCLUSIONS OF LAW

The Arbitrator adopts the above Findings of Fact in support of the Conclusions of Law set forth below.

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 Arbitrator finds that Petitioner failed to prove that he sustained accidental injuries which arose out of and in the course of his employment by Respondent on October 5, 2013, based upon the testimony of Petitioner and the medical records.

There was no proof of an accident or injury occurring on October 5, 2013. The claim for compensation is, therefore, denied.

WITH RESPECT TO ISSUE (E), WAS TIMELY NOTICE GIVEN TO RESPONDENT, ISSUE (F), IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY, WITH RESPECT TO ISSUE (J), WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY AND HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES, AND WITH RESPECT TO ISSUE (L), WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY, TEMPORARY PARTIAL DISABILITY AND/OR MAINTENANCE, THE ARBITRATOR FINDS AS FOLLOWS:

As the Arbitrator has found that Petitioner failed to prove that he sustained accidental injuries which arose out of and in the course of his employment by Respondent on October 5, 2013, the Arbitrator needs not decide the above issues.

STATE OF ILLINOIS	)		
	) SS.		
COUNTY OF WILL	)		

[X] Affirm and adopt (no changes)	[ ] Injured Workers' Benefit Fund (§4(d))
[ ] Affirm with changes	[ ] Rate Adjustment Fund (§8(g))
[ ] Reverse	[ ] Second Injury Fund (§8(e)18)
	[ ] PTD/Fatal denied
[ ] Modify	[X] None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Beth Kenealy,

Petitioner,

vs. NO: 14WC 18076

Excel Petroleum Transport, Inc.,

Respondent,

16IWCC0697

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of temporary total disability, medical, penalties and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 16, 2015, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner interest under §19(n) of the Act, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of Petitioner on account of said accidental injury.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $100.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: OCT 2 8 2016
o102616
CJD/jrc
049

Charles J. DeVriendt

Joshua D. Luskin

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b)/8(a) ARBITRATOR DECISION

KENEALY, BETH
Employee/Petitioner

Case# **14WC018076**

EXCEL PETROLEUM TRANSPORT INC
Employer/Respondent

16IWCC0697

On 7/16/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.10% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

0786 BRUSTIN & LUNDBLAD LTD
CHARLES E WEBSTER
10 N DEARBORN ST 7TH FL
CHICAGO, IL 60602

0445 RODDY LAW LTD
JOHN S MAGIERA
303 W MADISON ST SUITE 1900
CHICAGO, IL 60606

16IWCC0697

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)

Beth Kenealy,
Employee/Petitioner

v.

Excel Petroleum Transport, Inc.,
Employer/Respondent

Case # **14** WC **18076**

Consolidated cases: **none**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Peter M. O'Malley**, Arbitrator of the Commission, in the city of **New Lenox**, on **5/13/15**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] Is Petitioner entitled to any prospective medical care?
L. [x] What temporary benefits are in dispute?
[ ] TPD [x] Maintenance [x] TTD
M. [x] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [ ] Other _____

FINDINGS

On the date of accident, **1/26/14**, 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 **$49,800.92**; the average weekly wage was **$957.71**.

On the date of accident, Petitioner was **44** years of age, ***single*** with **2** dependent children.

Respondent ***has not*** paid all reasonable and necessary charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$20,432.32** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$20,432.32**.

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 $638.47 per week for 16-2/7 weeks, commencing 4/30/14 through 8/21/14, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from 1/27/14 through 5/13/15, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall be given a credit of $20,432.32 for temporary total disability benefits that have been paid.

Respondent shall pay reasonable and necessary medical services of $2,620.00, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay to Petitioner penalties of **$0.00**, as provided in Section 16 of the Act; **$0.00**, as provided in Section 19(k) of the Act; and **$0.00**, as provided in Section 19(l) of the Act.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

7/9/15
Date

ICArbDec19(b)

JUL 16 2015

STATEMENT OF FACTS:

The Arbitrator notes that at the commencement of trial, the parties indicated that they would not be proceeding on companion claim number 14 WC 17914. Instead, the present hearing and issues in dispute solely concern claim number 14 WC 18076 and a claimed date of accident of January 26, 2014.

The Arbitrator further notes that Commissioner Michael Brennan of the Illinois Workers' Compensation Commission was present during these proceedings as an observer as part of the Commission's annual arbitration evaluation process.

Petitioner, a 44 year old fuel hauler, testified that her job involved driving a tanker, loading product per customer specification and delivering product to the specified customer. The job required lifting and the taking of hoses off the truck, unloading of product, and working with additives. The lifting involved 75-80 pounds.

On January 26, 2014, Petitioner was carrying two 40 gallon jugs of additive when she slipped on diesel fuel that was covered by snow. Petitioner indicated that she held onto the additives and twisted backwards. She did not fall to the ground, but twisted to the left, and instantly felt back pain. However, Petitioner continued to work, finishing out her work day. She noted that the next morning she could not get out of bed. Petitioner described the back pain she was experiencing at the time in the lower left "soft spot" of her back. She denied any prior injury or treatment to her back. Due to her pain the morning following accident, Petitioner went to see Dr. Singla, who gave her muscle relaxants and Hydrocodone. The doctor examined Petitioner and referred her to Dr. Sharma. Dr. Sharma subsequently suggested an MRI and physical therapy, which was eventually performed at ATI. Dr. Sharma also prescribed injections, and Petitioner underwent two separate injections in her back.

Subsequently, Dr. Sharma referred Petitioner to Dr. Siemionow, who ordered a new and better quality MRI, which was performed at Advanced Physicians MRI. Petitioner was also seen by Dr. Rhode. In addition, Petitioner underwent a discogram, on the order of Dr. Siemionow. Following the discogram, Dr. Siemionow recommended fusion surgery. Petitioner desires to have the surgery. Presently, she uses a heating pad nightly, and obtained an elastic back brace. Petitioner says that she can stand pain free for one and a half to two hours.

Petitioner testified that Dr. Siemionow put her on modified work, with no prolonged standing, bending, or lifting over 20 pounds with a further restriction on driving, per DOT law, no more than 8-11 hours per day. Petitioner testified that with those restrictions she could not return to her old job with Respondent because the "head" of the ethanol hose is well over 20 pounds. The head is the loading rack which is made of cast iron.

Petitioner testified that she was off work from January 27, 2014 through September 17, 2014 and that she returned to work for Respondent on September 18, 2014. Petitioner also testified to another period off work with the Respondent beginning on February 20, 2015.

Petitioner testified that she never told Respondent about her restrictions per Dr. Siemionow and that she subsequently looked for another job within those restrictions. Petitioner indicated that she ultimately began working for United Parcel Service on approximately March 15, 2015. The UPS job involves no lifting, but does involve driving of trucks with manual and automatic transmissions, and hooking and unhooking of trailers, along with cranking of dolly wheels on the trailers. Petitioner continues to work for UPS as of the date of arbitration. Petitioner noted that she notices that her back hurts when she drives for UPS. She indicated that she recently drove to and from Dix, Illinois recently and that she had to lie on a heating pad all night and take ibuprofen as a result.

WITH RESPECT TO ISSUE (F), IS THE PETITIONER'S PRESENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY, AND (K), IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner testified on direct examination that she wishes to undergo a low back fusion surgery as recommended by her treating physician, Dr. Siemionow.

It is undisputed that Petitioner sustained accidental injuries arising out of and in the course of her employment with respect to her lower back on January 26, 2014. (See Arb.Ex.#1). Following the incident, Petitioner visited her family physician, Dr. Singla who diagnosed low back pain and referred her to Dr. Sharma. On April 30, 2014, Dr. Sharma ordered Petitioner off work and recommended a facet injection at L1-L2 and L2-L3 which was done on May 16, 2014. Petitioner next saw Dr. Sharma on June 5, 2014 and reported that the injection afforded no significant benefit. Petitioner returned on June 30, 2014 for an epidural steroid injection at L1, L2 for diagnostic purposes. On July 30, 2014, Petitioner returned and reported significant improvement with decreased lumbar pain but still complaining of para spinal muscle spasms. Dr. Sharma placed restrictions on her return to work as follows: carrying or lifting no more than 20 lbs. maximum, nor more than 4 hours per day pushing or pulling or lifting hands over shoulders.

Dr. Sharma referred Petitioner for physical therapy at Flexeon Rehabilitation where she completed 5 visits with good relief before she returned to Sharma on August 27, 2014. Dr. Sharma described her continuing pain as mild and maintained her light duty restrictions. Dr. Sharma ordered another 4 weeks of physical therapy. Petitioner returned on October 13, 2014 at which time Dr. Sharma noted that Petitioner's pain complaints were unchanged and he referred her to Dr. Siemionow for an orthopedic evaluation. On December 24, 2014, Petitioner returned to Dr. Sharma at which time he ordered a repeat MRI. On Jan. 14, 2015, the patient returned having had a new MRI on January 7, 2015 at Advanced Physician's MRI which showed disc bulging at L1-L2, L2-L3. Dr. Sharma ordered a discogram and possible further referral to Dr. Siemionow. On February 11, 2015, Petitioner returned to Dr. Sharma who ordered trigger point injections under fluoroscopic guidance. On February 24, 2015, Petitioner again presented to Dr. Sharma complaining of worsening symptoms. Dr. Sharma ordered s lumbar discogram and CT scan and released her to do full duty work. On March 4, 2015 Dr. Sharma performed the discogram at T12-L1, L1-L2. The patient was instructed to avoid lifting over 20 lbs. for the next two weeks.

Dr. Siemionow first saw the Petitioner on December 3, 2014 on referral from Dr. Sharma. Dr. Siemionow ordered a new MRI and felt Petitioner could work subject to a 50 pound weight restriction. Dr. Siemionow saw Petitioner again on April 8, 2015 at which time he reviewed the discogram that had been performed by Dr. Sharma on March 4, 2015 and the repeat MRI that had been performed on Jan. 7, 2015. Dr. Siemionow recommended a fusion at L1-L2 because he felt that her pain will worsen over time. Dr. Siemionow imposed a 20 pound maximum lifting restriction with frequent lifting of no more than 10 pounds, limited pushing pulling to 4 hours per day and limited work with hands above the shoulders to 4 hours per day. He also limited the Petitioner's bending twisting, squatting, kneeling and crawling without specific time limits. Subject to all the above restrictions, Dr. Siemionow noted that it would be okay to drive 8 hours a day subject to DOT rules.

Dr. Rhode saw Petitioner on October 15, 2014. In his opinion the Petitioner's low back pain was caused by her work injury of January 26, 2014. Dr. Rhode stated that Petitioner should consider lumbar disc fusion surgery but he would defer to the opinion of a spine surgeon.

At the request of Respondent, Petitioner visited Dr. Butler on August 21, 2014 for purposes of a §12 examination. (RX1). Dr. Butler was of the opinion that Petitioner was not in need of any additional medical

treatment related to the injury of January 26, 2014. Dr. Butler did not agree with Dr. Sharma's assessment of facet disease in the lumbar spine. Dr. Butler noted that Petitioner did not have significant facet arthropathy at any level in her lumbar spine, and that Petitioner had simply sustained a lumbar strain, without disc or spinal column injury. Dr. Butler further noted, in his report, that Petitioner had essentially normal findings on her lumbar MRI at all disc levels from L2 through S1, and disagreed with the radiologist's characterization of Petitioner's facet arthropathy. Dr. Butler noted that the only level of any abnormal disc pathology, per the MRI, had no description whatsoever of the facets. Dr. Butler's personal review of the MRI imaging did not suggest any significant facet disease in Petitioner's lumbar spine. Dr. Butler also noted that Petitioner's subjective complaints of pain did not correlate with her mild objective findings. Dr. Butler opined that Petitioner had reached MMI and was able to return to work in a regular duty capacity. While he indicated that physical therapy and imaging was reasonable and necessary, he indicated that injections were not indicated. Dr. Butler also noted that Petitioner had no radicular pain, for which an epidural would be reasonable or necessary. He also noted that Petitioner's facet joints were not abnormal at L1-2 and L2-3 and that he did not agree with the recommendation for injections by the Petitioner's treating doctors. Finally, Dr. Butler concluded that Petitioner had no resulting permanency from the injury sustained on January 26, 2014. (RX1).

Respondent also introduced evidence the UR report of Dr. Rana. (RX2). Based on the medical records provided to him, Dr. Rana diagnosed Petitioner with a lumbar strain. He noted the MRI dated February 26, 2014 did not support the prior diagnosis of "discogenic pain", with no documented evidence of a tear in the disc, as documented by the interpreted radiology. Furthermore, Dr. Rana indicated that the MRI from January 7, 2015 (RX3) showed little or no change from the earlier MRI, and again had no documentation of an annular tear. Dr. Rana noted that, as with the prior MRI, the MRI description was of disc bulges with facet arthrosis with no spinal stenosis present. Accordingly, Dr. Rana indicated that "discogenic" pain would not be entertained in the claimant's diagnoses. Dr. Rana indicated that Petitioner had evidence of tenderness to palpation of the muscles of the lumbar and thoracic region of the spine, supporting diagnoses of lumbar and thoracic spasm. With respect to causal relationship, Dr. Rana indicated that he was not able to ascertain whether the injury caused the disc bulging at L1-2, or whether that was preexisting.

Petitioner testified that she had returned to work for the Respondent driving an ethanol truck on September 18, 2014. She noted that work entailed lifting the "head" which weighted 75-80 pounds for one run per day, as opposed to her prior job involving multiple stops, delivering gasoline to gas stations. She is presently working for UPS, and is certified to drive both truck tractors with both automatic and manual transmissions. On the day prior arbitration, Petitioner drove a manual transmission UPS truck to Dix, Illinois, four hours each way, for a total of eight hours of driving. She admitted on cross-examination that she was certified by DOT via physical exam. She also described the mechanics of unhooking and re-hooking trailers, including manually rolling down the "landing gear" of the trailer, disconnecting air lines and electrical connections, pulling the "king pin" for the 5th wheel, with the reverse process involved in hooking up to trailers at freight transfer points. Petitioner last saw Dr. Sharma, on approximately March 20, 2015, after beginning her new job at UPS, and Dr. Sharma allowed the Petitioner to perform modify duty at full shift, with no limit to hours.

The last time she saw Dr. Siemionow was April 8, 2015. Petitioner testified on cross-examination that she wanted to have the fusion procedure as per Dr. Siemionow, but she has not told him that, she has not seen him since April 8, 2015, and she has no appointments to see him at present. Petitioner takes no current prescription medications and as of the arbitration date the Petitioner testified that she has no scheduled follow up doctor visits.

Based on the above, and the record taken as a whole, the Arbitrator finds that Petitioner failed to prove that her current condition of ill-being subsequent to August 21, 2014, or the date she reached maximum medical

improvement ("MMI") per Dr. Butler, was causally related to the accident on January 26, 2014. Along these lines, the Arbitrator finds the opinions of Drs. Butler and Rana as to the nature of the injury and Petitioner's need for further treatment, not to mention ability to return to work, more persuasive than those offered by Drs. Siemionow and Sharma. As a result, Petitioner's claim for benefits subsequent to August 21, 2014 is hereby denied. As such, Petitioner's claim for prospective medical treatment in the form of fusion surgery prescribed by Dr. Siemionow is likewise denied as being unreasonable and unnecessary, based on the record taken as a whole as well as the opinion of Dr. Butler, Respondent's §12 examining physician.

WITH RESPECT TO ISSUE (J), WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY AND HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES, THE ARBITRATOR FINDS AS FOLLOWS:

Based on the above, and the record taken as a whole, and in light of the Arbitrator's determination that Petitioner had reached MMI as of the date of Dr. Butler's examination on August 21, 2014 (see issue "F", supra), the Arbitrator finds that Petitioner is entitled to reasonable and necessary medical expenses incurred prior to said date totaling $2,620.00 pursuant to §8(a) and the fee schedule provisions of §8.2 of the Act. The Arbitrator notes that this includes the bill from Joliet Open MRI in the amount of $1,800.00 (PX12) and Dr. Sharma in the amount of $820.00 (PX7; DOS = 4/30/14, 6/5/14 & 7/30/14). The Arbitrator further notes that while Petitioner is entitled to expenses incurred at Flexeon Rehabilitation for dates of service from August 8, 2014 through August 21, 2014 (PX14), it appears that those bills have already been paid.

WITH RESPECT TO ISSUE (L), WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY AND/OR MAINTENANCE, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner has claimed entitlement of TTD benefits from January 27, 2014 to September 18, 2014 and again from February 20, 2015 to March 13, 2015. (See Arb.Ex.#1). The Arbitrator notes that the record does not show that Petitioner was taken off work until she first visited Dr. Sharma on April 30, 2014. Thereafter, it appears that Petitioner continued to be restricted from returning to work until the date of Dr. Butler's §12 examination on August 21, 2014.

Therefore, based on the above, and the record taken as a whole, and in light of the Arbitrator's determination that Petitioner had reached MMI as of the date of Dr. Butler's examination on August 21, 2014 (see issue "F", supra), the Arbitrator finds that Petitioner was temporarily totally disabled from April 30, 2014 through August 21, 2014, for a period of 16-2/7 weeks. Furthermore, in light of the Arbitrator's determination as to causation and prospective medical treatment (issue "F" and "K", supra), the Arbitrator finds that Petitioner failed to prove her entitled to maintenance benefits. Therefore, her claim for same is hereby denied.

WITH RESPECT TO ISSUE (M), SHOULD PENALTIES BE IMPOSED UPON THE RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that issues of law and fact existed between the parties and that Respondent's conduct in the defense of this claim was neither unreasonable nor vexatious under the circumstances. Therefore, Petitioner's request for additional compensation pursuant to §19(k) and §19(l) and attorneys' fees pursuant to §16 of the Act is hereby denied.

STATE OF ILLINOIS	)	☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
	) SS.	☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
COUNTY OF COOK	)	☒ Reverse Accident, Causal Connection	☐ Second Injury Fund (§8(e)18)
			☐ PTD/Fatal denied
		☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Love Moore,
Petitioner,

vs. No. 10 WC 16447

16IWCC0699

DCFS,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by Respondent and Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, notice, causal connection, medical expenses and temporary total disability, and being advised of the facts and law, reverses the Decision of the Arbitrator which is attached hereto and made a part hereof.

Petitioner, a 45-year old child protection investigator, alleged she developed right carpal tunnel syndrome on March 8, 2010 due to excessive keyboarding at work. The Arbitrator found that Petitioner proved she sustained a repetitive injury on that date, and awarded her temporary total disability benefits of $626.22 per week for 113-1/7 weeks for intermittent lost time between July 2, 2010 and February 24, 2014. Respondent filed a review, disputing the Arbitrator's findings of accident, notice, causation, medical and TTD. Petitioner then filed a cross-review in which she claimed the Arbitrator erred by not awarding TTD/maintenance benefits for the additional period of February 25, 2014 through June 11, 2014.

Petitioner, a child abuse investigator, testified her job duties required her to drive, interview witnesses, type and write. She testified that 80% to 90% of her 45-50 hour work week was spent typing reports on a laptop computer. On March 8, 2010, Petitioner started having pain, numbness, tingling and swelling in her hands, worse in her right. Her first medical treatment thereafter was with nurse practitioner Karen Davis, to whom Petitioner reported her symptoms started one year earlier. Petitioner told Davis she works on her computer, "all day," and that over 90% of her job was spent typing or writing.

Following unsuccessful conservative treatment under the care of Dr. Patrick Barrett, Petitioner saw Dr. Gregory Dumanian, who on June 15, 2010 performed a right endoscopic carpal tunnel release. She returned to her usual job in September 2010. Due to worsening right hand symptoms, Petitioner saw Dr. Daniel Mass, who performed an open right carpal tunnel release on January 9, 2012. Although her condition improved thereafter, Petitioner continued voicing subjective complaints to Dr. Mass, telling him she did not feel able to perform her job duties. Dr. Mass continued to treat her and authorize her off work until March 2013. Upon Petitioner's return to work, Dr. Mass recommended several ergonomic improvements to her workstation, which Respondent provided. On May 13, 2013, Dr. Mass authorized Petitioner off work, pending his recommendation that she switch jobs to one with less stress, typing and writing. Petitioner, without success, applied for other jobs within her restrictions, mostly supervisory positions which she believed required less typing.

Petitioner testified that she sustained a prior unrelated injury to her right shoulder and arm in 2008, when a computer monitor fell off a shelf striking her. According to her medical records, in November 2008 Petitioner sought treatment for right arm pain and paresthesias, the latter of which had been present even before her October 2008 shoulder injury. Since that time, Petitioner has continued to experience pain which shoots between her right shoulder and hand. In May 2013, Dr. Mass took Petitioner off work because of her complaints of right arm pain shooting into her trapezius and neck and her self-reported inability to preform full duty work. Dr. Mass recommended a TENS unit for Petitioner's pain shooting into her arm, shoulder and neck.

On cross-examination Petitioner admitted that she only spent 40% to 60% of her time at work typing. The rest of the time she performed various other tasks including filing, writing, driving her car, interviewing people, inspecting premises, taking photographs, attending meetings, speaking to other workers in the office, and going to court. She also admitted telling her doctor on July 18, 2008, almost two years before her alleged carpal tunnel injury, that she had been experiencing right arm numbness for several years.

Patricia Young testified on behalf of Respondent. She has worked for the DCFS for 22 years, six of which were as a child protection investigator. She is currently a supervisor for the Child Protection Unit, and was Petitioner's supervisor between March 2013 and May 2013. Ms. Young testified that Petitioner spent only about 30% of her time at work using a keyboard and spent the rest of her time on her other required duties, noted above.

Respondent took steps to accommodate Petitioner's condition. In April 2013, Respondent provided Petitioner with an ergonomic workstation which included a higher chair, a large ergonomic mouse and an ergonomic keyboard. Petitioner was provided with Dragon software to reduce the amount of time she needed to type, and she was moved to another location which afforded more privacy to use that dictation software. Petitioner was allowed to take breaks any time she needed to. When Petitioner requested a 4-day flex-time work schedule, Ms. Young submitted that request for approval, a process which usually took months.

In arriving at its Decision that Petitioner has not proven accident or causal connection, the Commission finds Petitioner's credibility, as well as her desire to return to her job, lacking. She gave contradicting testimony at arbitration, first testifying that her hand problems *started* on March 8, 2010, then admitting they were present before that date and that she even saw doctors for this problem in 2008. Dr. Fernandez' September 7, 2010 examination confirms Petitioner's history to him of experiencing pain, numbness and tingling in her fingers in 2009.

Petitioner misled her treating doctors regarding how much typing she did at work. She told Dr. Dumanian she spent 90% of her time at work typing (PX3), though she admitted at arbitration that it may have only been as little as 40% of her time.

When Petitioner requested a note for a 4-day/week restriction from her doctor on March 28, 2013, she told him this had already been approved by management. Dr. Mass reported, however, "Given that she would like to pursue a 4-day work week *and that the patient states this has been approved by management at her work*, we will give her note to this effect." In fact, Petitioner's request had not been approved by management, according to the testimony of Petitioner's supervisor Patricia Young, whom the Commission finds to be a credible witness. Ms. Young testified that Petitioner's request for this flex-schedule not been authorized prior to Petitioner leaving work.

Petitioner's medical records reveal that before March 8, 2010, she was not happy with her job and had been seeking other positions with DCFS as far back as 2005. Records from Dr. Mary Langley dated December 1, 2005 show she completed a form for Petitioner stating Petitioner was not able to return to her previous job, though she could work on other assignments within her agency (RX5).

In January 2007, Petitioner was working following a prolonged leave of absence due to stress and depression. Petitioner again sought treatment from Dr. Langley for complaints of somatic symptoms, and requested a medical note in order to obtain another leave of absence from her job. On March 19, 2007, while off work on *that* leave of absence, Petitioner told Dr. Langley she was terrified of going back to her job and she felt her, "only way out," was to remain on unpaid leave. Dr. Langley reported that merely discussing with Petitioner the possibility of her returning to her job brought Petitioner to tears. On March 13, 2008 Dr. Langley again reported that Petitioner should find a different, less stressful job – the same recommendation given to Petitioner by Dr. Mass on May 2013 (PX4, PX5).

Following Petitioner's January 9, 2012 carpal tunnel surgery, she displayed a similar reticence to return to her job. She told Dr. Fernandez in February 2013 that she did not wish to return to it, and was seeking other jobs which also required typing and writing (RX6).

Although Dr. Fernandez opined Petitioner's recovery following her carpal tunnel surgery should have taken only 4 months, Petitioner was able to persuade Dr. Mass to authorize her off work for 14 months, despite objective evidence showing that her recovery was progressing well. Two months after Petitioner's surgery, her therapist reported that Petitioner needed only 3 sessions to attain all of her goals. Following her last session in March 2012, Petitioner reportedly was pain free. On March 29, 2012, Petitioner was off pain medication. One month

later, Dr. Mass further documented her improving condition: her sensation had returned, she had full range of motion, and most of her Tinel's had resolved. In June 2012, Dr. Mass reported Petitioner's numbness and tingling had pretty much resolved. Notwithstanding those improvements, Petitioner continued to complain of subjective pain, and Dr. Mass continued treating her and authorizing her off work. (PX4). The Commission finds Dr. Fernandez' opinions, including his opinion that Petitioner was able to return to full duty work in her previous position as a child protection specialist without restrictions or limitations, more persuasive than those of Dr. Mass.

Causal Connection:

Both parties submitted opposing medical causation opinions via written records and reports. Drs. Barrett, Dumanian and Mass each provided an opinion that Petitioner's repetitive typing caused her right carpal tunnel syndrome. None of these doctors, however, offered any basis for their opinions, which, as even the Arbitrator noted, were conclusory. Further, their opinions were provided after receiving Petitioner's inaccurate history of having to type for up to 90% of her work day. That history was exaggerated. Patricia Young testified that Petitioner spent only about 30% of her time each day actually typing, and Petitioner admitted she only spent 40% to 60% of her day typing. Because the opinions of Drs. Barrett, Dumanian and Mass appear based on Petitioner's inaccurate history, the Commission does not find them persuasive.

Respondent presented written reports from its Section 12 expert, Dr. John Fernandez, who reviewed Petitioner's medical history and examined her on September 7, 2010 and February 14, 2013. He opined there was no evidence to support a relationship between Petitioner's work activities and the causation or aggravation of carpal tunnel syndrome. Unlike Petitioner's treating physicians, Dr. Fernandez did provide the bases of his opinion. He noted Petitioner's work activities were varied. He also reported that Petitioner was of the gender and age range in which this condition is most commonly seen. While Dr. Fernandez did report that the cause of carpal tunnel syndrome is multi-factorial, he expressly ruled out Petitioner's data entry work at Respondent as one of her causative factors (RX6). The Commission finds Dr. Fernandez' opinions to be credible and persuasive.

Accident:

The Commission finds Petitioner failed to meet her burden of proof that she had an accident or exposure to repetitive trauma on March 8, 2010. She sustained no physical trauma on that date. She did not receive any medical treatment on that date, and was not then diagnosed with carpal tunnel syndrome. There is no evidence she became unable to work due to physical collapse or need for medical treatment, or that her work performance on that date was affected. Although Petitioner testified that she "started" having problems with her hands that day, she subsequently acknowledged that her hand problems existed long before March 8, 2010.

Medical evidence strongly supports the conclusion that Petitioner's right carpal tunnel syndrome first manifested itself sometime before March 8, 2010, possibly even while she was off work on one of her leaves of absence. Petitioner saw a physician in February 2010 who gave her wrist braces to wear on both hands at night for numbness and tingling in her fingers. In May

2010 Petitioner told occupational therapist Kelly Tamberino that she had bilateral hand pain, numbness and tingling which began about one year prior. On March 4, 2009, nurse practitioner Karen Davis wrote in Petitioner's treatment plan, "...trial wrist splints as [patient] may have *some cts/tendonitis component*." One month after that, EMG and NCV tests were ordered for Petitioner by Dr. Puangpeth Jantra (RX5). Based on this evidence, the Commission finds Petitioner's condition did not manifest on March 8, 2010. For the foregoing reasons, the Commission reverses the Arbitrator's decision.

IT IS THEREFORE ORDERED BY THE COMMISSION that the July 9, 2015 Decision of the Arbitrator in this matter, 10 WC 016447, is hereby vacated and all benefits to Petitioner are denied.

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: OCT 2 8 2016

o-09/13/16
jdl/mcp
68

Joshua D. Luskin

Charles J. DeVriendt

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

MOORE, LOVE
Employee/Petitioner

Case# **10WC016447**

DCFS
Employer/Respondent

16IWCC0699

On 7/9/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.08% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

A copy of this decision is mailed to the following parties:

0062 TEPLITZ & BELL
JOEL BELL
221 N LASALLE ST SUITE 1900
CHICAGO, IL 60601

5273 ASSISTANT ATTORNEY GENERAL
MEGAN MURPHY
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

0502 STATE EMPLOYEES RETIREMENT
2101 S VETERANS PARKWAY
PO BOX 19255
SPRINGFIELD, IL 62794-9255

0499 CMS RISK MANAGEMENT
801 S SEVENTH ST 8M
PO BOX 19208
SPRINGFIELD, IL 62794-9208

CERTIFIED as a true and correct copy pursuant to 820 ILCS 305 / 14

JUL 9 - 2015

RONALD A.RASCIA, Acting Secretary
Illinois Workers' Compensation Commission

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

☐ Injured Workers' Benefit Fund (§4(d))
☐ Rate Adjustment Fund (§8(g))
☐ Second Injury Fund (§8(e)18)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Love Moore
Employee/Petitioner
v.
DCFS
Employer/Respondent

Case # 10 WC 016447

16IWCC0699

An *Application for Adjustment 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 **6/11/2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. X Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. X Was timely notice of the accident given to Respondent?
F. X Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☐ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☐ 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, **3/8/2010**, Respondent *was* operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship *did* exist between Petitioner and Respondent.

On this date, Petitioner *did* sustain an accident that arose out of and in the course of employment.

Timely notice of this accident *was* given to Respondent.

Petitioner's current condition of ill-being *is* causally related to the accident.

In the year preceding the injury, Petitioner earned **$48,843.08**; the average weekly wage was **$923.29**.

On the date of accident, Petitioner was **45** years of age, ***single*** with **1** dependent children.

Respondent *has* paid all reasonable and necessary charges for all reasonable and necessary medical services.

Respondent shall be given a credit of **$45,087.20** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$45,087.20**.

Respondent is entitled to a credit of **$0** under Section 8(j) of the Act.

ORDER

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of **$626.22** per week for **113 – 1/7** weeks, commencing **7/2/10** through **2/24/2014**, as provided in Section 8(b) of the Act and as set forth below. Respondent is entitled to a credit for TTD paid, as set forth above.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.

RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission.

STATEMENT OF INTEREST RATE If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

July 9, 2015
Date

ICArbDec19(b)

JUL 9 - 2015

FINDINGS OF FACT

On March 8, 2010, Petitioner was employed by Respondent as a Child Protection Investigator. She had worked in this position since 2006. She investigates abuse and neglect cases. She works in the office and in the field. She interviews everyone that speaks and must take complete notes. She has telephone and in-person interviews at the office. In the field, she usually hand writes notes and then types them into her computer at her office. She goes to about 4 off-site visits per week. She drives her personal car for these visits. Her car has a manual transmission and she shifts with her right hand. She works on a laptop at the office. There were no ergonomic adjustments to her work station at the time. At the office, she types forms and her notes. If the agency takes custody of a child, there are more than 100 pages of documents that must be typed. She types or takes notes while she is on the phone. Petitioner said that she worked 9 to 10 hour days, spending 80-90% of her time doing reports. Petitioner goes to court about 1 day a month. During the day, Petitioner has scheduled and unscheduled breaks and she is off work for lunch. Petitioner is right handed.

On March 8, 2010, Petitioner was having problems with her hands. She was experiencing numbness, tingling, swelling, and pain in her hands, the right more than the left. Petitioner told her supervisor about the problems that she was having with her hands.

Petitioner filled out a "Workers' Compensation Employee's Notice of Injury" form on March 11, 2010, stating: "My fingers went numb and started tingling while typing case notes." Petitioner was seen at Jesse Brown VA Medical Center on March 16, 2010. Notes from Karen Davis, FNP-BC show that Petitioner was seen on that day for "C/o feeling numbness and tingling in all fingers and pain coming down inner aspects of both forearms right index finger pain and swelling. This started over a year ago." Petitioner claimed that over 90% of her job was typing or writing. She had tried splints, heat/ice, Nsaids, adjusting her keyboard and using her other hand when using a mouse. The assessment was probable bilateral carpal tunnel syndrome. An EMG was ordered and Petitioner was referred for an orthopedic consult. She was given splints, shown exercises and given a script for Naproxen. She was off work until a diagnosis is made. Dr. Barrett authored a note of April 27, 2010 stating that Petitioner was under his care for carpal tunnel syndrome of the right wrist, due likely to repetitive typing and computer work. An ergonomic work station was required to allow the patient to return to work. (PetEx. 2)

The EMG/NCV was performed on April 27, 2010 and was said to show early or mild carpal tunnel syndrome on the right. Apparently, the findings were within normal limits, but the symptomatic right side showed half of the amplitude that the left side showed. (ResEx. 5)

Petitioner then sought care from Dr. Gregory Dumanian at Northwestern. She was seen on April 28, 2010. It was noted that Dr. Barrett thought that Petitioner's condition was work-related and that "90% of what she does is typing". At the end of the week, she complains of swelling, numbness and tingling in her hand. It gets better with rest. Her condition had been around for a year. Dr. Dumanian noted that the Tinel sign was not "significantly strong", but thought that the patient had intrinsic weakness. As conservative measures, including a steroid injection, had failed, the option of endoscopic carpal tunnel release was discussed. Dr. Dumanian thought that the condition was work related. Dr. Dumanian performed a right endoscopic carpal tunnel release on June 15, 2010. Petitioner had follow up care with Dr. Dumanian and was noted to be improving well with full range of motion. Therapy was thought to be not necessary when Petitioner was seen on June 23, 2010 and July 9, 2010. Eventually, OT was prescribed. (PetEx. 3)

Petitioner improved with therapy and returned to work on September 2, 2010. She went back to the same job. No ergonomic changes had been made. She missed a day from work on October 18, 2010. There is no off work slip for that date. As Petitioner continued to work, her hands got worse.

Petitioner next sought treatment with Dr. Daniel Mass at the University of Chicago. Dr. Mass saw Petitioner on March 15, 2011 and found that she had continued signs of Carpal tunnel syndrome. The condition was said to be "related to the original work related carpal tunnel syndrome." A repeat EMG was said to be normal, but the patient was symptomatic, so Dr. Mass recommended an open carpal tunnel release. Dr. Mass thought that the Patient had an incomplete release by the initial, endoscopic, procedure. The open procedure was done on January 9, 2012. (PetEx. 4)

Petitioner had therapy and returned to work as of March 17, 2013. When Petitioner returned to work, she was given a chair, a new mouse and voice activated dictation. The voice activated dictation did not work well at Respondent's facility. She continued to experience problems with her hand. Her job is fast paced and stressful, but she continued to work until she was taken off. As of May 13, 2013, Dr. Mass took Petitioner off work, because Respondent had not implemented Dr. Mass' recommended 4 days on, 3 days off work schedule. (PetEx. 4)

Petitioner gave Dr. Mass' note to her supervisor, Patricia Young, and has not worked since. Petitioner complained to the Office of Affirmative Action that Respondent was not accommodating her restrictions. She applied for alternative work and has not been placed. She has applied for 15 state jobs within her capabilities. Most of these positions were supervisor's positions.

Petitioner's last visit with Dr. Mass was on February 20, 2014. Dr. Mass recommended that Petitioner return to work effective February 24, 2014 at"Light Duty 12 hours/shift X 12 Weeks. Needs different position with less typing or writing." Petitioner has no follow-up visit with a physician scheduled. Petitioner has not had any contact with Respondent since May of 2013 regarding return to work. (PetEx. 5)

Petitioner had hand pain prior to March of 2010. Petitioner advised her supervisor, Michael Veamon, that her hands were bothering her in March of 2010. Veamon then instructed her to fill out the incident report documents. Petitioner testified that she had no hand injuries or problems prior to working for Respondent. She has not injured her hand since March of 2010.

She has pain in her right hand. The pain is sometimes worse than before the surgery. She takes Ibuprofen and does the exercises that were recommended by therapy. She uses her hands to drive and to go on the internet to look for jobs. She texts with her phone. Her computer work station at home is ergonomic. Petitioner is willing to try a job. She uses a TNS unit that was provided by the VA.

Petitioner was paid TTD benefits through March 16, 2013.

Petitioner was seen twice by Dr. John Fernandez for §12 examinations. In his first report of September 7, 2010, the history was of an onset of numbness and tingling in 2009, due to excessive typing and writing. Dr. Fernandez was of the opinion that carpal tunnel syndrome is multifactoral and, while its symptoms can be associated with repetitive activities, there was no evidence to support a causal connection between Petitioner's work activities and the development of or aggravation of carpal tunnel syndrome. Petitioner was at MMI and can return to full duty work. Dr. Fernandez also noted that Petitioner was symptomatic

and might need an open procedure. An Addendum Report of October 14, 2010 stated that Petitioner was capable of full duty work from March 18, 2010 to the June 15, 2010 surgery date. In his February 14, 2013 report, Dr. Fernandez noted that he discussed return to work with Petitioner and she did not think that she was capable of doing so. His diagnosis was right hand residual complaints of pain, numbness and tingling, status post 2 carpal tunnel releases. Work restrictions would be based on Petitioner's subjective complaints. Petitioner's repetitive, but varied, job activities would not cause or aggravate the condition. Petitioner is at MMI and capable of full duty work. She does not want to return to her old job, but would take a new position even if there were typing involved. Petitioner does not need further treatment. (ResEx. 6)

Petitioner's supervisor from March to May 2013, Patricia Young, testified for Respondent. Petitioner's job is difficult because you have to multi-task all the time. Petitioner's workstation was modified in April, 2013. She was given a large mouse, a new chair, a keyboard, and dragon. Petitioner requested a 4 day work schedule as an accommodation. The request was submitted and nothing came back. All the flex spots in her unit were filled in 2013. Dragon did not work well because of the noisy environment at Respondent's facility. Young was told that Petitioner's keyboard was ergonomic by a technician.

In the past, Petitioner was on non-service related leave from 1999 through 2006 and January 2007 through September of 2008.

CONCLUSIONS OF LAW

The Arbitrator adopts the above Findings of Fact in support of the Conclusions of Law set forth below.

WITH RESPECT TO ISSUE (C), DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF THE PETITIONER'S EMPLOYMENT BY THE RESPONDENT AND WITH RESPECT TO ISSUE (F), IS THE PETITIONER'S PRESENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that Petitioner sustained accidental injuries which arose out of and in the course of her employment by Respondent on March 8, 2010 and has proven that there is a causal connection between her present condition of ill-being with respect to her right hand (residual complaints of pain, numbness and tingling, status post 2 carpal tunnel release procedures) and the injury.

Petitioner's testimony and the testimony of Patricia Young establish that Petitioner's job was hand intensive and that her work station was not ergonomic. The only other risk factors for carpal tunnel syndrome that are of record are that Petitioner was a 45 year old female.

March 8, 2010 was the date that Petitioner told her supervisor of her hand pain and numbness and he asked her to fill out accident report documents. Clearly, Petitioner was noticing problems with her hands and related these problems to her work activities as of that date. The Arbitrator finds that the injury manifested on March 8, 2010, based upon Petitioner's testimony, the medical records and the injury report documents contained in Respondent's Exhibit 1. See: Durand v. Industrial Commission, 224 Ill. 2d 53 (2006)

The Arbitrator finds that Petitioner's right hand condition is causally related to the injury based on Petitioner's testimony, the medical records and the causal connection opinions set forth by Dr. Barrett, Dr. Dumanian and Dr. Mass. These opinions, while conclusary, are more persuasive than the opinion of Dr. Fernandez that typing and writing (data entry?) do not cause or aggravate carpal tunnel syndrome in light of the multifactoral etiology of carpal tunnel syndrome.

WITH RESPECT TO ISSUE (E), WAS TIMELY NOTICE OF THE ACCIDENT GIVEN TO THE RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner's testimony and Respondent's Exhibit 1 establish that timely notice, in accordance with §6 of the Act, was given.

WITH RESPECT TO ISSUE (L), WHAT AMOUNT OF COMPENSATION IS DUE FOR TEMPORARY TOTAL DISABILITY, TEMPORARY PARTIAL DISABILITY AND/OR MAINTENANCE, THE ARBITRATOR FINDS AS FOLLOWS:

Given the Arbitrator's findings above with respect to accident and causation and based upon the testimony of Petitioner, the medical records and Respondent's Exhibit 3, Petitioner establishes that she is entitled to TTD benefits for the time periods of 7/2/2010 – 9/1/2010; 10/18/2010 and 2/2/2012 – 3/16/2013, which the Parties agree is 72 weeks. Respondent disputed liability for TTD for this time period based upon its disputes on accident and causation.

Respondent does dispute the extent of TTD being claimed by Petitioner. Petitioner claims additional TTD for the time period of May 13, 2013 through June 11, 2014, a period of 21 – 3/7 weeks.

Petitioner returned to work on March 17, 2013 and worked until May 13, 2013 when Dr. Mass provided restrictions regarding days worked and a more ergonomic work station. Respondent was unable to accommodate these recommendations. Petitioner testified that her last contact with Respondent regarding return to work (other than applying for other jobs with the State) was on May 13, 2013. Respondent's witness said that some of the accommodations that were tried failed (e.g.: the dragon, the keyboard may have been ergonomic) and that Petitioner's request for a flex schedule was not followed up on. Respondent did not provide evidence of its compliance with Rule 7110.70 in response to Dr. Mass' May 13, 2013 recommendations (perhaps relying on Dr. Fernandez's no causal opinion, but having already paid TTD even after a no causal opinion was given on September 7, 2010). On the other hand, the Arbitrator is not convinced that Petitioner's efforts to find work or accommodation by Respondent have been extensive enough to award all of the requested TTD.

The Workers' Compensation Act is remedial in nature and its underlying purpose is to provide for temporary total disability, medical and rehabilitation expenses and permanent disability. The Petitioner obviously bears the burden of proving all of the elements of her case, including her entitlement to TTD benefits. Petitioner must show not only that she did not work, but that she was unable to work. Western Cartridge Co. v. Industrial Commission, 357 Ill. 29 (1934) Petitioner is entitled to TTD if she is not working and her condition has not stabilized. Interstate Scaffolding v. Illinois Workers' Compensation Comm'n, 236 Ill.2d 132 (2010)

Petitioner did not contact Respondent after tendering the May 13, 2013 note from Dr. Mass. Petitioner saw Dr. Mass on July 22, 2013 and he recommended a TNS unit (later supplied by the VA) and apparently kept petitioner off work. Petitioner had no medical care from July 22, 2013 until February 24, 2014, when Dr. Mass gave "light duty" (not defined, other than a new position with less typing or writing) restrictions. Respondent never made an effort to return Petitioner to work or follow up on her flex schedule and accommodation requests.

Given the above, the Arbitrator finds that Petitioner's condition stabilized as of February 24, 2014 and TTD benefits are awarded through that date. The total amount of TTD awarded is 113 - 1/7 weeks. Respondent is entitled to a credit for the prior benefits paid.

STATE OF ILLINOIS	)	☐ Affirm and adopt (no changes)	☐ Injured Workers' Benefit Fund (§4(d))
	) SS.	☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
COUNTY OF COOK	)	☐ Reverse Choose reason	☐ Second Injury Fund (§8(e)18)
			☐ PTD/Fatal denied
		☒ Modify down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

William Pisano,
Petitioner,

vs. No. 05 WC 49540
08 WC 47656
11 WC 16653

City of Chicago,
Respondent.

16IWCC0700

DECISION AND OPINION ON REMAND

This matter, consisting of three consolidated claims, comes before the Commission on remand from the Circuit Court of Cook County, "with instructions to evaluate the totality of evidence and provide a single award encompassing the full extent of the disability resulting from all accidents involved in this consolidated case."

Facts:

On October 31, 2005 (first claim, **05 WC 49540**), Petitioner, a 47 year old hoisting engineer for the City of Chicago, slipped on grease and fell landing on his right side with his right arm extended. He suffered a fracture of his right elbow, a sprain of his right shoulder and a contusion to and TFCC tear in his right wrist. He required surgery to his right wrist and was eventually released from care on July 13, 2007.

On December 12, 2007 (second claim, **08 WC 47656**), Petitioner sustained another injury to his right hand when, while directing traffic, a passing car's mirror struck it. He continued working after that injury for three months before receiving light duty restrictions due to wrist pain. On September 15, 2008, MercyWorks discharged Petitioner from care at maximum medical improvement (MMI), with a 30 pound lifting restriction. The parties stipulated to an average weekly wage of $1,694.28 for this claim.

On December 6, 2010 (third claim, **11 WC 16653**), Petitioner slipped and fell on ice while attending a vocational rehabilitation meeting, stemming from his December 12, 2007 claim, allegedly sustaining bilateral shoulder injuries, back strains, and requiring medical care.

On August 15, 2011, Respondent offered Petitioner an accommodated position as a watchman, at a rate of pay of $19.24 per hour, or $769.00 per week. At trial, Respondent's witness Daniel Misch testified to the duties of a watchman. Vocational rehabilitation counselor Edward Steffen testified that the watchman's position would be appropriate for Petitioner. However, Petitioner did not complete the hiring process and ultimately did not accept this job offer. The watchman's position was thereafter filled by another person.

At the time of arbitration hearing, Petitioner presented evidence that the job of a hoisting engineer which he held while working for Respondent was then paying $44.30/hour, or $1,772.00 per week.

Procedural History:

Petitioner's three claims were consolidated at a hearing on January 22, 2013. On November 15, 2013, Arbitrator Thompson-Smith issued a single opinion for all three claims.

In claim number **05 WC 49540** the Arbitrator awarded Petitioner 20% loss of his right arm ($591.77/week for 50.6 weeks) plus 30% loss of right hand (591.77/week for 61.5 weeks), under §8(e) of the Act. The Arbitrator also ordered Respondent be given a credit of $10,040.97 for medical benefits paid, and that Respondent hold Petitioner harmless from any claim by any providers of the services for which Respondent received that credit as provided by §8(j) of the Act. The Arbitrator denied the claim for penalties and attorney's fees.

In claim number **08 WC 47656** the Arbitrator found that Petitioner's injuries from that accident caused a loss of earnings, and awarded him permanent partial disability benefits of $616.45/week[1] pursuant §8(d)1 of the Act, commencing August 30, 2011 and continuing through the duration of his disability. The Arbitrator denied the claim for penalties and attorney's fees.

In claim number **11 WC 16653**, the Arbitrator awarded Petitioner no benefits, finding that his alleged injuries from December 6, 2010 arose out of and in the course of his December 12, 2007 accident alleged in **08 WC 47656**. The Arbitrator found that any award of benefits for injuries caused by the accident alleged in **11 WC 16653** were included in the award in Petitioner's claim number **08 WC 47656**.

Both parties sought review by the Commission. On May 29, 2015, the Commission entered a Decision and Opinion on Review, in which it affirmed and adopted the Arbitrator's awards in claim numbers **05 WC 49540** and **11 WC 16653**.

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[1] The Arbitrator calculated the §8(d)1 benefit to be $616.45, as follows: $1,694.28 (AWW stipulated to by the parties) - $769.60 (what Petitioner would have earned at the watchman's job) = $924.68. Two-thirds of that figure equals $616.45.

16IWCC0700

The Commission modified the Arbitrator's Decision in claim number **08 WC 47656**. In that claim, the Commission affirmed and adopted the Arbitrator's finding that Petitioner proved accident and causation. The Commission also found that the Arbitrator's award of a wage differential under §8(d)1 was appropriate, affirming the Arbitrator's finding that Petitioner failed to prove he was permanently and totally disabled, and failed to prove that there was no stable labor market for him. However, the Commission found that the Arbitrator did not correctly calculate the permanent partial disability award pursuant to §8(d)1, which requires calculating the weekly benefit rate by using the amount that Petitioner would have earned in the full performance of his duties in his prior employment at the time of hearing. The Commission modified the Arbitrator's §8(d)1 award by re-calculating the weekly benefit to be $668.27.[2] The Commission also ordered Respondent pay Petitioner: (1) $1,164.37/week for the period commencing March 12, 2008 through September 2, 2009, as temporary total disability benefits under §8(b) of the Act,[3]; (2) $1,164.37/week for the 101-4/7 week period commencing September 3, 2009 through August 14, 2011, as maintenance benefits due to incapacity from work under §8(a) of the Act,[4] and (3) related medical bills contained in Petitioner's exhibits 9 and 14 pursuant to §8(a) and §8.2 of the Act.[5]

Both parties appealed the Commission's Decision to the Circuit Court of Cook County, which entered an Order on February 16, 2016.

In claim number **05 WC 49540**, the Circuit Court found that the Commission's §8(e) permanent partial disability award was not against the manifest weight of the evidence (but see below), and it confirmed the Commission's denial of penalties and attorney's fees to Petitioner.

In claim number **11 WC 16653**, the Circuit Court confirmed the Commission's finding that benefits for any injuries arising in that claim were the result of and related to claim number **08 WC 47656.**

In claim number **08 WC 47656**, however, the Circuit Court affirmed the Commission's decision in part and reversed it in part. The Circuit Court confirmed the Commission's findings that Petitioner *did not* prove entitlement to an odd lot permanent total disability award; he *did not* prove entitlement to penalties or attorney's fees, but Petitioner *did* prove entitlement to a wage differential award pursuant to §8(d)1.

However, the Circuit Court disagreed with the Commission's Decision to award Petitioner specific injury benefits pursuant to §8(e) of the Act *and* a wage differential pursuant to §8(d)1 of the Act, relying on case law and the Act in support of its finding that this Petitioner should be awarded one or the other, but not both. The Circuit Court remanded this matter back to the Commission, with instructions to evaluate the totality of evidence and provide a single

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[2] The Commission found that the §8(d)1 weekly rate should be $668.27, calculated as follows: $1,772.00 (the amount which Petitioner could have earned as a hoisting engineer for Respondent at the time of hearing) - $769.60 (the amount he could have earned if he had accepted the watchman's job which he had been offered) = $1,002.40. Two-thirds of that figure equals $668.27.

[3] With credit to Respondent for temporary benefits paid. It should be noted that the Commission's original Order miscalculated this period as being *25 weeks*; it should be *77 weeks*.

[4] With credit to Respondent for maintenance benefits paid.

[5] With credit to Respondent for medical benefits paid, and Respondent to hold Petitioner harmless from any claim by any providers of services for which Respondent is receiving that credit as provided in §8(j) of the Act.

award encompassing the full extent of the disability resulting from all accidents involved in this consolidated case.

In so doing, the Circuit Court instructed that, "the Commissions' *[sic]* decision in all three claims should have been limited to one wage differential award stemming from the alleged accident of October 31, 2005." (Circuit Court Order, p 14). The Circuit Court relied on *Baumgardner v. Ill. Workers' Comp. Comm'n, 409 Ill. App. 3d 274 (1st Dist. 2011)* as precedent that, in cases of consolidated claims such as this, a Petitioner is entitled to a specific award under §8(e) of the Act, or a permanent partial disability award under §8(d)1 of the Act, but not both (Circuit Court Order, pp 15-17). The Circuit Court found that while Petitioner, "may have received PPD benefits for each injury[6] had they been tried separately does not require the granting of both awards." (Circuit Court Order, p 16). The Circuit Court also cited §8(d)1 of the Act as providing that the Commission may award a claimant wage-differential benefits except in cases compensated under the specific schedule set forth in paragraph (e) of §8 of the Act. The Court also found that §8(e) of the Act provides that a claimant may be granted a scheduled award but shall not receive any compensation under any other provision of the Act.

The Circuit Court found, "there is no discernable difference in Pisano's condition from the time of the reported permanent restrictions stated in May of 2007 to the time Dr. Nagel provided restrictions in June of 2008…", and therefore, "the wage differential claim should be calculated according to the alleged accident of October 21 *[sic]*, 2005." (Circuit Court Order, p 15).

In accordance with the Circuit Court's Order, the Commission has now reconsidered and reevaluated the totality of the evidence in support of Petitioner's disability. The Commission finds that the full extent of Petitioner's disability resulting from all of his accidents in this consolidated case warrants a finding of a wage differential award pursuant to §8(d)1 of the Act, commencing August 15, 2011. In so finding, the Commission now modifies its prior Order in this case dated May 29, 2015, by vacating its §8(e) award of 20% loss of use of the right arm and 30% loss of use of the right hand, in claim number **05 WC 49540**.

In further review of this matter, the Commission notes that regarding claim number **08 WC 47656**, the Commission, in its May 29, 2015 Decision, incorrectly used $1,164.37 as the TTD and Maintenance rates. Petitioner's average weekly wage, stipulated by the parties, was $1,694.28. Thus, Petitioner's weekly TTD and Maintenance awards in the Commission's May 29, 2015 Decision should have been two-thirds of that, or $1,129.52, not $1,164.37. Also, the period of TTD awarded in that Decision (March 12, 2008 through September 2, 2009) represents 77 weeks and not 25 weeks as erroneously calculated in the original Order. Accordingly, the Commission modifies its May 29, 2015 award of 25 weeks of TTD and 101-4/7 weeks of maintenance at $1,164.37/week, as indicated below.

IT IS THEREFORE ORDERED BY THE COMMISSION that its Decision of May 29, 2015 is modified as stated herein and otherwise affirmed and adopted.

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[6] The Court was referring to Petitioner's October 31, 2005 and December 12, 2007 injuries.

IT IS FURTHER ORDERED BY THE COMMISSION that the §8(e) permanent partial disability awards of 20% loss of use of the right arm and 30% loss of use of the right hand, made in its May 29, 2015 Decision, are hereby vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $1,129.52 per week commencing March 12, 2008 through September 2, 2009, a period of 77 weeks, that being the period of temporary total incapacity from work under §8(b) of the Act from claim 08 WC 47656. Respondent shall be given a credit for any benefits paid.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $1,129.52 per week commencing September 3, 2009 through August 14, 2011, a period of 101-4/7 weeks, that being the period of maintenance benefit due to incapacity from work under §8(a) of the Act from claim 08 WC 47656. Respondent shall be given a credit for any benefits paid.

IT IS FURTHER ORDERED BY THE COMMISSION that, because Petitioner's injuries from his alleged accidents caused a loss of earnings, Respondent shall pay Petitioner pursuant to §8(d)1, a wage differential in the sum of $668.27 per week commencing August 15, 2011 for the duration of Petitioner's disability. This award encompasses the full extent of Petitioner's permanent partial disability resulting from injuries relating to his October 31, 2005, December 12, 2007 and December 6, 2010 alleged accidents.

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 injuries.

No bond is required for removal of this cause to the Circuit Court. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: OCT 2 8 2016

o-10/26/16
jdl/mcp
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Joshua D. Luskin

Charles J. DeVriendt

Ruth W. White

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

Nasir Sahal,
Petitioner,

vs. NO: 08 WC 44562

Chicago Carriage Cab Company,
Respondent.

16IWCC0698

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issue of reinstatement of case and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 14, 2015 is hereby affirmed and adopted.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $100.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: OCT 2 8 2016

Joshua D. Luskin

Charles J. DeVriendt

Ruth W. White

o-10/05/16
jdl/wj
68

16IWCC0698

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF MOTION AND ORDER

ATTENTION. You must attach the motion to this notice. If the motion is not attached, this form may not be processed. Upon filing of a motion before a Commissioner on review, the moving party is responsible for payment for preparation of the transcript.

2015 DEC 14 AM 9:17

Nesir Sohal
Employee/Petitioner

Case # 08 WC 44562

v.

Chicago Carriage Cab
Employer/Respondent

TO:

On May 26, 2015, at 9:00 AM, or as soon thereafter as possible, I shall appear before the Honorable Arbitrator Carlson, or any arbitrator or commissioner appearing in his or her place at Chicago, IL, Illinois, and present the attached motion for:

___ Change of venue (#3072)
___ Consolidation of cases (#3071) (list case#)
___ Dismissal of attorney (#3052)
___ Dismissal of review (#3085)
___ Fees under Section 16 (#1600)
___ Fees under Section 16a (#1645)
___ Hearing under Sect. 19(b) (#1902)
___ Penalties under Sect. 19(k) (#1911)
___ Penalties under Sect. 19(l) (#1912)
✓ Reinstatement of case (#3074)
___ Request for hearing (#R33)
___ Withdrawal of attorney (#3073)
___ Other (explain)

Signature [signature] Petitioner ✓ Respondent ___
Matt Miller
Attorney's name and IC code # (please print)
Hetherington, Karpel, Bobber & Miller
Name of law firm, if applicable

120 N. LaSalle, Ste 2810
Street address
Chicago, IL 60602
City, State, Zip code
(312) 878-6680
Telephone number
mattmiller@hkbmlaw.com
E-mail address

ORDER

The motion is set for hearing on June 11, 2015

Signature of arbitrator or commissioner

Date

ORDER

The motion is ___ Granted ___ Withdrawn ___ Continued to ___
___ Denied ___ Dismissed ___ Set for trial (date certain) on ___

[signature]
Signature of arbitrator or commissioner

12/14/15
Date

16IWCC0698

BEFORE THE WORKERS' COMPENSATION COMMISSION
IN THE STATE OF ILLINOIS

2015 ... 14 AM 9:17

NASIR SAHAL,	)	
Petitioner,	)	
v.	)	Case No. 08 WC 44562
CHICAGO CARRIAGE CAB CO.,	)	Arbitrator Carlson
Respondent.	)	

REINSTATEMENT DENIED

STATEMENT OF FACTS

On August 20, 2014, Respondent filed its Stipulation to Substitute Attorneys. *See Attached Exhibit A.*

On August 20, 2014, at Arbitrator Carlson's status call, Case No. 08 WC 44562 was given a trial date of September 9, 2014. *See Attached Exhibit B.*

Neither Petitioner, his present counsel, nor Respondent's counsels for Case Nos. 08 WC 44561, 08 WC 50939, 12 WC 35958, and 14 WC 22744 appeared at the Chicago status call on August 20, 2014.

The clerk for Respondent's counsel on Case No. 08 WC 44562 did appear at the August 20, 2014 Chicago status call. *See Attached Exhibit B.*

On September 8, 2014, Respondent corresponded with Petitioner's former counsel Owolabi T. Alaba via telephone. Counselor informed Respondent that he had been fired by Petitioner almost two months prior. *See Attached Exhibit C.*

As of September 9, 2014, and every day prior, on information and belief, Petitioner was not represented by any attorney other than Owolabi T. Alaba on Case No. 08 WC 44562. *See Attached Exhibit C.*

As of September 9, 2014, and every day prior, on information and belief, the only appearance ever filed on behalf of Petitioner was that of his prior counselor Owolabi T. Alaba. *See Attached Exhibit C.*

Petitioner's new counsel alleges in his Motion to Reinstate 08 WC 44562 that he was employed by Petitioner as far back as July 7, 2014. Petitioner's new counsel did not file a substitution of attorney or an appearance on 08 WC 44562 until February 26, 2015. *See Petitioner's Motion in Support of Petition to Reinstate* ¶ 1-2. *See Attached Exhibit D.*

Section 7020.60 (b)(2)(C)(i) of the Rules Governing Practice Before the Workers' Compensation Commission states that for cases on file at the Commission for three years or more, the parties or their attorneys must be present at each status call and the case will be set for trial unless a written request has been made to continue the case for good cause.

Section 7020.60 (b)(2)(C) (ii) of the Rules Governing Practice Before the Workers' Compensation Commission states that failure of the Petitioner or the Petitioner's attorney to request or answer a request for a continuance in accordance with subsection (b)(2)(C)(i) above and to appear at the monthly status call on which the case appears shall result in the case being dismissed for want of prosecution, except upon a showing of good cause.

On September 9, 2014, Case No. 08 WC 44562 had been on file with the Commission for exactly five (5) years and eleven (11) months.

On September 9, 2014, Respondent appeared in front of Arbitrator Carlson. Petitioner did not appear on the September 9, 2014 trial date. Respondent informed the Arbitrator that Petitioner had fired his attorney Owolabi T. Alaba almost two months prior to September 9, 2014. No counsel appeared for Petitioner on September 9, 2014 even though Petitioner's new counsel alleges that he was employed by Petitioner as early as July 7, 2014. No other Respondent's attorneys appeared at the September 9, 2014 trial date. Arbitrator Carlson, on information and belief, on his own motion,

dismissed the case for want of prosecution. *See Attached Exhibit E. See Petitioner's Motion in Support of Petition to Reinstate* ¶ 1-2.

Petitioner's new counsel on Case No. 08 WC 44562 Matthew Miller of Hetherington, Karpel, Bobber & Miller LLC filed a Petition to Reinstate 08 WC 44562 on March 5, 2015. The Petition states that Petitioner was not informed of the dismissal until February 16, 2015. The Petition does not include an affidavit by Petitioner affirming the statement. *See Petitioner's Motion in Support of Petition to Reinstate* ¶ 15-17.

Petitioner's new counsel alleges in his Motion to Reinstate 08 WC 44562 that Case No. 08 WC 44562 had been consolidated with cases 08 WC 44561, 08 WC 50939, 12 WC 35958, and 14 WC 22744. *See Petitioner's Motion in Support of Petition to Reinstate.*

On August 18, 2014, Respondent's attorney Jennifer Rizk of Rusin Maciorowski in Case Nos. 12 WC 35958 and 14 WC 22744 filed a Motion to Consolidate cases 08 WC 44561, 08 WC 44562, 08 WC 50939, 12 WC 35958, and 14 WC 22744. *See Petitioner's Motion in Support of Petition to Reinstate* ¶ 9.

The Motion to Consolidate was heard and granted on September 23, 2014 which was 15 days after Case No. 08 WC 44562 was dismissed. *See Attached Exhibit F.*

Case No. 08 WC 44562 could not be consolidated because it had already been dismissed. *See Exhibit E.*

Petitioner's new counsel alleges in his Motion to Reinstate 08 WC 44562 that he was employed by Petitioner as far back as July 7, 2014. *See Petitioner's Motion in Support of Petition to Reinstate* ¶ 1-2.

Petitioner's new counsel did not file a substitution of attorney or an appearance on 08 WC 44562 until February 26, 2015. *See Attached Exhibit D.*

On May 8, 2015, Respondent filed its Response to Petitioner's Motion to Reinstate Case No.

08 WC 44562.

Petitioner's Petition for Reinstatement was given a hearing date of June 11, 2015.

On June 11, 2015, Petitioner's counsel and Respondent's counsel in Case No. 08 WC 44562 appeared for a hearing on reinstatement.

Petitioner did not appear for the hearing on June 11, 2015 for his own Petition to Reinstate.

At the hearing, both parties stated their arguments for the record.

Petitioner's counsel argued that Petitioner had no notice of the September 9, 2014 hearing date or the September 9, 2014 dismissal until February 16, 2015. Petitioner's counsel further argued that the case was allegedly consolidated twice in 2012. Petitioner's counsel then produced two 2012 documents which were allegedly granted motions to consolidate Case No. 08 WC 44562 with Case Nos. 08 WC 44561 and 08 WC 50939.

Respondent's counsel had never seen these alleged consolidations prior to June 11, 2015. Neither alleged consolidation was entered into evidence by Petitioner's counsel on June 11, 2015.

Irrespective of the two 2012 alleged consolidations, Case No. 08 WC 44562 was dismissed for the first time on December 16, 2013 by Arbitrator Cronin. It was subsequently reinstated and assigned to Arbitrator Carlson. *See Attached Exhibit G.*

Petitioner's counsel stated that Case No. 08 WC 44561 was allegedly settled and therefore severed from any of the three alleged consolidations.

After hearing both arguments, the Arbitrator instructed the parties to present proposed decisions and addendums to the Arbitrator no later than seven (7) days after the hearing – June 18, 2015.

ARGUMENT

I. CASE NO. 08 WC 44562 was properly dismissed on September 9, 2014.

December 16, 2013, Case No. 08 WC 44562 was dismissed by Arbitrator Cronin. Any

granted consolidations of Case No. 08 WC 44562 were effectively severed on December 16, 2013. On or about March 10, 2014 a Reinstatement hearing was held in which Case No. 08 WC 44562 was reinstated. At some point subsequent to March 10, 2014, Case No. 08 WC 44562 was reassigned by the Commission to Arbitrator Carlson.

The Commission has the right to reassign cases as it sees fit per legislative statute, the Commission's own rules and regulations, and all legal precedent since the creation of the Illinois Workers' Compensation Act.

Case No. 08 WC 44562 was given a status call date of August 20, 2014. The case was over five (5) years and ten (10) months old at the time it was given a status call date. Section 7020.60 (b)(2)(C)(i)and (ii) of the Rules Governing Practice Before the Workers' Compensation Commission states that for cases on file at the Commission for three years or more, the parties or their attorneys must be present at each status call and the case will be set for trial unless a written request has been made to continue the case for good cause. Section 7020.60 (b)(2)(C)(ii) of the Rules Governing Practice Before the Workers' Compensation Commission states that failure of the Petitioner or the Petitioner's attorney to request or answer a request for a continuance in accordance with subsection (b)(2)(C)(i) above and to appear at the monthly status call on which the case appears shall result in the case being dismissed for want of prosecution, except upon a showing of good cause. Neither Petitioner nor any counselor allegedly representing Petitioner appeared at the August 20, 2014 status call. At status call, Case No. 08 WC 44562 was assigned a trial date of September 9, 2014.

Respondent's counsel being advised of the upcoming trial date called counsel of record for Petitioner, attorney Owolabi T. Alaba, on September 8, 2014. Counselor Alaba informed Respondent's counsel that he had been fired by Petitioner over two months prior and was no longer representing Petitioner.

On August 20, 2014, Petitioner was obligated to present himself at the Commission for the status call or provide the Commission with a written request to continue the case for good cause per Sections 7020.60 (b)(2)(C)(i) and (ii) of the Rules Governing Practice Before the Workers' Compensation Commission. Petitioner nor any counsel alleging to represent Petitioner did either of these things. As of August 20, 2014, the Arbitrator had the right and responsibility to dismiss Case No. 08 WC 44562 for want of prosecution. Petitioner or any counsel alleging to represent Petitioner was given a second opportunity to comply with Sections 7020.60 (b)(2)(C)(i) and (ii) of the Rules Governing Practice Before the Workers' Compensation Commission on September 9, 2014. Neither Petitioner nor any counselor alleging to represent Petitioner did so. Case No. 08 WC 44562 was thus properly dismissed for a second time on September 9, 2014.

II. Petitioner offers this Arbitrator no reason why Case No. 08 WC 44562 was improperly dismissed.

On June 11, 2015, Petitioner's present counsel proffered no arguments to the Arbitrator as to why Case No. 08 WC 44562 was improperly dismissed on September 9, 2014. Petitioner's counsel did provide the Arbitrator with two excuses for why Case No. 08 WC 44562 should be reinstated for a second time.

Of note, Petitioner's counsel never alleged that Petitioner had no notice of the Status Call on August 20, 2014 nor the assigned trial date of September 9, 2014. Even so, if Petitioner's counsel had made such arguments, they would be irrelevant. Petitioner's counsel alleged in filed pleadings that he represented Petitioner beginning in as early as July 7, 2014. However, Petitioner's counsel failed to file his appearance on Case No. 08 WC 44562 until February 26, 2015. Thus any notice of the Status Call on August 20, 2014 would have been mailed by the Commission to Petitioner's address on file with the Commission. Legal precedent is clear that the courts take judicial notice that any correspondence placed within the possession

of the United States Postal Service is assumed to arrive at its intended destination. Petitioner was not present at the hearing on June 11, 2015 regarding the Petition to Reinstate and thus did not testify that he did not receive notice of the August 20, 2014 Status Call via USPS first class mail. No affidavit affirming the same has ever been provided to the Arbitrator or Respondent. Because Petitioner failed to appear at the June 11, 2015 hearing, Respondent was never given an opportunity to cross-examine Petitioner on whether he received notice of the August 20, 2014 Status Call via USPS first class mail. Therefore, the excuse that Petitioner had no notice of the Status Call on August 20, 2014 and thus the trial date of September 9, 2014 because of no notice should be ignored and not considered when making a determination of the merits of Petitioner's Petition to Reinstate.

Petitioner's counsel's first excuse is that a Petition to Reinstate was not timely filed within sixty (60) days of case dismissal because Petitioner allegedly never received notice of the September 9, 2014 dismissal order until February 16, 2015. Petitioner was not present at the hearing on June 11, 2015 regarding the Petition to Reinstate and thus did not testify as to the veracity of his counsel's statement. No affidavit affirming the same has ever been provided to the Arbitrator or Respondent. Because Petitioner failed to appear at the June 11, 2015 hearing, Respondent was never given an opportunity to cross-examine Petitioner on the veracity of his counsel's statement. Therefore, the excuse that the Petition to Reinstate was not timely filed because of no notice should be ignored and not considered when making a determination of the merits of Petitioner's Petition to Reinstate.

Petitioner's counsel's second excuse is that Case No. 08 WC 44562 had been consolidated on three occasions – twice in 2012, and again on September 23, 2014.

As to the alleged consolidations in 2012, no evidence by way of granted motions to consolidate was ever entered into the record on June 11, 2015. Therefore, the Arbitrator must

revert to what documentation has been filed with the Commission and/or listed on the Commission's information portal. The Commission's information portal shows that the case was consolidated on May 4, 2012. However, the Commission's portal also shows that the case was dismissed on December 16, 2013. Thus even if the case had been consolidated in 2012 it was subsequently dismissed in 2013 for want of prosecution and severed from any consolidation.

As to the thought that consolidated cases cannot be severed, Petitioner's counsel himself stated on June 11, 2015 at a pre-trial for reinstatement that Case No. 08 WC 44561 had been settled and such was severed from any consolidation. Opposing counsel's pre-trial statement lends credence to the concept that cases may be severed from consolidation by deed. In the present matter, Case No. 08 WC 44562 was effectively severed from any consolidation when it was first dismissed on December 16, 2013 and then again when it was dismissed for a second time on September 9, 2014.

As to the alleged consolidation of September 23, 2014. Any consolidation of Case No. 08 WC 44562 with any other cases is null and avoid as to the disposition of Case No. 08 WC 44562 because it had been effectively dismissed on September 9, 2014.

Petitioner has not offered this court any reason why this case was improperly dismissed on September 9, 2014. Further, Petitioner offers this court no reason why this case should be reinstated.

CONCLUSION

Petitioner failed to appear for the status call on August 20, 2014, the assigned trial date of September 9, 2014, and the hearing for reinstatement date of June 11, 2015. Petitioner was given three opportunities to comply with the rules set forth by the Commission and testify as to the merits of his

case. Petitioner failed to do so. This matter has now been dismissed on two occasions. Allowing this case to continue beyond the six (6) years and eight (8) months it has been filed with the Commission would only further prejudice Respondent's counsel's case and cause undue expense to the Respondent in the defense of this matter. WHEREFORE, for the aforementioned reasons, the Arbitrator denies Petitioner's Petition for Reinstatement of Case No. 08 WC 44562 be denied.